



Journal of Elder Policy



SPECIAL ISSUE

Older Adults' Perspectives on Service Needs and Policy Experience

IN THIS ISSUE

- *Community Aging Plans*
- *Gentrification*
- *Chosen Caregivers*
- *Senior Center Engagement*
- *Immigrant Care Workers*
- *Aging in Place*

Volume 2, Number 1 • Spring 2022



OLDER ADULTS' PERSPECTIVES ON SERVICE NEEDS AND POLICY EXPERIENCE

Facilitating Aging in Place: Planning for, Utilization and Satisfaction with Informal Supports and Formal Services for Older Adults 1

Eva Kahana PhD, Editor-in-Chief

The Chosen Child: Characteristics of Family Caregivers Selected at an Early Age to Provide Care to Their Parents 29

Joanne R. Campione, PhD, MSPH and Katarzyna A. Zebrak, PhD

A Comfort or a Threat? How Older Italians View Home Eldercare Assistants 51

Anne Barrett, PhD and Katia Vecchione, MS, RN

Residents' and Family Perspectives of Involuntary Healthcare Facility Closure and Relocation 75

*Raven H. Weaver, PhD, Karen A. Roberto, PhD, Nancy Brossoie, PhD,
and Pamela B. Teaster, PhD*

Why Don't Older Adults Use Senior Centers? Evidence from Adults Age 50 and Older in Massachusetts 103

*Ceara Somerville, MS, Nidya Velasco Roldán, MS, Cindy N. Bui, MS,
Caitlin Coyle, PhD, and Jan Mutchler, PhD*

Mobilizing a Community to Develop a Comprehensive Master Aging Plan 131

*Sallie Allgood, PhD, RN, Ryan Lavalley, PhD, OTR/L,
Cassandra Dictus, MPH, BSN, RN, Janice Tyler, BA, and
Cherie Rosemond, PhD*

(cont'd.)

**Regional Planning for Aging in Place: Older Adults’ Perceptions
of Needs and Awareness of Aging Services in Washington State 161**
*Cory Bolkan, PhD, Raven H. Weaver, PhD, Eunsae Kim, PhD,
and Bidisha Mandal, PhD*

**Anchored yet Displaced: Affordable Housing and Aging in a
Gentrifying Place 193**
Brian N. Sweeney, PhD

EDITORIAL BOARD

EDITOR IN CHIEF

Eva Kahana, PhD

Case Western Reserve University (CWRU)

Distinguished University Professor Robson Professor of Sociology, Humanities, Applied Social Science, Nursing and Medicine, Director, Elderly Care Research Center

MANAGING EDITOR

Kaitlyn Barnes Langendoerfer, MA, PhD Candidate, CWRU

EDITORIAL ASSISTANTS

Poshan Dahal, MA, CWRU

Polina Ermoshkina, MS, MGS, PhD Candidate, CWRU

Timothy Goler, PhD, Norfolk State University

EDITORIAL BOARD MEMBERS

Jacqueline Angel, PhD, University of Texas, Austin

Professor of Public Affairs and Sociology, Faculty affiliate at the Population Research Center and LBJ School Center for Health and Social Policy

Research Interests: social inequality, health, minority and Latino aging

Anne Barrett, PhD, Florida State University

Professor of Sociology, Director of Pepper Institute on Aging and Public Policy

Research Interests: subjective aging, gender and aging, social relationships in later life

Naomi R. Cahn, PhD, George Washington University

Harold H. Greene Professor of Law

Research Interests: gender and aging, familial caregiving, financial and medical planning and security

Lin Chen, PhD, Fudan University, Shanghai, China

Associate Professor of Social Work

Research Interests: older adults' caregiving relationship in the contexts of family, community, and nursing homes; implications of urbanization for caregiving in China; and developments in social and health policy for older adults

Ken Covinsky, MD, MPH, University of California, San Francisco

Professor of Medicine

Research Interests: hospital acquired disability; determinants and outcomes of functional impairment; quality of life in vulnerable elders

Richard H. Fortinsky, PhD, University of Connecticut

Professor and Health Net, Inc. Endowed Chair in Geriatrics and Gerontology, School of Medicine and UConn Center on Aging

Research Interests: home and community-based care services and models; interventions for older adults with cognitive vulnerability and their families; dementia care in health care systems; rehabilitation and functional recovery following hip fracture

Terry Hokenstad, PhD, Case Western Reserve University

Distinguished University Professor Emeritus, Ralph S. and Dorothy P. Schmitt Professor Emeritus, Jack, Joseph and Morton Mandel School of Applied Social Sciences, Professor of Global Health, School of Medicine

Research Interests: comparative service delivery systems (focused on the developed world); policies and programs promoting active ageing; age friendly cities

Robert (Bob) Hudson, PhD, Boston University

Professor of Social Welfare Policy

Research Interests: Politics and policies of aging; cross-national welfare state development; design and implementation of social policies

Nancy Kropf, PhD, Georgia State University

Dean, Perimeter College, Professor of Social Work

Research Interests: late life caregiving relationships, geriatric workforce issues, evidence based practice and interventions

Nina Kohn, JD, Syracuse University

Associate Dean of Online Education, David M. Levy L'48 Professor of Law

Research Interests: elder law and the civil rights of older adults and persons with diminished cognitive capacity, financial exploitations of the elderly, elder abuse legislation, ageism

Carol Musil, PhD, RN, FAAN, FGSA, Case Western Reserve University

The Marvin E. and Ruth Durr Denekas Professor of Nursing

Research Interests: caregiving; families; intergenerational relationships: mental health; depressive symptoms, grandparenthood

Holger Pfaff, PhD, University of Cologne

Professor, Institute for Medical Sociology, Health Services Research, and Rehabilitation Science (IMVR), Faculty of Human Sciences, Faculty of Medicine

Research Interests: health literacy, work and aging, health care systems

Jill Quadagno, PhD, Florida State University

Mildren and Claude Pepper Eminent Scholar Emerita, Research Associate, Pepper Institute on Aging and Public Policy

Research Interests: health policy, long term care, race/ethnic inequality

Karen A. Roberto, PhD, Virginia Tech

University Distinguished Professor, Center for Gerontology, Director, Institute for Society, Culture, & Environment

Research Interests: family relationships and dementia caregiving, elder abuse, rural health and aging

Richard Settersten, PhD, Oregon State University

Barbara E. Knudson Professor of Human Development and Family Sciences and Head of the School of Social and Behavioral Health Sciences

Research Interests: life transitions; social relationships; age; parenthood; social policy; inequality

Robyn Stone, DrPH, LeadingAge

Senior Vice President of Research and Co-Director, LeadingAge LTSS Center @UMass Boston

Research Interests: long term services and supports policy and delivery, affordable senior housing, aging services workforce, health and LTSS integration

Joseph White, PhD, Case Western Reserve University

Luxenberg Family Professor of Public Policy, Professor of Political Science and Professor of Population and Quantitative Health Sciences; Director, Center for Policy Studies

Research Interests: Comparing health care systems in the U.S. and other rich democracies; Social Security and Medicare; Policies to control health care spending

CASE WESTERN RESERVE UNIVERSITY ADVISORY COMMITTEE

Grover C. Gilmore, PhD

Dean Mandel School of Applied Social Sciences, Professor of Psychology

Brian Gran, PhD

Professor of Sociology and Law

David Hammack, PhD

Hiram C. Haydn Professor of History Emeritus

Sharona Hoffman, JD

*Edgar A. Hahn Professor of Law; Professor of Bioethics
sharonahoffman.com*

Diana Morris, PhD

*Florence Cellar Associate Professor of Gerontological Nursing,
Director Center on Aging and Health*

J. B. Silvers, PhD

*John R. Mannix Medical Mutual of Ohio Professor of Health Care Finance,
Professor, Banking and Finance*

Kurt Stange, MD, PhD

Distinguished University Professor, Gertrude Donnelly Hess, Professor of Oncology Research, Professor of Family Medicine & Community Health, Epidemiology & Biostatistics and Sociology

Facilitating Aging in Place: Planning for, Utilization and Satisfaction with Informal Supports and Formal Services for Older Adults

Eva Kahana PhD, *Editor-In-Chief*

The current issue of the *Journal of Elder Policy* (JEP) places services and programs for older adults in a broader environmental context. We are looking beyond specific services delivered to benefit older adults and consider the role of communities in service planning, organization, and delivery. Given our interest in macro context, it is appropriate to glance beyond the essays included in the journal and encompass our collective lived experiences. The articles published are generally submitted a few months ahead of the editorial commenting on them and describe completed research projects. Thus, recent historical events are not always reflected in articles of a given issue. Nevertheless, the macro context is important. For the past two years, the Covid Pandemic framed and shaped everyone's life experiences and we published a special issue of JEP in Spring 2021 focusing on Covid.

As spring of 2022 is arriving we are confronting another major historical trauma related to the war in Ukraine. Even though the events of this cruel war are occurring at a great distance, our access to around the clock news coverage brings the Ukrainian reality into our living rooms. Older people, who are often homebound, are thus surrounded by the brutal sounds and imagery of war. The services and programs designed to help older adults, that are the focus of issue 4 of JEP are thus contextualized against a larger backdrop of human suffering.

We cover a broad spectrum of resources and services in the current issue of JEP. These range from choice of informal caregivers to engagement with paid caregivers. We address participation in communitywide programs, such as subsidized housing and senior centers. Examples of communitywide planning efforts that solicit input from elderly residents are also considered. In most cases, older adults have a choice in availing themselves of the services offered. Location and accessibility of services as well as their appeal to users can play important roles in rates of utilization (Thomas et al., 2013). To the extent that older residents play an active role in development of services within their community, it is more likely that they will recognize the value of specific services and utilize them.

Senior centers offer recreational, educational and support programs. Such services are key features of the communities that older adults live in, as they age in place (Rowles, 2013). Community programs provide a context for and can facilitate aging in place. To the extent that older adults are aware of existing programs and perceive them to be beneficial, they are likely to utilize them and bring them alive (Wan & Odell, 1981). The programs that agencies and communities design to

benefit older adults are only viable if the services are used and appreciated. Similarly, informal supports and resources also hold benefits only if they are accepted and utilized.

Services that appeal to the young old (under age 80) typically differ from those that appeal to the old-old (over age 80) (Oswald et al., 2011). In the current issue of JEP, we also address instances of forced changes in protective environments. An important underpinning of our discussion relates to giving a voice and giving a choice to older adults in the ways that we facilitate aging in place in their community (Iwarsson et al., 2007).

As older adults age, they increasingly rely on their environment for familiarity and safety (Fincham & Weber, 2000). Such familiarity may enhance their feeling of control and comfort (Kirasic, 1991). Thus, they prefer to spend time at home and find congruence between their needs and preferences in the physical environment they live in (Kahana, 1982). Adapting their home environment to their needs and preferences provides comfort and reinforces the valuation of aging in place. Even when adverse changes take place in the neighborhood environment, many older persons prefer to remain in their familiar community (Gardner, 2011).

The current issue of JEP reaches from the individual older adult to their community. We consider existing services based on the acceptance they garner from community residents. As such, the work we present offers an ecological perspective considering the neighborhood as an important locus for aging in place. Older adults' desire to age in place, in their familiar and generally well-liked home environment (Wiles et al., 2012). Accordingly, aging in place is associated with familiarity and positive connection to both the neighborhood and the home environment, based on congruence with preferences and needs of the older person (Kahana et al., 2003). The choices older adults make in taking advantage of existing services vs. ignoring or rejecting them, to a great extent reflect their assessment that the program or service is congruent with their needs and preferences.

In my prior editorials, I took advantage of the opportunity to connect to our readers on a personal level and related the topics we covered in the Journal to my own lived experiences. Given my age (81) and my recent experiences as a widow who is dealing with some mobility challenges, I feel like a participant observer in the world of aging in place. I am grateful that my personal perspectives and lived experiences discussed thus far resonated with our readers.

A Glimpse into My Lived Experience Related to Aging in Place and the Times We Live In

As we watch the news, in March 2022, a major image we see relates to the flow of refugees leaving Ukraine under risky and harsh conditions. They are mostly young and middle-aged women and have elderly grandmothers

and children in tow. Our journal issue is focused on programs and services aimed at facilitating aging in place. The disturbing pictures we are seeing reflect a disruption of opportunities to age in place.

The news of the war in Ukraine are very salient to my past and relate to my lived experiences. My family, including my parents, my 80-year-old grandmother and me, escaped from Hungary after the revolution of 1956. I was 15 years old at the time. World War 2 ended 11 years earlier, but there were fears that Jews would again be persecuted in the aftermath of the Hungarian Revolution.

I remember sleeping restlessly on mattresses on the floor at a refugee center in Vienna, Austria. We too had to leave all of our possessions behind. My parents disagreed about taking a gold watch and wedding rings, since they were fearful of getting caught while carrying jewelry and being accused of smuggling. I remember not knowing what country would take us in. We were grateful to be accepted as immigrants to the United States. My late father, who was an appraiser of antiques in Hungary, could only find work as a dishwasher in the US. But I could realize my dreams of being able to study and become a scientist. The images I am seeing remind me of my grandmother, the vulnerability of older persons and the lack of regard for their frailty during times of war. I am hoping that the war will end with little further disruption to the lives of victims.

I am very grateful to still be working, writing, and making my voice heard. Our university had an incentive program for faculty retirements and many thought that as the oldest faculty member in my department (age 81), I would apply. But I was not tempted. The prospects of continuing to teach, mentor, and write symbolize mattering and serve as far greater rewards for me (Scarpa et al., 2021). I particularly enjoy ongoing collaboration on grants and publications with my former students.

Since we published the last issue of the JEP that was focused on the impact of the Covid pandemic on older adults, problems related to the pandemic had escalated. The recent Omicron variant of the virus has been extremely contagious and posed a major threat to wellbeing of older adults during the winter of 2022 (Kupferschmidt & Vogel, 2022). Although numbers of infections, as of March 2022, are diminishing, the virus continues to pose a threat to lives of older adults.

