Community-Based Models for Aging in Place

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Introduction

The *"graying of America"* calls for new solutions to enable older Americans to age in place in their communities of choice. Aging services offered at the local, state, and federal levels encompass a range of programs—like transportation, meal assistance, and home modifications—to help older people stay in their communities. Ideally, the service programs would be user-friendly and comprehensive. But instead, they are frequently a complicated maze characterized by significant gaps in the types of services offered and significant constraints on eligibility. Moreover, program funding does not come close to keeping pace with the rapid growth of the 65 and older population.

Against this backdrop, many community grassroots initiatives have emerged, as local leaders and older adults search for options that are not readily available. This issue brief reviews three community-based models—cohousing, villages, and livable communities—that are filling critical gaps in services directed at those who want to age in place. The brief discusses the benefits and challenges of each model and suggests pathways for their expansion and integration to advance and sustain policies and programs for aging in place.

Background

Community models to support aging in place have not evolved in a vacuum. The companion brief, "All Together Now: Integrating Health and Community Supports for Older Adults," provides some context for their emergence:

- Federal funding for community supports for aging in place is limited and disjointed.

- The number of seniors seeking community-based services is growing while informal supports provided by family members and friends are shrinking.

- Evidence indicates that 50% of modifiable health outcomes are driven by social, economic, and environmental factors, highlighting the importance of building healthy communities. (Only 20% are attributable to spending on acute care.)

- The full range of programs designed to support health care- and community-based services could be reframed as collaborative strategies, not investments in one option or the other.

In addition, federally funded aging programs, other than Medicare, focus largely on low-income seniors, particularly programs that provide community-based supports. That leaves out older individuals whose incomes, although not at the poverty level, are quite modest. Shrinking state and local budgets often result in eligibility restrictions and wait-lists even for those who are eligible.

Complexity compounds the problem of access. Support service programs and organizations are a patchwork that includes Area Agencies on Aging services, faith-based programs, health services, home modifications, and daily living supports (e.g., transportation and meal assistance) that often become confusing and overwhelming. Varying eligibility criteria further complicate the landscape. Individuals and family caregivers struggle to understand the range of services and how to access available options.

Taken together, these problems set the stage for new, grassroots models that seek a holistic, integrated, and less clinical approach to supporting an aging population. Moving beyond a sole focus on immediate physical needs, these models take a wider view of successful aging, with a particular focus on community engagement that reduces social isolation. Research supports such a focus, as loneliness is a common challenge as people age and one that causes declining health and increased risk of death.[1]

Each of the three models examined here (cohousing, villages, and livable communities) seeks to enable more purposeful and sustained connections for people as they age. However, these models differ in scope and approach. Livable communities work to enhance the surrounding environment to improve options and conditions for aging in place, regardless of an individual's specific housing arrangement. Villages and cohousing create a social structure for sustained engagement and mutual support, directly providing some needed services and, to some degree, forging relationships to foster characteristics of livable communities. Unlike Villages, however, cohousing offers a planned housing environment that includes homeownership.

In many instances, these models tend to focus on middle- and upper-income populations (with the exception of charitable organizations focused on underserved populations). The tendency to serve those in the middle- and higher income brackets arguably seeks to fill a void, as many public programs concentrate on low-income populations and may not serve the middle class.

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[1] Perissinotto, C. M., Stijacic, C. I., & Covinsky, K. E. (2012). Loneliness in older persons: A predictor of functional decline and death. *Archives of Internal Medicine, 172*(14), 1078–1083.

Cohousing

Background and Description

Cohousing began in Europe in the 1970s. Modern cohousing is described as "a form of collaborative housing designed to emphasize social contact among community members while preserving and respecting individual privacy. Private homes . . . are built within a compound that affords easy access to extensive common facilities such as open space, courtyards, a playground, and a common house. The common house is the center of most cohousing communities. Typically it includes a large dining room and kitchen, recreational facilities for adults and children, a guest room, and workshops."[2] Cohousing is an intentionally designed and built community in which the community residents are active participants, if not leaders, in the design and operation of the community. The process of designing and building results in shared ownership of the entire community.[3]

Based on self-reported information to the Cohousing Association of the United States, there were 172 established communities and 127 communities being formed in the United States in 2016.[4] In 2011, there were 118 built communities, 80 of which responded to a survey from the Cohousing Association of the United States. The number of households in each surveyed community ranged from single digits to 67, with the majority in the 25- to 35-unit range. Benefits include the sense of community, particularly sharing meals, and mutual assistance that is both social and economic, such as exercise, social groups, child care, carpooling, skill sharing, and equipment exchange.