Reflecting on my lived experience, I have a Sabbatical this winter, but canceled plans to travel to Florida and work in a more temperate climate due to concerns over Covid. Prior to the death of my husband, Boaz in November 2020, we typically spent 6 weeks or more in Florida every winter. This year I stayed at home and continued to work and derive enjoyment from my interactions with my family and my graduate students.

I appreciate the many comments of condolences I received from readers, related to the passing of my beloved husband, Boaz. There are numerous publica-

tions that appeared in the past year that he had worked on and have him listed as a coauthor. He received the Lifetime Contribution Award of the Ohio Network on Aging posthumously this past year. Somehow, his professional contributions confirm his continuing presence in my life. He was a very good and easy-going person and I continue to feel his support and constructive presence.

Since I am on Sabbatical, I did not teach this winter. However, I attend numerous committee meetings and interact with my graduate assistants mostly over Zoom. I volunteered to supervise three additional graduate students during this Sabbatical semester and now have six assistants assigned to the Elderly Care Research Center that I direct. I find that mentoring graduate students is a very fulfilling endeavor. For graduate students, learning to publish their research is an increasingly important requisite for obtaining an academic job.

My other significant interactions are with my son Jeffrey, his wife and their two children who live in Cleveland. My grandchildren are now vaccinated, and unlike last year, they are attending school in person. We have been testing them for Covid every Friday afternoon, and given that so far, they have been healthy, they, along with their parents, visit me every weekend. My older grandson, Zeke (age 14) has autism and has been struggling with anxiety during the pandemic. Nevertheless, his parents and I enjoy spending time with him. His younger brother, Rafi (age 11) is very studious and brings joy to my home by playing the violin.

On Saturday evenings we eat dinner at my house and afterwards play three-generational scrabble, with Rafi almost always the winner. Reflecting different generational perspectives and experiences, I propose words that are familiar to me, being satisfied with my vocabulary that is honed by many years of reading. The middle generation, Rafi's parents, each have a large vocabulary, but also look up proposed unusual words in a dictionary. Rafi has a laptop computer next to him where he checks rare words. This illustrates differences in the socialization of distinct age cohorts. We celebrate good word choices by all.

I interact with my younger son, Michael who lives in Philadelphia, by email and phone. Occasionally I also visit with my 5 grandchildren in Philadelphia by Zoom. Our hope is to visit them the coming summer.

My needed hip replacement surgery has now been postponed several times because of the Covid epidemic (Ulimonen et al., 2021). I walk with a cane or walker and try to be very careful not to fall, particularly with winter snow and ice outside. Given that most hospitals only very recently opened their doors to elective surgery, I decided to wait until the weather gets warmer, and I am comfortable to voluntarily enter a medical setting.

I recently turned 81 and thus I fit the topic of this issue. I am aging in place. I have lived in my house for 36 years and do not want to think about leaving or downsizing. I do not currently utilize any formal social services. Yet, I do benefit

from commercial services that have become popular during Covid, such as Zoom conferencing and grocery delivery. Reliance on Zoom enables me to avoid travel to my office that has become difficult due to my mobility limitations. I order groceries weekly online. Furthermore, during the winter my children insisted that they drive me on errands, while there is ice and snow. On a few occasions, I was tempted to drive my car, but in the end, I stayed home and had them drive me. With the weather warming up I was able to drive to the grocery store last week. It felt like a welcome adventure.

Gerontological Perspectives on Services That Facilitate Aging in Place Included in the Current JEP Issue

An important topic we focus on in the current issue of JEP is the voluntary aspect of program participation and the underlying dimension of locus of control. Although it is generally understood that informal services and caregiving reflect greater opportunities for choices by elderly service recipients than do formal services, there are relatively few attempts to simultaneously consider informal as well as formal service programs. Ecological perspectives allow us to look at the community context in broader ways that allow consideration of the overall community that older adults inhabit. A good example of such perspectives is offered in the paper by Brian Sweeney: "Anchored, yet displaced: affordable housing and aging in a gentrifying place." This paper considers older adults experiences with the broader community, even as they benefit from subsidized housing.

Another unique feature of the current issue is simultaneous consideration of perspectives by older adults requiring services, their family members and representatives of the larger community who are involved in planning of services and policies for older adults.

Based on the papers included in this issue of JEP we gain a closer and more textured view of the interpersonal and organizational challenges involved in helping older adults age in place. There are difficult choices to be made by older individuals and their families. The organizations developing services and policies to ensure wellbeing of vulnerable older adults also encounter challenges in ensuring service utilization and satisfaction.

The papers included in this issue of JEP represent diverse disciplinary orientations of authors and diverse methodologies. Information is collected both from service planners and providers and from service utilizers and groups of older adults who are only anticipating utilization of future services.

The present issue of JEP addresses the community context of aging in place and raises questions about elder-perceived congruence between programs and services and the preferences and needs of older adults. We also have papers em-

bedded in the broader community and environmental context. We thus learn that even carefully designed and implemented programs may not always gain acceptance or broad utilization. We hope that the examples provided about the intersection between community service programs and their acceptance by older adults who are aging in place offers a broad landscape of opportunities for aging in place in one's community.

Below I provide a brief synopsis of papers included in this issue:

The Chosen Child: Characteristics of Family Caregivers Selected at an Early Age to Provide Care to Their Parents

Joanne R. Campione, PhD, MSPH and Katarzyna A. Zebrak, PhD

While we know that family members take on a large portion of the caregiving responsibilities for older adults, it is seldom discussed how the family caregiver is chosen. The authors explored this understudied topic by identifying caregivers who have been aware of their caregiving obligation since childhood. They call these individuals "Chosen Child" caregivers. These designated caregivers were less likely to be employed, less likely to receive respite care and were more bothered by emotional distress than caregivers who were not "Chosen Child" caregivers. Findings of this study support previous research showing that caregivers who do not feel like they have choice in their responsibilities are at higher risk for depression, distress and anxiety. The authors conclude with policy recommendations that encourage community and healthcare organizations to identify a caregiver's motivation for caring and to offer support in developing active coping strategies. Additionally, they suggest that broader financial compensation should be offered to caregivers who can no longer work or who may have cut back on work hours due to their caregiving responsibilities.

A Comfort or a Threat? How Older Italians View Home Eldercare Assistants

Anne Barrett, PhD and Katia Vecchione, MS, RN

Barrett and Vecchione's study examines older Italian's views of home eldercare assistants called badanti who are often immigrant women. Their approach is interesting as it explores the opinions of older adults who have not yet received care from such assistants. Despite not having received care, the participants held strong views of the badanti. These perceptions were both positive and negative. Those who knew of friends or family who received care from badanti often shared positive views. Those who expressed negative views perceived badanti as threats to their independence. Additionally, some older adults did not feel comfortable

with a stranger entering their space (home), particularly an immigrant worker. Surprisingly, some participants shared that they would rather receive care from professionals in a nursing home. The fears and concerns about formal eldercare assistants highlight anxieties about the disruption of aging in place.

Residents' and Family Perspectives of Involuntary Healthcare Facility Closure and Relocation

Raven H. Weaver, PhD, Karen A. Roberto, PhD, Nancy Brossoie, PhD, and Pamela B. Teaster, PhD

This paper examined the impacts of facility decertification and closure on residents and their families. Using a qualitative approach, the authors interviewed 27 residents and 93 family members from two facilities that lost their certification. Interviews focused on perceptions of relocation, challenges and stressors of relocation, and physical and mental effects on residents. Four themes emerged from their analysis: 1) awareness of need to relocate, 2) notification of need to relocate, 3) involvement in relocation decisions, and 4) relocation stressors (e.g. distance from family, loss of friends). In many instances, the family and residents were not alerted in a timely manner that the facility was closing and did not receive any notification of where the resident would be moved. Based on their findings, the authors suggest policy recommendations which include benefits of timely, transparent, and specific notification about closures, involvement of family and residents in decision about new arrangements, and assistance with the physical support of moving.

This paper calls attention to the importance of communication to help buffer the stressors of forced relocation. The need for institutional placement poses major stressors to older adults who can no longer age in place. Yet, a further involuntary relocation poses additional stressors that represent loss of control and unpredictability.

Why Don't Older Adults Use Senior Centers? Evidence from Adults Age 50 and Older in Massachusetts

Ceara Somerville, MS, Nidya Velasco Roldán, MS, Cindy N. Bui, MS, Caitlin Coyle, PhD, and Jan Mutchler, PhD

Using data from community-dwelling older adults aged 50 and older in eight Massachusetts communities, Somerville and colleagues set out to identify the reasons for non-participation in local senior centers. Their results found that non-attendees were likely to be younger, male, in good physical and mental health and resided in their neighborhoods for shorter amounts of time when compared to attendees. Stated reasons for non-attendance included respondents feeling that they were not

old enough, had no need or interest, not having time, not familiar with programming, and not having anyone to attend with. A small subset of the sample shared that they were still working, or had poor health, did not have transportation, that the center had inconvenient hours and that their needs were not met by the center. The authors provide recommendations for centers that may aid in recruiting current non-attendees and future cohorts of older adults. They suggest that centers should remove age requirements to encourage age integration, become more interest or service based, expand transportation, and modify their hours to accommodate the needs of current and future older adults. It thus appears that lack of program utilization is partially based on program appeal and partially due to convenience.

Mobilizing a Community to Develop a Comprehensive Master Aging Plan

Sallie Allgood, PhD, RN, Ryan Lavalley, PhD, OTR/L, Cassandra Dictus, MPH, BSN, RN, Janice Tyler, BA, and Cherie Rosemond, PhD

This paper presents a case study of developing a Master Aging Plan (MAP) in a North Carolina community. A MAP is a guide for creating an age-friendly community for older adults. This paper walks us through the steps the researchers took to engage older adults in developing the MAP. Community dwelling older adults were included in the assessment, planning, implementing and evaluations phases. Older residents expressed their views about community assets and needs. For instance, concerns included safety and walkability of neighborhoods, transportation issues, housing (affordability, livable design), social isolation, and access and knowledge of community services (health and aging). Details about planning and implementation of age-friendly initiatives were also provided. This case study provides useful guidance for other communities who wish to develop more age friendly initiatives that include partnerships between public, private, and non-profit community organizations.

Regional Planning for Aging in Place: Older Adults' Perceptions of Needs and Awareness of Aging Services in Washington State

Cory Bolkan, PhD, Raven H. Weaver, PhD, Eunsuem Kim, PhD, and Bidisha Mandal, PhD

The article by Bolkan and colleagues explored the perspectives of aging in place (AIP) from 252 community dwelling older adults (age 60+) living in a five-county region in southwest Washington state. Using telephone interviews, the authors assessed access to health services, functional support needs, and awareness of sourc-

es of support. Their results indicated that almost a third of participants had unmet care needs, with most needs related to home maintenance. This need increased with poor health but was lowered for those with adequate knowledge of aging services. Unfortunately, many respondents were not aware of local services and did not know where to get help if they should need it. Most indicated that they would rely on family members if they needed help followed by the government or community services or referrals from medical professionals. The authors suggest that local aging agencies and health care settings should partner together to educate older adults about available services to support AIP other than family members.

Anchored yet Displaced: Affordable Housing and Aging in a Gentrifying Place

Brian N. Sweeney, PhD

Sweeney's paper addresses "gentrification" that is a foundational concept of urban sociology and relates to social change in urban areas that is likely to have an impact on the lives of older adults who, based on their limited incomes, represent an economically precarious group. Sweeney conducted an ethnographic study of older adults living in two rent-controlled buildings in a gentrifying neighborhood of New York City. The elderly residents of these buildings were grateful that they could continue to live in their familiar homes and age in place in neighborhoods that have relatively high costs of living. At the same time, they were apprehensive about further neighborhood changes that could pose threats to their aging in place. Even if they can continue to afford the rent, there are other costs of gentrification, such as rising grocery costs that could pose a threat. Rosenwohl-Mack and colleagues' conceptual model that is cited by the author offers a useful explanatory framework for aging in place. The older adults identified in this paper are described as "anchored and yet simultaneously displaced." This characterization may relate to the absence of other older people in the neighborhood resulting in age segregation and a form of displacement. This paper also touches on racial inequality in housing and aging in place. Sweeney concludes the paper by asking, "In an era of urban gentrification and rising economic inequality, how can policies better address the needs of older city residents who wish to age in place?"

Facilitar el envejecimiento en su lugar: Planificación, utilización y satisfacción con apoyos informales y servicios formales para adultos mayores

Eva Kahana PhD, *Editora Principal*

La edición actual del Journal of Elder Policy (JEP) ubica los servicios y programas para adultos mayores en un contexto ambiental más amplio. Estamos mirando más allá de los servicios específicos prestados para beneficiar a los adultos mayores y consideramos el papel de las comunidades en la planificación, organización y prestación de servicios. Dado nuestro interés en el contexto macro, es apropiado mirar más allá de los ensayos incluidos en la revista y abarcar nuestras experiencias colectivas vividas. Los artículos publicados generalmente se envían unos meses antes del editorial que los comenta y describen proyectos de investigación terminados. Por lo tanto, los acontecimientos históricos recientes no siempre se reflejan en los artículos de un número determinado. Sin embargo, el contexto macro es importante. Durante los últimos dos años, la pandemia de Covid enmarcó y dio forma a las experiencias de vida de todos y publicamos un número especial de JEP en la primavera de 2021 centrado en Covid.

A medida que se acerca la primavera de 2022, nos enfrentamos a otro gran trauma histórico relacionado con la guerra en Ucrania. A pesar de que los eventos de esta guerra cruel están ocurriendo a una gran distancia, nuestro acceso a la cobertura de noticias las 24 horas del día trae la realidad ucraniana a nuestras salas de estar. Las personas mayores, que a menudo están confinadas en sus hogares, se ven rodeadas de sonidos e imágenes brutales de la guerra. Los servicios y programas diseñados para ayudar a los adultos mayores, que son el foco del número 4 de la JEP, se contextualizan así en un contexto más amplio de sufrimiento humano.

Cubrimos un amplio espectro de recursos y servicios en la edición actual de JEP. Estos van desde la elección de cuidadores informales hasta el compromiso con cuidadores pagados. Abordamos la participación en programas comunitarios, como viviendas subsidiadas y centros para personas mayores. También se consideran ejemplos de esfuerzos de planificación en toda la comunidad que solicitan aportes de los residentes mayores. En la mayoría de los casos, los adultos mayores tienen la opción de hacer uso de los servicios ofrecidos. La ubicación y la accesibilidad de los servicios, así como su atractivo para los usuarios, pueden desempeñar un papel importante en las tasas de utilización (Thomas et al., 2013). En la medida en que los residentes mayores desempeñen un papel activo en el desarrollo de servicios dentro de su comunidad, es más probable que reconozcan el valor de servicios específicos y los utilicen.

Los centros para personas mayores ofrecen programas recreativos, educativos y de apoyo. Dichos servicios son características clave de las comunidades en

las que viven los adultos mayores, a medida que envejecen en el lugar (Rowles, 2013). Los programas comunitarios brindan un contexto y pueden facilitar el envejecimiento en el lugar. En la medida en que los adultos mayores conozcan los programas existentes y los perciban como beneficiosos, es probable que los utilicen y les den vida (Wan & Odell, 1981). Los programas que las agencias y las comunidades diseñan para beneficiar a los adultos mayores solo son viables si los servicios son utilizados y apreciados. De manera similar, los apoyos y recursos informales también tienen beneficios solo si se aceptan y utilizan.

Los servicios que atraen a los jóvenes mayores (menores de 80 años) generalmente difieren de los que atraen a los mayores (mayores de 80 años) (Oswald et al., 2011). En la edición actual de JEP, también abordamos instancias de cambios forzados en entornos de protección. Una base importante de nuestra discusión se relaciona con dar voz y opciones a los adultos mayores en las formas en que facilitamos el envejecimiento en su comunidad (Iwarsson et al., 2007).

A medida que los adultos mayores envejecen, confían cada vez más en su entorno para familiarizarse y estar seguros (Finchum & Weber, 2000). Tal familiaridad puede mejorar su sensación de control y comodidad (Kirasic, 1991). Así, prefieren pasar tiempo en casa y encontrar congruencia entre sus necesidades y preferencias en el entorno físico en el que viven (Kahana, 1982). Adaptar el entorno de su hogar a sus necesidades y preferencias proporciona comodidad y refuerza la valoración del envejecimiento en el lugar. Incluso cuando se producen cambios adversos en el entorno del barrio, muchas personas mayores prefieren permanecer en su comunidad familiar (Gardner, 2011).

La edición actual de la JEP alcanza desde el adulto mayor individual a su comunidad. Consideramos los servicios existentes en función de la aceptación que obtienen de los residentes de la comunidad. Como tal, el trabajo que presentamos ofrece una perspectiva ecológica considerando el barrio como un lugar importante para envejecer en el lugar. El deseo de los adultos mayores de envejecer en su lugar, en su entorno hogareño familiar y generalmente agradable (Wiles et al., 2012). En consecuencia, envejecer en el lugar se asocia con la familiaridad y la conexión positiva tanto con el vecindario como con el entorno del hogar, en función de la congruencia con las preferencias y necesidades de la persona mayor (Kahana et al., 2003). Las elecciones que hacen los adultos mayores al aprovechar los servicios existentes versus ignorarlos o rechazarlos, en gran medida reflejan su evaluación de que el programa o servicio es congruente con sus necesidades y preferencias.

En mis editoriales anteriores, aproveché la oportunidad de conectarme con nuestros lectores a nivel personal y relacioné los temas que cubrimos en el Diario con mis propias experiencias vividas. Dada mi edad (81) y mis experiencias recientes como viuda que enfrenta algunos desafíos de movilidad, me siento como un observador participante en el mundo del envejecimiento en el lugar. Estoy

agradecido de que mis perspectivas personales y experiencias vividas discutidas hasta ahora hayan resonado con nuestros lectores.

Un vistazo a mi experiencia vivida relacionada con el envejecimiento en el lugar y los tiempos en que vivimos

Mientras miramos las noticias, en marzo de 2022, una imagen importante que vemos se relaciona con el flujo de refugiados que salen de Ucrania en condiciones duras y riesgosas. En su mayoría son mujeres jóvenes y de mediana edad y tienen abuelas ancianas e hijos a cuestas. El número de nuestra revista se centra en programas y servicios destinados a facilitar el envejecimiento en el lugar. Las imágenes inquietantes que estamos viendo reflejan una interrupción de las oportunidades para envejecer en el lugar.

Las noticias de la guerra en Ucrania son muy importantes para mi pasado y se relacionan con mis experiencias vividas. Mi familia, incluidos mis padres, mi abuela de 80 años y yo, escapamos de Hungría después de la revolución de 1956. Yo tenía 15 años en ese momento. La Segunda Guerra Mundial terminó 11 años antes, pero se temía que los judíos fueran perseguidos nuevamente después de la Revolución Húngara.

Recuerdo dormir inquieto sobre colchones en el suelo en un centro de refugiados en Viena, Austria. Nosotros también tuvimos que dejar atrás todas nuestras posesiones. Mis padres no estaban de acuerdo en llevarse un reloj de oro y anillos de matrimonio, ya que tenían miedo de que los atraparan portando joyas y los acusaran de contrabando. Recuerdo no saber en qué país nos acogería. Estábamos agradecidos de ser aceptados como inmigrantes en los Estados Unidos. Mi difunto padre, que era tasador de antigüedades en Hungría, solo pudo encontrar trabajo como lavaplatos en Estados Unidos. Pero pude realizar mis sueños de poder estudiar y convertirme en científica. Las imágenes que estoy viendo me recuerdan a mi abuela, la vulnerabilidad de las personas mayores y la falta de consideración por su fragilidad en tiempos de guerra. Espero que la guerra termine con pocas perturbaciones adicionales en la vida de las víctimas.

Estoy muy agradecida de seguir trabajando, escribiendo y haciendo oír mi voz. Nuestra universidad tenía un programa de incentivos para la jubilación de los docentes y muchos pensaron que, como el docente de mayor edad en mi departamento (81 años), presentaría una solicitud. Pero no fui tentado. Las perspectivas de continuar enseñando, asesorando y escribiendo simbolizan la importancia y sirven como recompensas mucho mayores para mí (Scarpa et al., 2021). Disfruto particularmente de la colaboración continua en subvenciones y publicaciones con mis antiguos alumnos.

Desde que publicamos el último número de la JEP que se centró en el impacto de la pandemia de Covid en los adultos mayores, los problemas relacionados

con la pandemia se habían intensificado. La variante reciente del virus Omicron ha sido extremadamente contagiosa y representó una gran amenaza para el bienestar de los adultos mayores durante el invierno de 2022 (Kupferschmidt & Vogel, 2022). Aunque el número de infecciones, a partir de marzo de 2022, está disminuyendo, el virus continúa representando una amenaza para la vida de los adultos mayores.

Reflexionando sobre mi experiencia vivida, tengo un año sabático este invierno, pero cancelé los planes para viajar a Florida y trabajar en un clima más templado debido a las preocupaciones sobre Covid. Antes de la muerte de mi esposo, Boaz, en noviembre de 2020, normalmente pasábamos 6 semanas o más en Florida cada invierno. Este año me quedé en casa y seguí trabajando y disfruté de mis interacciones con mi familia y mis estudiantes de posgrado.

Agradezco los muchos comentarios de condolencias que recibí de los lectores, relacionados con el fallecimiento de mi amado esposo, Boaz. Hay numerosas publicaciones que aparecieron el año pasado en las que había trabajado y que lo incluyen como coautor. Recibió el premio Lifetime Contribution Award de Ohio Network on Aging póstumamente el año pasado. De alguna manera, sus aportes profesionales confirman su presencia continua en mi vida. Era una persona muy buena y tranquila y sigo sintiendo su apoyo y su presencia constructiva.

Como estoy en año sabático, no enseñé este invierno. Sin embargo, asisto a numerosas reuniones de comités e interactúo con mis asistentes graduados principalmente a través de Zoom. Me ofrecí para supervisar a otros tres estudiantes graduados durante este semestre sabático y ahora tengo seis asistentes asignados al Centro de Investigación de Cuidado de Ancianos que dirijo. Encuentro que ser mentor de estudiantes de posgrado es un esfuerzo muy gratificante. Para los estudiantes de posgrado, aprender a publicar sus investigaciones es un requisito cada vez más importante para obtener un trabajo académico.

Mis otras interacciones significativas son con mi hijo Jeffrey, su esposa y sus dos hijos que viven en Cleveland. Mis nietos ahora están vacunados y, a diferencia del año pasado, asisten a la escuela en persona. Los hemos estado haciendo pruebas de Covid todos los viernes por la tarde, y dado que hasta ahora han estado sanos, ellos, junto con sus padres, me visitan todos los fines de semana. Mi nieto mayor, Zeke (14 años) tiene autismo y ha estado luchando contra la ansiedad durante la pandemia. Sin embargo, sus padres y yo disfrutamos pasar tiempo con él. Su hermano menor, Rafi (11 años) es muy estudioso y trae alegría a mi hogar tocando el violín.

Los sábados por la noche cenamos en mi casa y después jugamos al scrabble trigeracional, con Rafi casi siempre como ganador. Reflejando diferentes perspectivas y experiencias generacionales, propongo palabras que me son familiares, satisfecha con mi vocabulario afinado por muchos años de lectura. La generación intermedia, los padres de Rafi, tienen un amplio vocabulario, pero también buscan palabras inusuales propuestas en un diccionario. Rafi tiene una computadora

portátil a su lado donde revisa las palabras raras. Esto ilustra las diferencias en la socialización de distintas cohortes de edad. Celebramos las buenas elecciones de palabras de todos.

Interactúo con mi hijo menor, Michael, que vive en Filadelfia, por correo electrónico y por teléfono. De vez en cuando también visito a mis 5 nietos en Filadelfia por Zoom. Nuestra esperanza es visitarlos el próximo verano.

Mi cirugía de reemplazo de cadera necesaria ahora se pospuso varias veces debido a la epidemia de Covid (Ulimonenen al., 2021). Camino con un bastón o un andador y trato de tener mucho cuidado de no caerme, particularmente con la nieve y el hielo del invierno afuera. Dado que la mayoría de los hospitales abrieron sus puertas a la cirugía electiva recientemente, decidí esperar hasta que el clima sea más cálido y me sienta cómodo para ingresar voluntariamente a un entorno médico.

Hace poco cumplí 81 años y por lo tanto encajo en el tema de este número. Estoy envejeciendo en el lugar. Hace 36 años que vivo en mi casa y no quiero pensar en irme o reducir mi espacio. Actualmente no utilizo ningún servicio social formal. Sin embargo, me beneficio de los servicios comerciales que se han vuelto populares durante Covid, como las conferencias Zoom y la entrega de comestibles. La confianza en Zoom me permite evitar viajar a mi oficina que se ha vuelto difícil debido a mis limitaciones de movilidad. Ordeno comestibles semanalmente en línea. Además, durante el invierno mis hijos insistían en que me llevaran a hacer los mandados, mientras haya hielo y nieve. En algunas ocasiones, tuve la tentación de conducir mi automóvil, pero al final me quedé en casa y pedí que me llevaran. Con el clima más cálido, pude conducir a la tienda de comestibles la semana pasada. Se sintió como una aventura bienvenida.

Perspectivas gerontológicas sobre los servicios que facilitan el envejecimiento en el lugar incluidos en la edición actual de la JEP

Un tema importante en el que nos centramos en la edición actual de JEP es el aspecto voluntario de la participación en el programa y la dimensión subyacente del locus de control. Aunque en general se entiende que los servicios informales y el cuidado reflejan mayores oportunidades de elección para los beneficiarios de servicios de edad avanzada que los servicios formales, hay relativamente pocos intentos de considerar simultáneamente los programas de servicios formales e informales. Las perspectivas ecológicas nos permiten mirar el contexto de la comunidad de maneras más amplias que permiten la consideración de la comunidad en general que habitan los adultos mayores. Un buen ejemplo de tales perspectivas se ofrece en el artículo de Brian Sweeney: “Anclados, pero desplazados: vivienda asequible y envejecimiento en un lugar gentrificado”. Este documento considera las experiencias de los adultos mayores con la comunidad en general, incluso cuando se benefician de viviendas subsidiadas.

Otra característica única del número actual es la consideración simultánea de las perspectivas de los adultos mayores que requieren servicios, sus familiares y representantes de la comunidad en general que están involucrados en la planificación de servicios y políticas para adultos mayores.

Con base en los artículos incluidos en esta edición de JEP, obtenemos una visión más cercana y estructurada de los desafíos interpersonales y organizacionales involucrados en ayudar a los adultos mayores a envejecer en su hogar. Las personas mayores y sus familias deben tomar decisiones difíciles. Las organizaciones que desarrollan servicios y políticas para garantizar el bienestar de los adultos mayores vulnerables también enfrentan desafíos para garantizar la utilización y satisfacción del servicio.

Los artículos incluidos en este número de JEP representan diversas orientaciones disciplinarias de autores y diversas metodologías. La información se recopila tanto de los planificadores y proveedores de servicios como de los usuarios de servicios y grupos de adultos mayores que solo anticipan la utilización de servicios futuros.

El presente número de JEP aborda el contexto comunitario del envejecimiento en el lugar y plantea preguntas sobre la congruencia percibida por los ancianos entre los programas y servicios y las preferencias y necesidades de los adultos mayores. También tenemos documentos integrados en el contexto comunitario y ambiental más amplio. Por lo tanto, aprendemos que incluso los programas cuidadosamente diseñados e implementados no siempre obtienen aceptación o una amplia utilización. Esperamos que los ejemplos proporcionados sobre la intersección entre los programas de servicio comunitario y su aceptación por parte de los adultos mayores que envejecen en el lugar ofrezcan un amplio panorama de oportunidades para envejecer en el lugar en la propia comunidad.