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Cohousing is predominantly organized as a condominium association and often located near large cities or universities. However, 17% of cohousing communities are located in rural areas. Cohousers usually own their units, and a few organizations typically have one or two rental units in a community. Some initiatives have a larger percentage of rental units.[5]

To date, most communities are multigenerational and offer affordable housing to both ends of the age continuum. Individuals and families starting out in their careers and older adults without family nearby take advantage of shared resources and services, including shared office space and skills exchange.

The multigenerational aspects of most cohousing communities are considered a significant benefit. However, there is growing interest in elder cohousing models. Elder-intentional communities are viewed as a way to

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2 Margolis, D., & Entin, D. (n.d.). *Report on survey of cohousing communities 2011* (p. 2.). Retrieved from http://www.cohousing.org/sites/default/files/attachments/survey_of_cohousing_communities_2011.pdf

3 Bezaitis, A. G. (2008, Summer). Changing choices—Aging in place in the 21st century. *Aging Well, 1*(3), 30. Retrieved from http://www.todaysgeriatricmedicine.com/archive/071708p30.shtml

4 The Cohousing Association of the United States. (n.d.). The cohousing directory, community metrics. Retrieved from http://www.cohousing.org/directory

5 Glass, A. P. (2013). Lessons learned from a new elder cohousing community. *Journal of Housing for the Elderly, 27*(4), 348–368.

sustain and grow relationships in existing communities and add amenities and social engagement and support through shared activities and resources. When an existing cohousing community retools to become elder cohousing, it shares many similarities with naturally occurring retirement communities (NORCs).[6] Both multigenerational and elder cohousing communities are considering how to provide more health-related support, including how to house caregivers either in communal space or in the guest rooms of an individual's unit.[7]

Cohousing is perhaps the most *intentional* community-based model, with a physical architecture that also represents perhaps the greatest shift from traditional, independent living models in the United States.[8] Cohousing's genesis in Denmark, where communal approaches are more common, may explain what early cohousers in the United States characterize as the strangeness of this model.

Relevant Research

Research about and evaluation of cohousing tends to be qualitative and to focus on individual communities. The cohousing association survey referenced above focused on descriptive characteristics of the responding organizations and used open-ended questions regarding the benefits and challenges of cohousing. More rigorous analysis has been undertaken in Europe, but the context may be too different to apply findings to a U.S. context.[9] This research concluded that rather than being utopian community models, cohousing can help to solve practical problems and can offer sustainable urban development. The review also recognized a limited amount of quantitative data and an insufficient focus on failed attempts at cohousing.

Villages

Background and Description

Villages are membership-driven, grassroots organizations run by volunteers and paid staff that provide services in members' homes and connect them to affordable services in the community.[10] The Village to Village Network estimates 205 operating and 150 forming villages in the United States in 2016. Villages

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[6] NORCS were first established to support aging residents in New York City apartment complexes. (NORC. [n.d.]. History of the Jewish Federations of North America's Aging in Place initiative. NORCs are a community-level initiative in geographic locations with high concentrations of older adults in which building owners, service providers, and older adults collaborate to provide support services to seniors in housing that is not designated for seniors [Greenfield, E. A., Scharlach, A. E., Lehning, A. J., Davitt, J. K., & Graham, C. L. (2013). A tale of two community initiatives for promoting aging in place: Similarities and differences in the national implementation of NORC programs and villages. *The Gerontologist, 53*(6), 928–938. Retrieved from http://gerontologist.oxfordjournals.org/content/53/6/928]

[7] Baker, B. (2016, February 22). *Conscious aging in cohousing community*. Retrieved from http://changingaging.org/blog/conscious-aging-in-cohousing-community/

[8] Glass, 2013.