A continuación, proporciono una breve sinopsis de los artículos incluidos en este número:

El niño elegido: características de los cuidadores familiares seleccionados a edades tempranas para cuidar a sus padres

Joanne R. Campione, PhD, MSPH y Katarzyna A. Zebrak, PhD

Si bien sabemos que los miembros de la familia asumen una gran parte de las responsabilidades del cuidado de los adultos mayores, rara vez se discute cómo se elige al cuidador familiar. Los autores exploraron este tema poco estudiado al identificar a los cuidadores que han sido conscientes de su obligación de cuidar desde la infancia. Llamamos a estos individuos cuidadores de “niños elegidos”. Estos cuidadores designados tenían menos probabilidades de estar empleados, menos probabilidades de recibir cuidado de relevo y estaban más molestos por la angus-

tia emocional que los cuidadores que no eran cuidadores de “niños elegidos”. Los hallazgos de este estudio respaldan investigaciones anteriores que muestran que los cuidadores que sienten que no tienen opciones en sus responsabilidades tienen un mayor riesgo de depresión, angustia y ansiedad. Los autores concluyen con recomendaciones de políticas que alientan a las organizaciones comunitarias y de atención médica a identificar la motivación de un cuidador para cuidar y ofrecer apoyo en el desarrollo de estrategias activas de afrontamiento. Además, sugieren que se debe ofrecer una compensación financiera más amplia a los cuidadores que ya no pueden trabajar o que pueden haber reducido las horas de trabajo debido a sus responsabilidades de cuidado.

¿Un consuelo o una amenaza? Cómo los italianos mayores ven a los asistentes de cuidado de ancianos en el hogar

Anne Barrett, PhD y Katia Vecchione, MS, RN

El estudio de Barrett y Vecchione examina las opiniones de los italianos mayores sobre las asistentes de cuidado de ancianos en el hogar llamadas badanti, que a menudo son mujeres inmigrantes. Su abordaje es interesante ya que explora las opiniones de los adultos mayores que aún no han recibido atención de tales asistentes. A pesar de no haber recibido atención, los participantes tenían fuertes opiniones sobre los badanti. Estas percepciones eran tanto positivas como negativas. Aquellos que sabían de amigos o familiares que recibieron atención de badanti a menudo compartieron opiniones positivas. Aquellos que expresaron opiniones negativas percibieron a los badanti como amenazas a su independencia. Además, algunos adultos mayores no se sentían cómodos con la entrada de un extraño en su espacio (hogar), particularmente un trabajador inmigrante. Sorprendentemente, algunos participantes compartieron que preferirían recibir atención de profesionales en un asilo de ancianos. Los temores y las preocupaciones acerca de los asistentes formales para el cuidado de personas mayores resaltan las ansiedades sobre la interrupción del envejecimiento en el lugar.

Perspectivas de los residentes y sus familias sobre el cierre y la reubicación involuntarios de los establecimientos de salud

Raven H. Weaver, PhD, Karen A. Roberto, PhD, Nancy Brossoie, PhD, y Pamela B. Teaster, PhD

Este documento examinó los impactos de la descertificación y el cierre de instalaciones en los residentes y sus familias. Utilizando un enfoque cualitativo, los autores entrevistaron a 27 residentes y 93 familiares de dos establecimientos que perdieron su certificación. Las entrevistas se centraron en las percepciones de la reubicación, los desafíos y factores estresantes de la reubicación y los efectos fi-

sicos y mentales en los residentes. De su análisis surgieron cuatro temas: 1) conciencia de la necesidad de reubicarse, 2) notificación de la necesidad de reubicarse, 3) participación en las decisiones de reubicación y 4) factores estresantes de la reubicación (p. ej., distancia de la familia, pérdida de amigos). En muchos casos, la familia y los residentes no fueron alertados de manera oportuna de que la instalación estaba cerrando y no recibieron ninguna notificación de adónde se trasladaría al residente. Con base en sus hallazgos, los autores sugieren recomendaciones de políticas que incluyen beneficios de notificación oportuna, transparente y específica sobre cierres, participación de la familia y los residentes en la decisión sobre nuevos arreglos y asistencia con el apoyo físico de la mudanza.

Este documento llama la atención sobre la importancia de la comunicación para ayudar a amortiguar los factores estresantes de la reubicación forzosa. La necesidad de una colocación institucional plantea grandes factores de estrés para los adultos mayores que ya no pueden envejecer en el lugar. Sin embargo, una nueva reubicación involuntaria plantea factores estresantes adicionales que representan la pérdida de control y la imprevisibilidad.

¿Por qué los adultos mayores no utilizan los centros para mayores? Evidencia de los adultos mayores de 50 años en Massachusetts

*Ceara Somerville, MS, Nidya Velasco Roldán, MS, Cindy N. Bui, MS,
Caitlin Coyle, PhD y Jan Mutchler, PhD*

Utilizando datos de adultos mayores de 50 años o más que viven en la comunidad en ocho comunidades de Massachusetts, Somerville y sus colegas se propusieron identificar las razones de la no participación en los centros locales para personas mayores. Sus resultados encontraron que los que no asistieron probablemente eran más jóvenes, hombres, con buena salud física y mental y residían en sus vecindarios por períodos más cortos en comparación con los asistentes. Las razones declaradas para la no asistencia incluyeron que los encuestados sintieran que no tenían la edad suficiente, que no tenían necesidad o interés, que no tenían tiempo, que no estaban familiarizados con la programación y que no tenían a nadie con quien asistir. Un pequeño subconjunto de la muestra compartió que todavía estaban trabajando, o tenían problemas de salud, no tenían transporte, que el centro tenía horarios inconvenientes y que el centro no satisfacía sus necesidades. Los autores brindan recomendaciones para los centros que pueden ayudar a reclutar a los no asistentes actuales y futuras cohortes de adultos mayores. Sugieren que los centros deben eliminar los requisitos de edad para fomentar la integración de edades, basarse más en los intereses o servicios, ampliar el transporte y modificar sus horarios para adaptarse a las necesidades de los adultos mayores actuales y futuros. Por lo tanto, parece que la falta de utilización del programa se basa en parte en el atractivo del programa y en parte debido a la conveniencia.

Movilización de una comunidad para desarrollar un plan maestro integral para el envejecimiento

Sallie Allgood, PhD, RN, Ryan Lavalley, PhD, OTR/L, Cassandra Dictus, MPH, BSN, RN, Janice Tyler, BA y Cherie Rosemond, PhD

Este documento presenta un estudio de caso del desarrollo de un Plan Maestro para el Envejecimiento (MAP) en una comunidad de Carolina del Norte. Un MAP es una guía para crear una comunidad amigable para los adultos mayores. Este documento nos guía a través de los pasos que tomaron los investigadores para involucrar a los adultos mayores en el desarrollo del MAP. Los adultos mayores residentes en la comunidad fueron incluidos en las fases de diagnóstico, planificación, implementación y evaluación. Los residentes mayores expresaron sus puntos de vista sobre los bienes y necesidades de la comunidad. Por ejemplo, las preocupaciones incluyeron la seguridad y la accesibilidad para peatones de los vecindarios, problemas de transporte, vivienda (asequibilidad, diseño habitable), aislamiento social y acceso y conocimiento de los servicios comunitarios (salud y envejecimiento). También se proporcionaron detalles sobre la planificación e implementación de iniciativas adaptadas a las personas mayores. Este estudio de caso proporciona una guía útil para otras comunidades que deseen desarrollar iniciativas más amigables con las personas mayores que incluyan asociaciones entre organizaciones comunitarias públicas, privadas y sin fines de lucro.

Planificación Regional para el Envejecimiento en el Lugar: Percepciones de los Adultos Mayores sobre las Necesidades y Conciencia de los Servicios para el Envejecimiento en el Estado de Washington

Cory Bolkan, PhD, Raven H. Weaver, PhD, Eunsam Kim, PhD y Bidisha Mandal, PhD

El artículo de Bolkan y sus colegas exploró las perspectivas del envejecimiento en el lugar (AIP, por sus siglas en inglés) de 252 adultos mayores que viven en la comunidad (mayores de 60 años) que viven en una región de cinco condados en el suroeste del estado de Washington. Mediante entrevistas telefónicas, los autores evaluaron el acceso a los servicios de salud, las necesidades de apoyo funcional y el conocimiento de las fuentes de apoyo. Sus resultados indicaron que casi un tercio de los participantes tenían necesidades de atención no satisfechas, y la mayoría de las necesidades estaban relacionadas con el mantenimiento del hogar. Esta necesidad aumentó con la mala salud, pero disminuyó para aquellos con un conocimiento adecuado de los servicios para el envejecimiento. Desafortunadamente, muchos encuestados no conocían los servicios locales y no sabían dónde obtener ayuda en caso de necesitarla. La mayoría indicó que confiarían en los miembros

de la familia si necesitaran ayuda, seguida de los servicios del gobierno o de la comunidad o referencias de profesionales médicos. Los autores sugieren que las agencias locales de envejecimiento y los entornos de atención de la salud deberían asociarse para educar a los adultos mayores sobre los servicios disponibles para apoyar a AIP que no sean miembros de la familia.

Anclados pero desplazados: vivienda asequible y envejecimiento en un lugar en proceso de gentrificación

Brian N. Sweeney, PhD

El artículo de Sweeney aborda la “gentrificación”, que es un concepto fundamental de la sociología urbana y se relaciona con el cambio social en las áreas urbanas que probablemente tendrá un impacto en la vida de los adultos mayores que, en función de sus ingresos limitados, representan un grupo económicamente precario. Sweeney realizó un estudio etnográfico de adultos mayores que vivían en dos edificios de alquiler controlado en un barrio aburguesado de la ciudad de Nueva York. Los ancianos residentes de estos edificios estaban agradecidos de poder continuar viviendo en sus hogares familiares y envejecer en vecindarios que tienen costos de vida relativamente altos. Al mismo tiempo, estaban preocupados por los cambios adicionales en el vecindario que podrían representar una amenaza para su envejecimiento en el lugar. Incluso si pueden continuar pagando el alquiler, existen otros costos de gentrificación, como el aumento de los costos de los comestibles que podrían representar una amenaza. El modelo conceptual de Rosenwohl-Mack y colegas que cita el autor ofrece un marco explicativo útil para el envejecimiento en el lugar. Los adultos mayores identificados en este documento se describen como “anclados y, sin embargo, simultáneamente desplazados”. Esta caracterización puede estar relacionada con la ausencia de otras personas mayores en el barrio, lo que genera una segregación por edad y una forma de desplazamiento. Este documento también aborda la desigualdad racial en la vivienda y el envejecimiento en el lugar. Sweeney concluye el documento preguntando: “En una era de gentrificación urbana y creciente desigualdad económica, ¿cómo pueden las políticas abordar mejor las necesidades de los residentes mayores de la ciudad que desean envejecer en el lugar?”

促进就地养老：面向老年人的非正式支持和正式服务的规划、利用以及满意度

EVA KAHANA 博士，主编

本期《老年政策杂志》（JEP）将面向老年人的服务和项目置于更广泛的环境情境中。我们不仅关注让老年人受益的特定服务，还考量了社区在服务规划、组织和交付中的作用。鉴于我们对宏观情境的关注，除了本刊收录的文章，将我们的集体生活经历也纳入探讨范围内是合适的。待发表的文章通常在社论撰写前几个月提交，并描述已完成的研究课题。因此，近期的历史事件并不总是反映在研究特定问题的文章中。尽管如此，宏观背景是重要的。过去两年里，新冠疫情大流行建构并塑造了每个人的生活经历，我们在 2021 年春季出版了以Covid为重点的 JEP 特刊。

随着 2022 年春天的到来，我们正面临与乌克兰战争相关的另一重大历史创伤。尽管这场残酷战争发生在遥远的地方，但我们对全天候新闻报道的获取将乌克兰的现实带入了我们的客厅。经常居家的老年人因此被残酷的战争声响和图像所包围。JEP 第4期内容聚焦于旨在帮助老年人的服务和计划，这些服务和计划因此被置于更大的人类苦难情境中。

我们在本期 JEP 中涵盖了广泛的资源和服务。研究范围包括非正式照顾者的选择和有偿照顾者的参与。我们研究了社区计划中的参与，例如补贴住房和老年人中心。考量的实例包括征求老年居民意见的社区规划工作。在大多数情况下，老年人可以选择使用所提供的服务。服务的位置和可获取性以及其对用户的吸引力能在利用率方面发挥重要作用（Thomas et al., 2013）。如果老年居民在社区内的服务发展中发挥积极作用，他们就更有可能认可特定服务的价值并加以利用。

老年中心提供一系列娱乐性、教育性和支持项目。鉴于老年人就地养老，此类服务是其所居住社区的关键特征（Rowles, 2013）。社区项目为就地养老提供了情境，并能促进就地养老。如果老年人了解现有项目并认为其是有益的，他们很可能会利用这些项目，让其真正发挥作用（Wan & Odell, 1981）。机构和社区为使老年人受益而设计的项目只有在服务得到使用和赞赏的情况下才可行。同样，非正式的支持和资源也只有在被接受和利用时才具有价值。

针对较年轻的老年人（80 岁以下）和较年长的老年人（80 岁以上）的服务通常有所不同（Oswald et al., 2011）。本期 JEP 中，我们还研究了关于保护性环境下的强制变化的实例。我们所探讨的一个重要基础有关于以促进老年人在其社区就地养老的方式给予老年人发言权和选择权（Iwarsson et al., 2007）。

随着年龄的增长，老年人越来越依赖其环境来获取熟悉感和安全感（Fin-

chum & Weber, 2000)。这种熟悉感能增强他们的控制感和舒适感（Kirasic, 1991）。因此，他们更愿意花时间在家，并在他们所居住的物理环境中找到其需求和偏好之间的平衡（Kahana, 1982）。将他们的家庭环境适应其需求和偏好，这能提供舒适感并加强就地养老的价值。即使邻里环境发生不利变化，许多老年人也更愿意留在其熟悉的社区（Gardner, 2011）。