[9] Tummers, L. (2015). The re-emergence of self-managed co-housing in Europe: A critical review of co-housing research. *Urban Studies Journal*. Retrieved from http://usj.sagepub.com/content/early/2015/05/21/0042098015586696.abstract

[10] Village to Village Network. (n.d.). About village to village network. Retrieved from http://vtvnetwork.org/content.aspx?page_id=22&club_id=691012&module_id=65139

are located in urban, suburban, and rural areas. No two villages are the same, but they share many common characteristics. Villages are

- Membership organizations that serve a targeted geography, often a neighborhood or subdivision; and

- Nonprofit, largely volunteer organizations that offer core services, such as:

  - Recreation and social events;

  - Transportation;

  - Reassurance calls and friendly visits;

  - Coordination of services;

  - Health advocacy;

  - Grocery shopping; and

  - Technology assistance.

Villages started as an aging in place initiative in 2001 but increasingly target multigenerational services. Most villages have some type of dues structure, but some are free or seek nominal payment (e.g., $25 per year). Most villages have single and household memberships; some distinguish between full memberships and associate memberships (social and referral only; not eligible for volunteer services); and many offer reduced fees for members in financial need.[11] Dues and organizational budgets vary widely: Dues range up to $948 for individuals and up to $1,285 for household memberships; and operating budgets range from $1,000 to $674,000.[12]

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The cost to individuals and households is highly affordable when considered in the broader context of healthy aging and other options. For example, annual dues may cost $1,200 per year compared with assisted living fees that could range between $3,000 and $5,000 per month.[13] Is this an unreasonable comparison? It depends on the vantage point. Assisted living offers more health services and includes the cost of housing, but it is usually a single or shared room in a facility in which individuals have little to no history and the goal of trying to keep people engaged in their community of choice is rarely part of the services or vision.

Historically, villages have been largely established by and comprised of middle- and upper-income members. Recent efforts are creating villages in communities with lower incomes. Villages also serve varying geographies from neighborhoods to cities, counties, and regions.

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[11] Average fees in 2012 were $430.75 for individual memberships and $117.30 for discounted individual memberships, or $586.91 for household memberships and $157.02 for discounted household memberships [Greenfield, E. A., Scharlach, A. E., Graham, C. L., Davitt, J. K., & Lehning, A. J. (2012, December 1). *A national overview of villages: Results of a 2012 organizational survey* (p. 4). Retrieved from http://www.neighborsnetworkfl.org/media/2012-Village-Org-Survey.pdf].

[12] Davitt, J. K., Lehning, A. J., Scharlach, A., & Greenfield, E. A. (2015). Sociopolitical and cultural contexts of community-based models in aging: The Village Initiative. *Public Policy & Aging Report, 25*(1), 15–19.

[13] Lenzner, R. (2013, May 23). Save a small fortune by forming your own retirement village. *Forbes*. Retrieved from http://www.forbes.com/sites/robertlenzner/2013/05/23/socially-minded-seniors-keep-co-op-spirit-alive-in-cambridge/#7864c1ee3d15

The Village to Village Network and regional networks like the Washington Area Villages Exchange (WAVE) continue to develop ways to share resources and infrastructure across villages and to serve as a learning network. Two examples are shared administrative information technology resources and a hub-and-spoke services model, in which more of the administrative supports for multiple villages is handled by one office with augmented staffing. These village organizations and networks seek to help new villages to minimize administrative costs and reinvention. For example, the health department in Montgomery County, Maryland, has a village coordinator and the one in Fairfax County, Virginia, has a liaison. Staff in these roles seek to form and grow villages in the suburbs that surround Washington, DC. This may explain why WAVE's Village Directory lists a large concentration of villages in the Maryland-Virginia-DC area, with 53 villages, 19 of which are in development.

Relevant Research

Despite a growing base of research on villages, gaps remain, particularly in data on longitudinal health outcomes and sustainability. Villages have been found to improve quality of life; sustain social engagement; assist individuals, particularly those living alone, with health care transitions to home; and support daily living needs, perhaps the most critical being transportation.[14] Yet village members "tend to be fairly healthy."[15] Villages are a reflection of their local particularities, including diversity or lack thereof.[16] They fill critical social gaps, such as creating a sense of purpose for retirees and facilitating awareness of and access to services and a support structure that reduces the risk of social isolation.

Villages face two main challenges:

- Possible income barriers due to the predominance of villages among middle and upper-middle income populations; and

- Concerns about the sustainability of the village infrastructure given the predominant volunteer model and the need for more integrated health care services as members age.

To address this last concern, most villages offer educational events and information about health care services and supports in their community. Villages are increasingly offering supportive health services and partnering with health services organizations. Established villages with aging members are most likely to have these services.[17] Approaches to facilitate health care services include training staff and volunteers as health advocates and note takers; hiring social workers; partnering with care management companies; affiliating with home care organizations; and working with local provider institutions.

A study about village sustainability and diverse membership[18] attributes shrinking memberships and less confidence in sustainability to the overall aging of the population that villages serve—specifically members passing away or moving to higher levels of care or closer to their families. Growth is largely attributed to marketing and promotion by word-of-mouth. Funding challenges are attributed to dues that do not cover the

[14] Graham, C. L., Scharlach, A. E., & Price Wolf, J. (2014). The impact of the "Village" Model on health, well-being, service access, and social engagement of older adults. *Health Education & Behavior, 41*(1S), 91S–97S.

[15] Graham, Scharlach, & Wolf, 2014.

[16] Davitt et al., 2015.

[17] Baker, B. (2016, February 26). How will the villages age with their members? Older residents need more help, but their neighbors are also aging. Retrieved from http://www.nextavenue.org/how-will-the-villages-age-with-their-members/

[18] Lehning, A., Davitt, J., Scharlach, A., & Greenfield, E. (2014, March 24). *Village sustainability and engaging a diverse membership: Key findings from a 2013 national survey*. Retrieved from http://www.giaging.org/documents/Village_sustainability_study_2013.pdf

cost of operations.[19] Challenges and gaps in research about villages include potential nonresponse bias that influences diversity findings; lack of longitudinal studies; reliance on self-reported data; and uncertainty about the effectiveness of villages on more frail and vulnerable individuals.

Livable Communities

Background and Description

The concept of livable communities builds on a number of initiatives, including naturally occurring retirement communities (NORCs); the World Health Organization's (WHO's) global network of age-friendly cities and its essential age-friendly city features[20]; and a commitment to improving community supports that people need throughout the life span. In the NORCs model, as the name suggests, a multidisciplinary partnership helps to create or increase access to needed services for communities that have naturally high concentrations of older individuals.[21] WHO's network started in 2006 with 33 cities from 22 countries and now includes 54 U.S. cities and communities. AARP's livable communities' network has 108 U.S. communities in 30 states; Washington, DC; and Puerto Rico.[22] These communities represent more than 50 million people (about 15.6% of the U.S. population), although the scope and status of each community's efforts differ. Livable communities tend to be publically and privately funded, but information on costs and anticipated investments is limited.

> A livable community is one that is safe and secure, has affordable and appropriate housing and transportation options, and offers supportive community features and services. Once in place, those resources enhance personal independence; allow residents to age in place; and foster residents' engagement in the community's civic, economic, and social life.

According to AARP, *"A livable community is one that is safe and secure, has affordable and appropriate housing and transportation options, and offers supportive community features and services. Once in place, those resources enhance personal independence; allow residents to age in place; and foster residents' engagement in the community's civic, economic, and social life."*

Many organizations offer support to communities seeking to become more livable (e.g., Partners for Livable Communities, Smart Growth America, Walkable and Livable Communities Institute, AARP, Grantmakers in Aging, and Community Innovations for Aging in Place [CIAIP]). These organizations often focus on a particular vantage point, such as transportation, environment and walkability, accessibility for the disabled, or architectural design.

Communities seeking to become "livable" have extensive guidance on the many infrastructure characteristics and improved services recommended to fully enable livability. WHO's eight domains of livability are outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, and community support and health services. Prioritizing changes and improvements and then the funding needed are ongoing challenges.

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[19] Lehning et al., 2014.

[20] Started in 2010, WHOs Global Network of Age-Friendly Cities and Communities "provides a global platform for information exchange, mutual learning, and support" [World Health Organization. (n.d.). About the global network of age-friendly cities and communities. Retrieved from https://extranet.who.int/agefriendlyworld/who-network/].