本期 JEP 从个体老年人延伸到他们的社区。我们根据社区居民对现有服务的接受程度来衡量现有服务。照此，我们收录的文章提供生态视角，将社区视为就地养老的重要场所。老年人希望在他们熟悉且大体受欢迎的家庭环境中养老（Wiles et al., 2012）。因此，基于老年人偏好和需求的一致性，就地养老有关于社区和家庭环境的熟悉度以及积极联系（Kahana et al., 2003）。老年人在利用、忽视或拒绝现有服务时所做的选择，在很大程度上反映了他们对“项目或服务是否符合其需求和偏好”的评估。

在我之前撰写的社论中，我将社论内容与我们的读者建立人际联系，并将期刊所覆盖的主题与我自己的生活经历联系起来。鉴于我的年龄（81 岁）以及我作为一名应对某些流动性挑战的遗孀经历，我觉得自己是就地养老环境中的一名参与者和观察者。我很感激迄今为止所探讨的我的个人观点及生活经历与读者产生了共鸣。

简要描述我在就地养老方面的生活经历以及我们所处的时代

当我们观看 2022 年 3 月的新闻时，一个主要的画面有关于在危险和严酷条件下逃离乌克兰的难民潮。她们大多是年轻妇女和中年妇女，并且带着年迈的祖母和孩子。我们的期刊议题聚焦于一系列旨在促进就地养老的项目和服务。我们看到的令人不安的画面反映了就地养老机会的中断。

乌克兰战争新闻对我的过去而言十分重要，并且与我的生活经历有关。我的家人，包括我的父母、80 岁的祖母和我，在 1956 年革命爆发后逃离匈牙利。当时我 15 岁。第二次世界大战在 11 年前结束，但人们担心犹太人会在匈牙利革命之后再次受到迫害。

我记得我曾不安地睡在奥地利维也纳的一个难民中心的地板床垫上。我们也不得不把所有的财产都抛在脑后。我的父母在携带一只金表和结婚戒指一事上争执，因为他们害怕在携带珠宝时被抓住并被指控走私。我记得不知道哪个国家会接纳我们。我们很高兴被接纳为美国的移民。我已故的父亲曾在匈牙利做古董鉴定师，但却只能在美国找到洗碗工的工作。不过，我却可以实现我的梦想—学习并成为一名科学家。我看到的图像让我想起了我的祖母、老年人的脆弱性以及战争期间他们所需关注的缺乏。我希望战争结束时受害者的生活不会受到进一步的破坏。

我非常感激能继续工作、写作和发声。我们大学有一个教师退休激励计划，许多人认为我会申请该计划，因为我是学院里最年长的教师（81 岁）

。但我没有动心。继续教学、指导和写作象征着意义，并为我提供了更大的回报（Scarpa et al., 2021）。我特别喜欢与我指导过的学生在经费和出版物方面持续合作。

自从我们出版了上一期JEP（聚焦于 Covid 大流行对老年人产生的影响），与大流行相关的问题已经升级。最近的奥密克戎（Omicron）病毒变种具有极强的传染性，并在 2022 年冬季对老年人的福祉造成重大威胁（Kupferschmidt & Vogel, 2022）。尽管截至 2022 年 3 月，感染人数正在减少，但该病毒继续对老年人的生命造成威胁。

回顾我的生活经历，今年冬天我有一个休假，但出于对 Covid 的担忧，我取消了前往佛罗里达州并在更温和的气候下工作的计划。在我丈夫 Boaz 于 2020 年 11 月去世之前，我们通常每年冬天会在佛罗里达州待上 6 周或更长时间。今年我待在家里继续工作，在与家人和学生互动的过程中收获乐趣。

我很感谢读者对我深爱的丈夫Boaz的逝世所表示的哀悼。过去一年有许多出版物是他作为合著者曾参与研究过的。去年他被追授予俄亥俄州老龄化网络终身贡献奖。不知何故，他的专业贡献证实了他在我生活中的持续存在。他是一个非常优秀且随和的人，我还能感受到他的支持和建设性的存在。

因为我在休假，所以今年冬天我没有教学工作。不过，我参加了许多委员会会议，并主要通过 Zoom 与我的研究生助理互动。我自愿在这个休假学期指导另外三名研究生，现在有六名助理分配到我所指导的老年护理研究中心。我发现指导研究生是一项非常有成就感的工作。对研究生而言，学会发表他们的研究是获得学术工作的一个越来越重要的必要条件。

我的其他重要互动有关于我的儿子Jeffrey、他的妻子以及他们的两个孩子，他们住在克利夫兰。我的孙辈们现在接种了疫苗，与去年不同的是，现在他们去学校上学。我们每周五下午都对他们进行新冠病毒检测，目前为止他们都很健康，他们及其父母每个周末都会来看我。我的大孙子Zeke（14 岁）患有自闭症，他在大流行期间一直感到焦虑。尽管如此，他的父母和我都喜欢和他在一起。他的弟弟Rafi（11 岁）非常好学，他会拉小提琴，这给我的家带来了欢乐。

每周六晚上我们都在我家吃晚饭，然后玩三代拼字游戏，Rafi几乎总是赢家。在回顾不同世代的看法和经历时，我提出了我所熟悉的词，并对我多年阅读所积累的词汇感到满意。中间一代，即Rafi的父母，他们的词汇量都很丰富，但也会在字典中查找罕见的单词。Rafi用身旁的笔记本电脑检查生僻词。这表明了不同年龄段的社会化差异。我们庆祝所有人提出的好词。

我通过电子邮件和电话与住在费城的小儿子Michael互动。有时，我还会

通过 Zoom 与住在费城的 5 个孙辈聊天。我们希望在即将到来的夏天拜访他们。

由于新冠疫情，我的髋关节置换手术已被推迟数次（Ulimonenen al., 2021）。我拄着拐杖或助行器走路，并尽量防止摔倒，尤其是在冰雪天。鉴于大多数医院最近才开始接受选择性手术，我决定等到天气变暖，在我乐意进入医疗机构时再进行手术。

我最近刚满 81 岁，因此适合本期的主题。我属于就地养老。我在我家住了 36 年，不想考虑离家或缩小家庭面积。我目前没有使用任何正式的社会服务。不过，我确实受益于 Covid 期间流行的商业服务，例如 Zoom 会议和杂货配送。我因行动不便而难以往往办公室，对 Zoom 的依赖让我能避免出行。我每周在网上订购杂货。此外，我的孩子们坚持在冬季冰天雪地的情况下开车送我办理杂事。有几次我很想亲自开车，但我最后待在家里，让他们开车送我。随着天气变暖，上周我能够开车去杂货店了。这感觉像是一次令人愉快的冒险。

本期 JEP 收录的促进就地养老服务的老年学观点

本期 JEP 中，我们关注的一个重要主题是项目的自愿参与和控制点的潜在维度。尽管人们普遍认为，与正式服务相比，非正式服务和看护为老年服务接受者提供更多的选择机会，但同时考虑非正式和正式服务项目的尝试相对较少。生态学视角使我们能够以更广泛的方式看待社区情境，这种方式允许考量老年人所居住的整个社区。Brian Sweeney 的文章《安置却又流离失所：绅士化地区的可负担住房与养老》为此类观点提供了一个很好的例证。本文衡量了老年人在更广泛的社区中的经历，即使他们受益于补贴住房。

本期内容的另一个独特之处是同时考虑了需要服务的老年人、他们的家庭成员以及参与规划老年人服务和政策的社区代表的观点。

基于本期 JEP 收录的文章，我们对帮助老年人就地养老所涉及的人际关系和组织挑战有了更深入和更有层次的看法。老年人及其家人要作出艰难的选择。制定服务和政策以确保弱势老年人福祉的组织在确保服务利用和满意度方面也面临挑战。

本期 JEP 收录的文章代表了作者的不同学科方向和方法论。信息既来自服务规划者和提供者，也来自服务利用者和只期望利用未来服务的老年群体。

本期 JEP 探讨了就地养老的社区背景，并提出了一系列问题，后者有关于老年人对项目和服务的一致性感知以及老年人的偏好和需求。我们收录的文章也聚焦于更广泛的社区和环境情境。因此，我们了解到，即使是精心设计和实施的计划也不一定总能获得认可或广泛使用。我们希望所提供的

例子—关于社区服务项目与就地养老的老年人对其接受度之间的交叉—能够为社区就地养老提供广泛的机遇。

下面我简要总结一下本期收录的文章：

《被选中的孩子：儿童时期被选为照顾父母的家庭照顾者的特征》

Joanne R. Campione, PhD, MSPH and Katarzyna A. Zebrak, PhD

虽然我们知道家庭成员承担了照顾老年人的大部分责任，但很少有研究聚焦于家庭照顾者是如何被选中的。作者通过识别从小就意识到其照顾义务的照顾者，进而探究了这一未被充分研究的主题。作者将这些人称为“被选中的孩子”照顾者。这些指定的看护人不太可能被雇用，不太可能接受临时托护，并且比不是“被选中的孩子”照顾者更容易遭受情绪痛苦。这项研究的结果支持先前的研究，即认为自己没有责任选择权的照顾者面临更高的抑郁症、痛苦和焦虑症风险。作者的结论提出了政策建议，鼓励社区和医疗组织识别护理人员的护理动机，并为制定积极的应对策略提供支持。此外，作者建议应向无法工作或因照顾责任而可能减少工作时间的照顾者提供更广泛的经济补偿。

《舒适还是威胁？意大利老年人如何看待家庭老年护理助手》

Anne Barrett, PhD and Katia Vecchione, MS, RN

Barrett 和 Vecchione 的研究分析了意大利老年人对被称为 badanti 的家庭老年护理助手的看法，这些助手通常是移民女性。他们的方法很有趣，因为其探究了尚未接受此类护理的老年人的意见。尽管尚未得到护理，但参与者对 badanti 持有强烈的看法。这些看法喜忧参半。经常持正面看法的那部分人的朋友或家人接受过 badanti 护理。那些表达负面观点的人认为 badanti 对其独立性造成威胁。此外，一些老年人对陌生人进入他们的空间（家）感到不舒服，尤其是移民工人。出乎意料的是，一些参与者表示他们宁愿接受疗养院专业人员的护理。对正式老年护理助手的恐惧和担忧强调了人们在就地养老中断方面的焦虑。

《居民和家庭对非自愿医疗设施关闭及搬迁的看法》

Raven H. Weaver, PhD, Karen A. Roberto, PhD,
Nancy Brossoie, PhD, and Pamela B. Teaster, PhD

这篇文章研究了取消设施认证和设施关闭对居民及其家人的影响。通过使用定性方法，作者采访了来自两个失去认证的设施的 27 名居民及 93 名家庭成员。访谈聚焦于搬迁感知、搬迁的挑战和压力源、以及搬迁对居民的身心影响。分析提出了四个主题：1）对需要搬迁的认识，2）需要搬迁

的通知，3）参与搬迁决策，以及 4）搬迁压力源（例如远离家人、失去朋友）。在许多情况下，家人和居民没有及时收到设施关闭的通知，也没有收到任何关于居民将被转移到哪里的通知。基于调查结果，作者提出了政策建议，包括及时、透明和具体的关闭通知所带来的益处、家庭和居民参与有关新安排的决策、以及协助搬家所需的物理支持。

这篇文章呼吁关注沟通的重要性，以帮助缓冲被迫搬迁的压力源。机构安置的需求给无法就地养老的老年人带来了重大压力。不过，进一步的非自愿搬迁会带来额外的压力，这种压力代表了失控和不可预测性。

《为何老年人不使用老年中心？马萨诸塞州50岁及以上老年人提供的证据》

Ceara Somerville, MS, Nidya Velasco Roldán, MS,
Cindy N. Bui, MS, Caitlin Coyle, PhD, and Jan Mutchler, PhD

Somerville 及其同事使用来自马萨诸塞州 8 个社区的 50 岁及以上老年人的数据，用于识别不参与当地老年中心的原因。研究结果发现，与参与者相比，不参与者可能更年轻、男性、身体和心理健康状况良好，并且在其社区居住的时间更短。不参与的原因包括：受访者认为其年龄不够大、没有需要或兴趣、没有时间、不熟悉项目以及无人陪同参加。一小部分样本表示其仍在工作、或健康状况不佳、没有交通工具、老年中心营业时间不便、以及老年中心无法满足其需求。作者为老年中心提供一系列建议，用于帮助吸引现有的未参与者和未来的老年人群。作者建议，老年中心应取消年龄限制，以鼓励不同年龄段人群的融入，更加以兴趣或服务为基础，扩大交通，并调整其营业时间以适应当前和未来老年人的需求。因此，项目利用的缺乏似乎一部分归因于项目的吸引力，另一部分归因于便利程度。

《动员社区发展全面的重要老龄化计划》

Sallie Allgood, PhD, RN, Ryan Lavalley, PhD, OTR/L, Cassandra Dictus, MPH, BSN, RN, Janice Tyler, BA, and Cherie Rosemond, PhD

这篇文章介绍了关于在北卡罗来纳州一社区制定重要老龄化计划（MAP）的案例研究。MAP 是为老年人创建老年友好社区的指南。文章向我们介绍了研究人员为让老年人参与制定 MAP 所采取的步骤。居住在社区的老年人参与了评估、规划、实施和评价阶段。老年居民表达了他们对社区资产和需求看法。例如，顾虑包括社区的安全和可步行性、交通问题、住房（可负担性、宜居设计）、社会隔离、以及社区服务（健康和老龄化）的获取和了解。文章还提供了关于老年友好倡议的规划和实施细节。本案例研究为希望制定更老年友好的倡议（包括公共、私人和非营利社区组织之间的伙伴关系）的其他社区提供了有用指导。

《关于就地养老的区域规划：华盛顿州老年人的需求感知和对养老服务的认识》

Cory Bolkan, PhD, Raven H. Weaver, PhD, Eunsae Kim, PhD,
and Bidisha Mandal, PhD

Bolkan 及其同事撰写的文章探究了居住在华盛顿州西南部五个县的 252 名社区老年人（60 岁以上）对就地养老（AIP）的看法。作者通过电话访谈评估了医疗服务的获取性、功能支持需求、以及对支持来源的认识。研究结果表明，近三分之一的参与者有未满足的护理需求，其中大部分需求与家庭维护相关。这种需求随着健康状况不佳而增加，但对那些充分了解养老服务的人而言，这种需求会降低。不幸的是，许多受访者不了解本地服务，也不知道在需要时从哪里获得帮助。大多数人表示在其需要帮助时，他们会首先依赖家庭成员，然后是政府或社区服务、或者是医疗专业人员的转介。作者建议，当地的养老机构和医疗机构应采取合作，帮助老年人了解可供使用的就地养老支持服务，而不是让家庭成员承担这部分工作。

《安置却又流离失所：绅士化地区的可负担住房与养老》

Brian N. Sweeney, PhD

Sweeney 的文章研究了“绅士化”这一城市社会学的基本概念，其与城市地区的社会变革有关，这些变革可能对老年人的生活产生影响，后者由于收入有限而代表了一个经济不稳定的群体。Sweeney 对居住在纽约市绅士化社区的两栋租金管制住房中的老年人进行了民族志研究。这些老年居民很感激其能继续住在他们熟悉的家中，并在周边生活成本相对较高的社区中养老。与此同时，他们担心进一步的社区变化可能会对其就地养老造成威胁。即使他们能继续支付租金，但绅士化还有其他成本，例如可能造成威胁的杂货成本上涨。作者引用了由 Rosenwohl-Mack 及其同事提出的概念模型，为就地养老提供了有用的解释框架。文章识别的老年人被描述为“安置的同时却又流离失所”。这种特征可能有关于周边社区没有其他老年人，从而导致年龄隔离和某种形式的流离失所。文章还提及了住房和就地养老方面的种族不平等。Sweeney 的结论提出一个疑问：“在城市绅士化和经济不平等加剧的时代，政策如何能更好地满足希望就地养老的老年城市居民的需求？”

References

- Donizetti, A. R. (2019). Ageism in an aging society: The role of knowledge, anxiety about aging, and stereotypes in young people and adults. *International Journal of Environmental Research and Public Health*, 16(8), 1329. <https://doi.org/10.3390/ijerph16081329>
- Finchum, T., & Weber, J. A. (2000). Applying continuity theory to older adult friendships. *Journal of Aging and Identity*, 5(3), 159-168. <https://doi.org/10.1023/A:1009513304519>
- Gardner, P. J. (2011). Natural neighborhood networks - Important social networks in the lives of older adults aging in place. *Journal of Aging Studies*, 25(3), 263-271. <https://doi.org/10.1016/j.jaging.2011.03.007>
- Iwarsson, S., Wahl, H. W., Nygren, C., Oswald, F., Sixsmith, A., Sixsmith, J., & Tomsone, S. (2007). Importance of the home environment for healthy aging: Conceptual and methodological background of the European EN-ABLE-AGE Project. *Gerontologist*, 47(1), 78-84.
- Kahana, E. (1982). A congruence model of person-environment interaction. In M. P. Lawton, P. Windley, & T. O. Byerts (Eds.), *Aging and the environment: Theoretical approaches* (pp. 97-121). New York: Springer.
- Kahana, E., Lovegreen, L., Kahana, B., & Kahana, M. (2003). Person, environment, and person-environment fit as influences on residential satisfaction of elders. *Environment and Behavior*, 35(3), 434-453. <https://doi.org/10.1177/0013916503035003007>
- Kirasic, K. C. (1991). Spatial cognition and behavior in young and elderly adults: Implications for learning new environments. *Psychology and Aging*, 6(1), 10-18. <https://doi.org/10.1037/0882-7974.6.1.10>
- Kupferschmidt, K., & Vogel, G. (2022). Omicron threat remains fuzzy as cases explode. *Science (New York, NY)*, 375(6576), 9-10. <https://doi.org/10.1126/science.acz9928>
- Oswald, F., Jopp, D., Rott, C., & Wahl, H. W. (2011). Is aging in place a resource for or risk to life satisfaction?. *The Gerontologist*, 51(2), 238-250. <https://doi.org/10.1093/geront/gnq096>
- Rowles, G. D. (2013). *Environmental gerontology: Making meaningful places in old age*. Springer Publishing Company.
- Scarpa, M. P., Zopluoglu, C., & Prilleltensky, I. (2021). Mattering in the community: Domain and demographic differences in a US sample. *Journal of Community Psychology*, 50, 1481-1502. <https://doi.org/10.1002/jcop.22728>

- Thomas, L., Little, L., Briggs, P., McInnes, L., Jones, E., & Nicholson, J. (2013). Location tracking: Views from the older adult population. *Age and Ageing*, 42(6), 758-763. <https://doi.org/10.1093/ageing/aft069>
- Uimonen, M., Kuitunen, I., Paloneva, J., Launonen, A. P., Ponkilainen, V., & Mattila, V. M. (2021). The impact of the COVID-19 pandemic on waiting times for elective surgery patients: A multicenter study. *PLoS One*, 16(7), e0253875. <https://doi.org/10.1371/journal.pone.0253875>
- Wan, T. T., & Odell, B. G. (1981). Factors affecting the use of social and health services among the elderly. *Ageing & Society*, 1(1), 95-115. <https://doi.org/10.1017/S0144686X81000068>
- Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. (2012). The meaning of “aging in place” to older people. *The Gerontologist*, 52(3), 357-366. <https://doi.org/10.1093/geront/gnr098>

The Chosen Child: Characteristics of Family Caregivers Selected at an Early Age to Provide Care to Their Parents

Joanne R. Campione,¹ PhD, MSPH and Katarzyna A. Zebrak,¹ PhD

Affiliations: 1. Westat, Inc.

Corresponding author:

Joanne R. Campione, PhD, MSPH

2530 Meridian Pkwy, Suite 200 Durham, NC 27703

Phone: (919) 474-3506

e-mail: joannecampione@westat.com

ABSTRACT

Background and Objective: Family caregivers who have been chosen by their family for the caregiving role may be under a unique type of stress due to familism and/or lack of choice. The purpose of this exploratory analysis was to investigate the characteristics of family caregivers who self-identified as the “Chosen Child” caregiver.

Methods: We used survey data from 652 child caregivers collected in December 2016 as part of the outcome evaluation of the National Family Caregiver Support Program (NFCSP). We compared the characteristics between the caregivers who responded “definitely true” when asked if they were chosen by their family as a child to provide care (“Chosen Child”) and the caregivers who answered “definitely false” to chosen child (DFCC).

Results: Compared to DFCC caregivers ($n=214$), Chosen Child caregivers ($n=168$) experienced emotional distress more often ($p=0.009$), were more likely to have annual household income $\leq \$40,000$ ($p=0.018$), were less likely to be employed ($p=0.009$), and were less likely to have received respite care in the past 6 months from family or friends ($p=0.009$). The mean emotional distress score remained significantly different between Chosen Child and DFCC caregivers after adjusting for potential confounders (2.64 vs. 2.43, respectively).

Conclusion: Family and friends should be aware that the Chosen Child caregiver may be at risk for emotional distress and may be hesitant to ask for respite care or other types of support. Interventions for the Chosen Child should help them seek support when needed.

Keywords: caregiver distress, informal caregiving, caregiver support

El niño o la niña elegidos: características de los cuidadores familiares seleccionados a una edad temprana para cuidar a sus padres

RESUMEN

Antecedentes y objetivo: Los cuidadores familiares que han sido elegidos por su familia para el rol de cuidador pueden estar bajo un tipo único de estrés debido al familiarismo y/o la falta de elección. El propósito de este análisis exploratorio fue investigar las características de los cuidadores familiares que se autoidentificaron como el cuidador del “Niño Elegido”.

Métodos: Utilizamos datos de encuestas de 652 cuidadores de niños recopilados en diciembre de 2016 como parte de la evaluación de resultados del Programa Nacional de Apoyo a Cuidadores Familiares (NFCSP). Comparamos las características entre los cuidadores que respondieron “definitivamente cierto” cuando se les preguntó si fueron elegidos por su familia cuando eran niños para brindar cuidado (“Niño elegido”) y los cuidadores que respondieron “definitivamente falso” al niño elegido (DFCC).

Resultados: En comparación con los cuidadores de DFCC ($n=214$), los cuidadores de niños elegidos ($n=168$) experimentaron angustia emocional con más frecuencia ($p=0,009$), tenían más probabilidades de tener un ingreso familiar anual $\leq \$40\,000$ ($p=0,018$), tenían menos probabilidades de ser empleados ($p=0,009$), y tenían menos probabilidades de haber recibido cuidados de relevo en los últimos 6 meses de familiares o amigos ($p=0,009$). La puntuación media de angustia emocional siguió siendo significativamente diferente entre los cuidadores de Chosen Child y DFCC después de ajustar los posibles factores de confusión (2,64 frente a 2,43, respectivamente).

Conclusión: Los familiares y amigos deben ser conscientes de que el cuidador del niño elegido puede estar en riesgo de sufrir angus-

tia emocional y puede dudar en solicitar cuidados de relevo u otros tipos de apoyo. Las intervenciones para el Niño Elegido deberían ayudarlo a buscar apoyo cuando sea necesario.

Palabras clave: angustia del cuidador, cuidado informal, apoyo del cuidador

被选中的孩子：儿童时期被选为照顾父母的家庭照顾者的特征

摘要

背景和目标：由家庭指定承担照顾角色的家庭照顾者可能由于家庭主义和/或缺乏选择而遭受独特的压力。本探究性分析旨在研究自我认定为“被选中的孩子”的家庭照顾者的特征。

方法：我们使用652名儿童照顾者的调查数据，该数据收集于2016年12月并作为国家家庭照顾者支持计划（NFCSP）成果评价的一部分。我们比较了当被问及是否在儿童时期被家人选择提供护理时回答“绝对正确”的照顾者（“被选中的孩子”）和对此回答“绝对错误”的照顾者（DFCC）的特征。

结果：与DFCC照顾者（n=214）相比，“被选中的孩子”照顾者（n=168）经历情感痛苦的频率更高（ $p=0.009$ ），家庭年收入 $\leq 40,000$ 美元的可能性更大（ $p=0.018$ ），不太可能被雇用（ $p=0.009$ ），并且在过去6个月内从家人或朋友那里得到临时托护的可能性较小（ $p=0.009$ ）。在调整了潜在的干扰因素后，“被选中的孩子”和DFCC照顾者的平均情感痛苦评分仍然存在显著差异（分别为2.64和2.43）。

结论：家人和朋友应该意识到，“被选中的孩子”照顾者可能有情感痛苦的风险，并且可能不愿寻求临时托护或其他类型的支持。对“被选中的孩子”的干预措施应帮助其在需要时寻求支持。

关键词：照顾者的痛苦，非正式照顾，照顾者支持

Introduction

The family caregiver is a relative, spouse, partner, or friend who provides care and support to someone at home without pay. The family caregiver assumes a critical role in caring for older Americans living at home, and is a vital component of long-term care (National Academies of Sciences, Engineering, and Medicine, 2016). The family caregiver helps their family member—most often a spouse or parent—with activities of daily living, health care activities, and complex medical/nursing tasks (Sorrell, 2014; Wolff et al., 2016). The replacement of family caregivers, who care for millions of older adults and people with disabilities in America, with paid services could cost up to \$470 billion a year (Reinhard, Feinberg, et al., 2019).

Estimates from the year 2020 indicate that approximately 41.8 million Americans have provided unpaid care to an adult age 50 or older in the prior 12 months, representing approximately a quarter of households in the United States (AARP & National Alliance for Caregiving, 2020). While taking care of an adult family member can be a source of joy and fulfillment, for many caregivers it is also associated with considerable stress, depression, anxiety, social isolation, and burden, which can compromise the caregiver's mental health and physical health (Adelman et al. 2014; Judge et al., 2011; Schulz & Sherwood, 2008).

Familism, Coping, Choice, and the “Chosen Child” Caregiver

Familism is a multidimensional concept that involves a person's beliefs, interests, and prerogatives embedded in family core values, such as strong family identification, attachment, mutual support, family obligation, and familial interconnectedness (Mendez-Luck et al., 2016). Pearlin's caregiver stress and coping model considers people's beliefs to be an important influence on their mental health (Pearlin, 1994). As a key factor in explaining family roles and obligations, familism can have both a positive and negative effect on caregivers' health and well-being (Mendez-Luck et al., 2016). For example, Cox (2013) found that familism has a positive influence on caregiver well-being when the caregiver perceives that the family is a strong source of support. However, other caregiver studies have found familism to be associated with higher levels of depression, more emotional distress, and poorer subjective physical health (Del-Pino-Casado et al., 2017; Rozario & DeRienzi, 2008).

When emotionally distressed or burdened by caregiving, caregivers can attempt to improve their quality of life through various coping strategies (Greenglass, 2002; Rodríguez-Pérez et al., 2017). For example, an active coping strategy includes attempts to solve or modify problems through planning, acceptance, and help-seeking (Del-Pino-Casado et al., 2011; Pérez-Cruz et al., 2019). Receiving respite care, so-

cial support, and counseling are a few examples of the help that is available to improve coping and to reduce the negative effect of caregiving and/or familism on a caregiver's emotional and physical health (Clay et al., 2008; Del Pino et al., 2011; Sorrell, 2014; Vandepitte et al., 2016). The opposite of active coping is avoidance coping, in which a person attempts to avoid problems often coupled with a self-management approach and/or denial of problems (Carver et al., 1998; Rozario & DeRienzi, 2008). Familism has been found to be associated with avoidance coping, which several researchers believe is a key reason why familism results in poorer outcomes for mental and physical health among caregivers (Kim et al., 2007; Sayegh & Knight, 2010).