[21] https://norcs.org/norc-national-initiative/history

[22] AARP. (n.d.). AARP network of age-friendly communities tool kit: The member list. Retrieved from http://www.aarp.org/livable-communities/network-age-friendly-communities/info-2014/member-list.html

The livable communities' concept can support a broad range of economic, social, structural, health-related, and societal benefits. Creating environments that maintain diversity and the breadth of skills, services, and purchasing power that older adults represent can help to maintain and transform communities. It can be, in essence, a win-win, making the community attractive to the growing aging population (along with the upcoming aging population) and enabling the community to harness the strengths of that growing population.[23]

Relevant Research

The amount of research on livable or age-friendly communities in the United States or elsewhere is limited. Most data are self-reported information about satisfaction. In many respects, each community tackles a different set of priorities, and high-level consensus is reached on only what they are trying to achieve.[24]

Stanford Center on Longevity and MetLife Mature Market Institute developed indicators to help communities assess their livability. According to their report, "[T]his indicator system primarily focuses on the existence of goods, services, and infrastructure that the existing empirical literature and aging in place experts suggest may be particularly promising strategies for promoting sustainable aging in place."[25] The indicators reflect some of the research challenges and cover eight categories with no preferred ranking. The report goes on to say that communities should tailor the indicators to those that are most relevant to their needs and should prioritize which gaps to address first. In annual rankings many of the top livable cities have expensive housing and limited transportation, highlighting the potential for some benefits to overshadow other benefits, such as health care, employment, education, and community engagement.[26] Does this suggest each livable community is in the eye of the beholders or developers?

Traditional evaluation methods are stymied by the view that all livable communities are unique and their goals, design, and approach to evaluation all need to be shaped by the community's needs and priorities. The CIAIP final report[27] from a 3-year initiative to test strategies to facilitate aging in place noted that formal evaluation might be difficult because causal relationships are hard to prove given the many variables involved. If the primary goal of livable communities is sustained and healthier aging in place, then another significant challenge is insufficient longitudinal data. Critics say that livable communities are trying to do too much for too many and consequently not meeting the more pressing needs of the aging population, such as more

[23] Neal, M. B., & DeLaTorre, A. (2016, February). *The case for age-friendly communities*. Retrieved from http://www.giaging.org/documents/160302_Case_for_AFC.pdf

[24] Golant, S. M. (2014, February). Age-friendly communities: Are we expecting too much? *IRPP Insight*, 5, 13–14. Retrieved from http://irpp.org/wp-content/uploads/assets/research/faces-of-aging/age-friendly/golant-feb-2014.pdf

[25] The report touches on several models. (Stanford Center on Longevity and Metlife Mature Market Institute. [2013, March]. Livable community indicators for sustainable aging in place [p. 4]. Retrieved from https://www.metlife.com/assets/cao/mmi/publications/studies/2013/mmi-livable-communities-study.pdf)

[26] Chatterjee, A., King, J., & Irving, P (2014). *Best cities for successful aging 2014*. Santa Monica, CA: Milken Institute. http://successfulaging.milkeninstitute.org/2014/best-cities-for-successful-aging-report-2014.pdf

[27] Oberlink, M. (2014, April). *Community Innovations Aging in Place (CIAIP) final report*. Retrieved from http://www.ciaip.org/docs/final_grantee_report.pdf

tangible improved health outcomes or meeting the enhanced clinical needs of the frail elderly in a more cost-effective way.[28]

Common Characteristics and Challenges

The models described here are not mutually exclusive but can be mutually reinforcing. For example, villages and cohousing can benefit from efforts to make their surrounding environments more livable.

Similarly, all three approaches prioritize social engagement. Social isolation and loneliness, both perceived and actual, increase the risk of poorer health and mortality.[29,30] Self-reported metrics, such as enhanced social engagement and quality of life for participants in villages and cohousing, are positive and, apart from the many added services and supports, could independently warrant continued support of these initiatives. The purposeful and participatory characteristics of these initiatives among reasonably healthy individuals can also be seen as a positive trend in healthy aging, particularly in the context of demographic trends showing fewer nearby family and informal resources to support older individuals. These models recognize that, as member's age, they need options for health-related supports. This recognition also suggests an opportunity to forge the right mix of community and health services.

Cohousing and villages share some common characteristics. For example, the initial conceptualization and implementation tends to fall to a set of founding volunteers and visionaries. In addition, both skew toward individuals with middle and upper incomes, particularly cohousing given its predominant model of home ownership. Finally, both are also smaller community-based models that do not depend heavily on the broader community, public dollars, or regional infrastructure.

Livable communities require a broader stakeholder collaboration to enhance infrastructure, access to services, and opportunities to enable the more explicit goals of villages and cohousing. In essence, they provide fertile ground for individuals and groups to stay active, form social connections, and maintain their lives with needed supports that are more readily available.

All these efforts have sustainability challenges and should perhaps be viewed as the grassroots and community equivalents of the underfunded federal aging programs mentioned at the outset. This then begs several questions: Do all these programs merit replication and expansion? If so, are there cost-effective and efficient ways to replicate these and similar programs? Can this be achieved by shifting funding from health care to community-based services and initiatives?

More and more communities are seeking to improve livability and sustainability to support an aging population. There is sustained interest from a cross-section of disciplines in supporting livable communities and, to a somewhat lesser degree, villages and cohousing. There are, however, many uncertainties in the underlying drivers of if and when a community pursues any of these models, including leadership, funding, demonstrated outcomes, and the ability to measure impacts—all of which leave questions regarding sustainability and value.

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[28] Golant, 2014.

[29] Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science, 10*(2), 227–237. Retrieved from http://www.ahsw.org.uk/userfiles/ Research/Perspectives%20on%20Psychological%20Science-2015-Holt-Lunstad-227-37.pdf

[30] Perissinotto et al., 2012.

Next Steps and Considerations

The relative underfunding of community-based supports for older adults compared with health care expenditures suggests missed opportunities that could improve health and reduce health care costs. Federal programs interested in expanding community-based supports should invest in more rigorous analysis of the models that focus on such supports. In addition, given the initial success of villages and cohousing, federal, state, and local governments should identify ways to help these models and other aging in place efforts as more rigorous analysis is conducted. The initial findings on these models also suggest that public and private programs should shift their attention and investments toward a more balanced comprehensive model that provides health care services and systematically includes community-based supports that address sustained engagement and aging in place.

Government programs, and their public and private counterparts, should explore creative uses of existing health care dollars to determine how they could be redirected and how communities could be rewarded for supporting critical life-improving and sustaining activities. Given the recognized variability of community needs and initiative designs, flexible funding is critical. Here are some ways to approach these types of holistic, integrated, and community-based models:

- Building on calls for an integrated federal policy strategy[31] on aging, community-based models should be included as components of such a strategy, and partnering with community organizations could foster needed integration.

- Medicare and Medicaid managed care plans could receive enhanced payment for programs that integrate services and promote community engagement, which is consistent with emerging federal trends to incorporate community-based services.

- All relevant federal programs could build on the Sustainable Communities initiative (from the U.S. Departments of Housing and Urban Development, U.S. Department of Transportation, and the Environmental Protection Agency), perhaps through community set-asides under existing funding streams. Funding could be linked to the percentage of the "older" population.

- Existing programs for underserved older adults could cover the costs of some of these initiatives to expand their reach beyond the middle- and upper-income groups currently being served; self-directed care dollars could be used to cover support costs for villages.

- Public health funding that generally flows to county and city health departments could fund state and local programs that support community-based initiatives, similar to the county liaison (in Fairfax County, Virginia) and the village coordinator (in Montgomery County, Maryland).

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[31] Government Accountability Office. (2015, May). *Older adults: Federal strategy needed to help ensure efficient and effective delivery of home and community-based services and supports* (GAO-15-190). Retrieved from http://www.gao.gov/assets/680/670306.pdf

As programs shift some of their health care investments toward more community-based options, evaluators and program administrators should assess how these models and emerging care delivery models seeking to add community-based services meet in the middle—that is:

- What is the right mix of investments and services in specific models?

- Are blended models emerging with shifted emphasis and outcomes?

Furthermore, the programs and systems in these community-based models need to be evaluated continually to better define the impacts of the range of interventions on an agreed set of outcome metrics that measure both quality of life and clinical care. The evaluations should focus on longitudinal data for participants in all three models. For villages and cohousing, picking communities that have sufficient levels of participation in a given model, finding valid comparative populations in the same or comparable communities, and tracking data for both could dispel or validate key assertions regarding the baseline health of participants and the significance of the impacts.

The three models underscore the social fabric needed to support aging in place and to make aging in place a core component of how neighbors and communities live day-to-day, regardless of age. Community models that give the growing older population more choice and improved health warrant sustained resources to broadly expand their availability.

About the Authors

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