Other risk factors for negative outcomes associated with familism are a sense of obligation and a lack of choice in taking on the caregiver role (Schulz et al., 2012; Winter et al., 2010). Sayegh and Knight (2010) found that a significant proportion of familism's unfavorable effect on caregiver outcomes was due to feelings of obligation. Additionally, Schulz et al. (2012) found that lack of choice in becoming a caregiver was associated with higher levels of emotional stress and physical strain, after controlling for multiple confounders including level of care, care recipient primary health condition, and demographics. While familism may act as a cultural endorsement of the caregiving role, individuals who self-identify as the person at an early age chosen by their family for the caregiving role ("Chosen Child") could be driven to ac-

cept the role out of a sense of family obligation or duty (Dilworth-Anderson et al., 2004; Vandepitte et al., 2016) which may not be equally distributed across the family. Therefore, because the "Chosen Child" knew of their caregiving obligation since childhood, he or she may perceive a lack of choice in having to provide care, thus exacerbating their own risk for negative outcomes (Winter et al., 2010).

Our study uses self-reported data to identify "Chosen Child" caregivers—who may have had little choice in assuming the role of caring for a parent—and to explore the caregiver characteristics associated with "Chosen Child" in comparison to other child caregivers.

Data and Methods

Survey data were collected in December 2016 from a random sample of family caregivers across the nation who were participants in the Administration for Community Living's outcome evaluation of the National Family Caregiver Support Program (NFCSP) (Westat, 2018). The NFCSP is a federal program designed to support family caregivers by providing caregiver education and training, individual counseling, information about available services, and support groups to help caregivers better manage their responsibilities and to help cope with the stress of caregiving. The NFCSP also provides respite care either at home or at adult day care facilities, so that caregivers can rest or attend to their own needs.

To identify a sample of NFCSP clients, the sample design for the evaluation was based on a two-stage stratified probability sample of Area Agencies on Aging (AAA) clients who were listed as recipients of NFCSP services. The first stage was a stratified sample of 316 AAAs across the nation and the second stage consisted of a systematic random sampling of NFCSP clients within the sampled AAAs. The NFCSP evaluation's study sample consisted of 1,568 caregivers. The caregivers' relationships to care recipients were 43% spouse ($n=678$), 42% child ($n=652$), 2% in-law child ($n=37$), and 13% other, including grandchildren and friends ($n=201$).

We used survey data collected from caregivers who were caring for a parent. In other words, they were the care recipients' children. The sample of caregivers for this exploratory analysis consisted of 646 child caregivers. While the evaluation had 652 child caregivers, six were excluded due to missing responses to the Chosen Child question.

Determination of Chosen Child

The survey instrument for the NFCSP outcome evaluation included a question developed by Rozario and DeRienzi (2008) that operationalized caregivers' beliefs about their caregiving role amongst their family. Each of the 652 child caregivers were asked to rate how well the following statement fit with their beliefs about their caregiving situation: "I was chosen by my family as a child to provide care for all my family members." Response options were defi-

nately true, somewhat true, somewhat false, and definitely false. The caregivers that responded "Definitely true" were categorized as Chosen Child and those that responded "Definitely false" were categorized as Definitely False Chosen Child (DFCC). We chose the caregivers who answered the extreme responses to the question because we wanted to compare caregivers who were certain about their status as Chosen Child or non-Chosen Child.

Among the 646 caregivers, we examined responses to the Chosen Child question by gender and race. We also examined the recent use of NFCSP caregiver educational services and NFCSP respite care by Chosen Child response among a subgroup of caregivers who received any NFCSP service. More specifically, NFCSP service use could only be examined among 79% of the full sample of child caregivers due to the design of the Outcome Evaluation, which had a comparison group of caregivers that had never used NFCSP services.

Caregiver Characteristics

The survey collected the basic demographics of each caregiver such as their annual household income level category, if the caregiver lives in an urban or rural location, if the caregiver was currently employed (either full or part-time), educational attainment level, marital status, age, gender, and race ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, other). We hypothesized that the Chosen Child in comparison to DFCC would have

lower income, less education, and be of minority race (Falzarano et al., 2021).

The survey also asked several questions related to a caregiver's situation. Therefore, we examined items from the survey that best measured the intensity of the caregiving role (Bastawrous et al., 2015). We compared how many years the caregiver had been caregiving, their care recipient's age, if the caregiver cares for another older adult, if the caregiver also cares for children, the daily intensity level (ranging from 0-5 with 5 being the highest) was measured by the caregiver reporting the frequency of helping their care recipient with activities of daily living (ADL). Also collected were the caregivers' weekly caregiving hours, if the caregiver thought caregiving was financially difficult or not, the caregivers' self-reported confidence level of caregiving, the caregiver's satisfaction of caregiving, if the caregiver felt appreciated by the care recipient, and if the caregiver lived with their care recipient. We hypothesized that the Chosen Child caregivers would report more confidence in caregiving than the DFCC caregivers (Falzarano et al., 2021).

Lastly, we explored whether the Chosen Child group was more or less likely to be caring for a parent with Alzheimer's disease or related dementias (ADRD) and if they reported that their care recipient argues a lot with him or her.

Support with Caregiving

The survey had many items that asked about the caregiver support they re-

ceive. More specifically, we explored responses to the following items: use of caregiver educational services by NFCSP and/or any organization; use of NFCSP caregiver supplemental services such as transportation, home modifications, and medical equipment; number of respite hours received by NFCSP, any organization, family and/ or friends; perception of unmet need for caregiving; and, among NFCSP users only ($n=510$), the perception that the services definitely helped them continue caregiving.

Caregiver Well-Being

The survey measured a caregiver's perception that caregiving is emotionally difficult, caregiver burden, caregiver mental health and caregiver physical health. Burden was measured using the short Zarit Burden Inventory (Bedard et al., 2001; Zarit et al., 1980), which included four items designed to assess different aspects of caregiver burden: (a) not having sufficient time for self, (b) feeling stressed between caregiving and other responsibilities, (c) feeling strained when around the care recipient, and (d) feeling uncertain about what to do about the care recipient. The overall burden score from the set ranged from 1-5 with 5 representing the greatest burden. Perception that caregiving is emotionally difficult was asked with this question: "How emotionally difficult would you say that caring for care recipient is for you?" The response options were 1=not at all difficult, 2=a little, 3=somewhat, and 4=very difficult.

The survey also included four

items from the validated Patient-Reported Outcomes Measurement Information System (PROMIS) Short Forms for Global Mental Health and Global Physical Health (version 1.1): quality of life, frequency of emotional distress, level of fatigue, and physical health (Hays et al., 2009). Each of the PROMIS items use a 5-point response scale. For example, “How would you rate your physical health?” had response options of 1=poor, 2=fair, 3=good, 4=very good, and 5=excellent. The question “In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?” had response options of 1=never, 2=rarely, 3=sometimes, 4=often, and 5=always. This last question is the item that we label “emotional distress.”

Analysis

To determine which characteristics collected in the survey were significantly associated with Chosen Child status, we compared group mean percentages and scores between the Chosen Child group and the DFCC group. T-test, Chi-square, and Mantel-Haenszel chi-square statistics were used to test significant differences at $p < 0.05$ between the two groups.

Adjusted Mean of Emotional Distress

We performed a sensitivity analysis on the emotional distress mean scores of all five groups of child caregivers. We tested to see if the group mean scores were significantly different after controlling

for confounders that could influence emotional distress (Del-Pino-Casado et al., 2019; Del-Pino-Casado et al., 2015). More specifically, for this analysis, we performed a regression model to adjust the mean scores by employment status, rate of physical health, Zarit burden score, and caregiving daily intensity.

Results

The full sample of child caregivers were 523 females and 123 males. Eighty-one percent were the care recipient’s daughter. The distribution by caregiver race was 63% White, 19% Black, 13% Hispanic, and 5% other race, including Asian ($n=13$), Hawaiian ($n=2$), American Indian ($n=5$), and Other ($n=19$). The mean age of the caregivers was 59 and the mean age of the care recipients was 85. On average, child caregivers had been caregiving for their parent for 6 ½ years. Fifty two percent of the care recipients were diagnosed with Alzheimer’s Disease or related dementias (ADRD).

As shown in Figure 1, the response frequencies to the Chosen Child survey item were 33% Definitely False (“DFCC”), 9% Somewhat False, 23% Somewhat True, and 26% Definitely True Chosen Child.

Race and Gender of Chosen Child

Table 1 presents the distribution of child caregivers by race. Twenty-five percent of the White and Black caregivers were Chosen Child and 31% of Hispanic caregivers and other racial/ethnic caregivers were Chosen Child. These

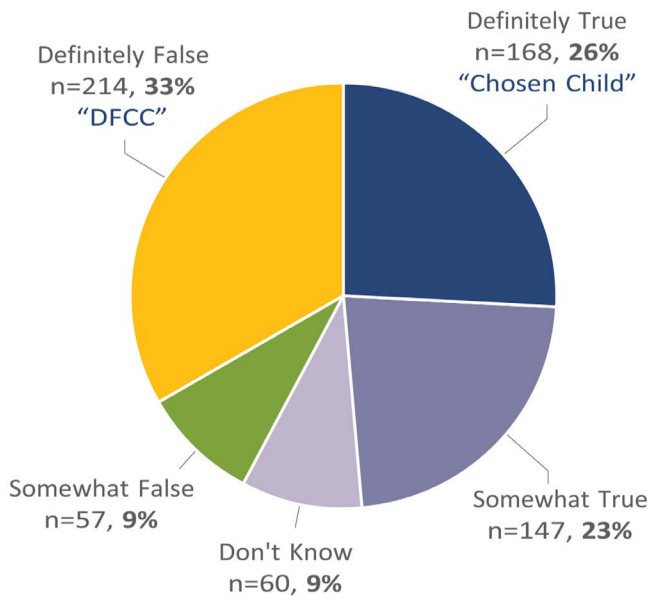


Figure 1: Response frequencies to the Chosen Child survey item “I was chosen by family as a child to provide care for all my family members” (n=646)

Table 1. Chosen Child item response prevalence by caregiver race

Response Frequencies Among Each Race Category					
Response Category	White (n=404)	Black (n=122)	Hispanic (n=81)	Other (n=39)	All (n=646)
Definitely True: Chosen Child	25%	25%	31%	31%	26%
Other	41%	41%	43%	33%	41%
Definitely False: DFCC	34%	34%	26%	36%	33%
Total	100%	100%	100%	100%	100%

frequencies did not differ significantly across race categories. Twenty-seven percent of the women were Chosen Child and 23% of the males were Chosen Child. The gender frequencies were also not statistically significant.

Use of NFCSP Caregiver Services

Because some of the child caregivers in the full had not used NFCSP services,

there were 510 child caregivers who used any NFCSP service. Among them, the percent who used any NFCSP educational services in the past 6 months were: 24% of Chosen Child, 25% of Somewhat True, 21% of Don't Know, 19% of Somewhat False, and 20% of DFCC. The percent who used NFCSP respite care in the past 6 months were: 40% of Chosen Child, 50% of Some-

what True, 47% of Don't Know, 33% of Somewhat False, and 42% of DFCC. The use percentages for these two services were not significantly different across groups. Lastly, among those who used NFCSP respite care, the mean number of respite hours per week did not significantly vary by group, with 8 hours for Chosen Child, 9 hours for Somewhat true, 10 hours for Do not know, 7 hours for Somewhat false, and 8 hours for DFCC.

Characteristics Associated with the Chosen Child Caregiver

Our analysis shows that, among all the survey items analyzed, there were five characteristics that differed significantly between Chosen Child and DFCC caregivers. In comparison to DFCC caregivers, on average, the Chosen Child caregivers were 1) more likely to have an annual household income \leq \$40,000 (60.7% vs. 48.6%; $p = 0.018$), 2) less likely to be employed (39.3% vs. 52.3%; $p=0.009$), 3) less likely to have received respite care from family or friends (40.1% vs. 53.5%; $p=0.009$), 4) more likely to say that NFCSP services enabled them to be a caregiver longer (51.6% vs 39.3%; $p=0.35$), and 5) more often bothered by emotional distress (a score of 2.68 vs. 2.38; $p=0.009$). The results for the five characteristics are shown in Table 2.

Care Recipient Characteristics, Caregiving Dynamics, and Caregiver Burden

The percentage of CRs with ADRD was not significantly different between

the Chosen Child and DFCC caregiver groups (56.0% and 49.5%, respectively). Each group also reported similar caregiving intensity, caregiving hours per week, if they felt appreciated by CR, level of satisfaction from being a caregiver, self-reported physical health, and if they were receiving all the help they need. Lastly, the Chosen Child caregivers did not report higher levels of caregiver burden. On a scale from 1-5, with 5 representing the most burden, Chosen Child caregivers reported a mean burden score of 2.8 and DFCC caregivers reported a mean score of 2.7.

As shown in Table 3, the unadjusted mean emotional distress score for DFCC (2.38) was significantly lower than the unadjusted mean score for Chosen Child (2.68). After adjusting for caregiver employment status, self-reported physical health, self-reported caregiver burden, and caregiving daily intensity, the mean emotional distress scores remained significantly different between the Chosen Child (2.64) and the DFCC (2.43). The regression model's fit as measured by adjusted r-square was 0.3521. The significant parameters in the regression model to calculate adjusted means were Chosen child group (0.054, $p= 0.0092$), Employed (-0.17, $p=0.0137$), Self-rated Physical Health (-0.23, $p <.0001$); Zarit burden mean score (0.61, $p <.0001$); and Caregiving daily intensity = (-0.04, $p= 0.0345$).

To understand these scores as they relate to a caregivers' daily situation, Figure 2 shows that the 8% of Chosen Child caregivers reported that they were always bothered by emo-

Table 2. Characteristics that significantly differed between Definitely True Chosen Child caregivers (N=168) and Definitely False Chosen Child (DFCC) caregivers (N=214)

Characteristic / Survey Item	Chosen Child % Yes or Mean	DFCC % Yes or Mean	p-value
Caregiver Annual Household Income <=40K annually. Item: During the last year what was your total household income before taxes from all sources, including Veterans benefits, Social Security, and other government programs? <i>Values: Yes or No (based on income range selected by respondent)</i>	60.7%	48.6%	0.018
Employment status. Item: Are you currently employed full or part time? <i>Values: Yes or No</i>	39.3%	52.3%	0.009
Received respite care from family or friends. Item: In the past 6 months, have you received respite care from a family member, friend, neighbor, or other volunteers? <i>Values: Yes or No</i>	40.1%	53.5%	0.009
Perception that NFCSP services enables longer caregiving.* Item: Have the services you received enabled you to provide care longer than would have been possible without these services? <i>Values: Yes = Definitely yes; No = all other responses including probably yes, probably not, and definitely not</i>	51.6%	39.3%	0.035
Frequency of Emotional Distress. Item: In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?" <i>Values: 1=never; 2=rarely; 3=sometimes; 4=often; 5=always</i>	2.68	2.38	0.009

* The number of caregivers who used services from the National Family Caregiver Support Program (NFCSP) in the past 6 months and were asked this item was 124 from the Chosen Child group and 173 from the DFCC group.

Table 3. Mean scores for Emotional Distress by Chosen Child group

Chosen Child Response	N	%	Mean of Emotional Distress Frequency	
			Unadjusted Mean	Adjusted Mean*
Definitely False (DFCC)	214	33.13	2.38	2.43**
Somewhat False	57	8.82	2.53	2.53
Don't Know	60	9.29	2.58	2.46
Somewhat True	147	22.76	2.59	2.61
Definitely True: Chosen Child	168	26.01	2.68	2.64**

* Mean scores adjusted for caregiver employed or not, self-reported physical health, self-reported caregiver burden, and caregiving daily intensity.

** The DFCC's adjusted mean significantly different ($p < 0.05$) from Chosen Child's adjusted mean.

Response frequency to “How often are you bothered by emotional problems such as feeling anxious, depressed, or irritable?”

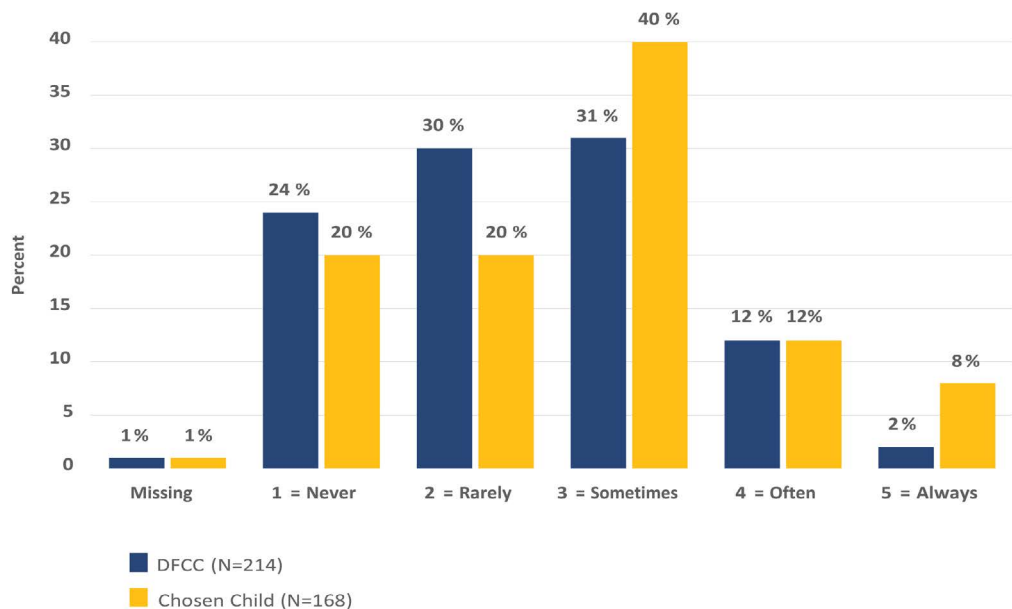


Figure 2. Frequency of emotional distress between Definitely False Chosen Child (DFCC) caregivers and Chosen Child

tional problems compared to 2% of the DFCC caregivers. Clinically, more than half of the Chosen Child caregivers (60%) felt bothered sometimes, often, or always by emotional problems such as feeling anxious, depressed, or irritable. In comparison, less than half of the DFCC caregivers (45%) felt bothered sometimes, often, or always by emotional problems due to these feelings.

Caregiver Support

When comparing Chosen Child to DFCC, there were 124 Chosen Child caregivers and 173 DFCC caregivers who used NFCSP services in the past 6 months. The Chosen Child caregivers reported receiving less respite care support from family, friends, neighbors, or other volunteers than DFCC caregivers (40.1% and 53.5%, respectively; $p=0.009$). The Chosen Child caregivers also reported less respite care support (not significantly different) from other organizations including Medicare and Medicaid in comparison to DFCC caregivers (15.0% and 22.9%, respectively).

Lastly, the percentage of Chosen Child with a college degree (32%) or any education past high school (71%) was not significantly different than the percentage of DFCCs with a college degree (39%) or any education past high school (73%). Interestingly, we found no difference in gender or race/ethnicity between the Chosen Child and DFCC groups. Both groups had a mean age of 59 years.

Discussion

Our analysis found evidence that there are family caregivers who felt chosen by their family as a child to be the caregiver to their parent(s). Surprisingly, this phenomenon was found equally across race/ethnicity and gender. We also did not find that the Chosen Child caregiver had higher levels of self-reported confidence in caregiving.

The Chosen Child caregivers reported receiving less respite support from family, friends, and non-NFCSP organizations. These results support previous findings that link familism with caregivers not receiving the potential support available from family members (Mendez-Luck et al., 2016). It is possible that the Chosen Child with a high sense of familism and/or desire to manage and provide care for their elder relative on their own is less willing or struggles to ask a relative or friend to stay with the care recipient when they need a break due to avoidance coping (Sayegh & Knight, 2010).

Although we hypothesized less employment among the Chosen Child caregivers than the DFCC caregivers, we found the difference striking (39% vs. 52%, respectively). However, there was no difference in their responses to the financial difficulty of caregiving, although, as hypothesized, the Chosen Child caregivers had lower annual incomes than the DFCC caregivers. This is an interesting finding that needs exploration. Additionally, more research is needed to understand if the Chosen

Child's knowledge of their future obligation during young adulthood had an effect on career choice.

Caregiver burden was not higher for the Chosen Child. This finding aligns with findings from Losada et al. (2010), which suggest that familism does not affect emotional distress through burden, but through rigid and unrealistic beliefs about caregiving that are maladaptive to active coping. Additionally, Crist et al. (2007) found that familism was not related to caregiving burden among Mexican American caregivers.

Furthermore, when asked "How emotionally difficult would you say that caring for CR is for you?" there were no significant differences in rates of response between Chosen Child caregivers and DFCC caregivers. This question was specific to emotional problems associated with caregiving. Yet when asked about emotional problems without mention of caregiving, the Chosen Child caregivers reported experiencing emotional problems such as feeling anxious, distressed, depressed or irritable more often compared to the DFCC caregivers. These findings support previous studies that found that caregivers without choice are at higher risk for depression and anxiety (Schulz et al., 2012) and that caregivers with low levels of social support or respite care from family and friends are more frequently distressed (Falzarano et al., 2021).

A significantly higher percent of Chosen Child caregivers than DFCC caregivers responded with "Definitely yes" when asked if the NFCSP services

enabled him or her to provide care longer (51.6% and 39.3%, respectively). Thus, when support was received, it appears that the majority of Chosen Child caregivers perceive the support to be helpful. (This question in the survey was about NFCSP services in general and not specific to caregiver educational services or respite care.) It is unclear why the DFCC group responded less favorably to this item about NFCSP services enabling longer caregiving, especially because this group may have been less prepared for their caregiving role. A limitation to this question is that it asked about all the NFCSP services the caregiver had received and, thus, the caregivers were responding to varying levels of support.

Limitations

Due to the cross-sectional nature of this analysis, we were unable to determine if Chosen Child caregivers had higher levels of emotional distress and less employment than DFCC caregivers before the commencement of caregiving. Future research on Chosen Child caregivers should include longitudinal studies to gain a deeper understanding of the mental health of the caregivers and the effects of increasing caregiver support on their well-being. Another limitation is that our study does not have any measures of coping. More specifically, caregivers were not asked about their motivation for caregiving (to determine if they really lacked choice) or their coping levels or styles (Romero-Moreno et al., 2011). In addition, the p-values for

multiple tests were not adjusted, potentially resulting in an increased possibility of type 1 error and chance findings.

Implications

Support organizations and health care providers can assist Chosen Child caregivers by encouraging involvement from multiple family members as an avenue for additional support either physically, emotionally, or financially. Individuals performing caregiver assessments should ask caregivers about their motivation for caregiving to identify those who may be at risk for negative outcomes associated with familism. Support groups, education, and training for the Chosen Child caregiver should focus on active coping strategies such as planning, seeking help, and positive mindsets to help improve the Chosen Child's emotional health. Furthermore, community support services must also be aware that the risk of unmet caregiver needs, burden, and emotional stress of non-White caregivers could be heightened due to language and/or cultural barriers and the impact of the COVID-19 pandemic (Greenwood et al., 2015; Li, 2004; Potter, 2018; Campione & Zebrak, 2020; Longacre et al., 2021).

Since 2014, legislation at the State and Federal level have brought more attention to the role of the family caregiver. The majority of States have enacted the Caregiver Advise, Record, Enable (CARE) Act which requires the identification of a patient's caregiver during hospitalization and the integration of the caregiver in the discharge

process. Furthermore, while there is variability to how each State adopts the CARE Act, another key element is for the hospital staff to perform an assessment of the caregiver's capacity to provide the post-acute home care (Reinhard, Young, et al., 2019). During the assessment of the caregiver's capacity and needs, providers should remind caregivers to seek support from their family and friends. Furthermore, if additional family is in attendance, the clinicians should take this opportunity to help families identify and validate the caregiver's needs (Chi, Demiris, Lewis, Walker, & Langer, 2016).

The medical field, social workers, and caregiver support programs should be aware of how familism and a child caregiver's lack of choice when caring for a parent can negatively affect their well-being and their ability to ask for help. While all can agree that care plans for an elderly patient need to be family-centered, the assessment of the caregiver by a healthcare, clinical, or social service professional may be just as important (Kelly, Wolfe, Gibson, & Feinberg, 2013). These professionals should be trained to identify the child caregiver who did not choose their role and/or feel obligated through familism, and thus may be suffering from a unique type of emotional distress. Once identified, the Chosen Child may need to be counseled about avoidance coping and should be encouraged to seek social support and respite care.

Lastly, in addition to improving the coordination of federal programs and activities that support family caregivers through the National Family

Caregiving Strategy (RAISE Council, 2021), new state and federal policies and programs for family caregiver compensation beyond those offered by Medicaid and the Veterans Affairs are needed, especially for the child caregiver who can no longer work, or has to cut back work hours due to caregiving.

Conclusion

Using data collected from caregivers across the nation, we found that among a sample of child caregivers, one-fourth identified themselves as the person in their family

who was chosen at an early age to provide care to their parents. Our analysis found that the characteristics associated with Chosen Child caregivers were lower annual household income, less employment, less respite care received from family and friends, higher perception that NFCSP services enable them to care longer, and more frequent emotional distress. Family and friends should be aware that the Chosen Child caregiver may be hesitant to ask for respite care or other types of support and, thus, they should not assume that their help is not needed in caring for the caregiver's parent or any other family member.

References

- AARP and National Alliance for Caregiving. *Caregiving in the United States 2020*. Washington, D.C.: AARP. May 2020. <https://doi.org/10.26419/ppi.00103.001>.
- Adelman, R. D., Tmanova, L. L., Delgado, D., Dion, S., & Lachs, M. S. (2014). Caregiver burden: A clinical review. *JAMA*, 311(10), 1052–1060. <https://doi.org/10.1001/jama.2014.304>.
- Bedard, M., Molloy, D. W., Squire, L., Dubois, S., Lever, J. A., & O'Donnell, M. (2001). The Zarit Burden Interview: A new short version and screening version. *The Gerontologist*, 41, 652–657.
- Bastawrous, M., Gignac, M. A., Kapral, M. K., & Cameron, J. I. (2015). Factors that contribute to adult children caregivers' well-being: a scoping review. *Health & social care in the community*, 23(5), 449–466. <https://doi.org/10.1111/hsc.12144>
- Campione, J. R., & Zebrak, K. A. (2020). Predictors of unmet need among informal caregivers. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, 75(10), 2181–2192. <https://doi.org/10.1093/geronb/gbz165>
- Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1998). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*

- gy, 56(2), 267–283. <https://doi.org/10.1037//0022-3514.56.2.267>.
- Chi, N. C., Demir, G., Lewis, F. M., Walker, A. J., & Langer, S. L. (2016). Behavioral and educational interventions to support family caregivers in end-of-life care: A systematic review. *American Journal of Hospice & Palliative Medicine*, 33, 894–908. doi:10.1177/1049909115593938
- Clay, O. J., Roth, D. L., Wadley, V. G., & Haley, W. E. (2008). Changes in social support and their impact on psychosocial outcome over a 5-year period for African American and White dementia caregivers. *International Journal of Geriatric Psychiatry*, 23(8), 857–862. <https://doi.org/10.1002/gps.1996>
- Coe, N. B., & Van Houtven, C. H. (2009). Caring for mom and neglecting yourself? The health effects of caring for an elderly parent. *Health Economics*, 18(9), 991–1010. <https://doi.org/10.1002/hec.1512>
- Cox, C. (2013). Factors associated with the health and well-being of dementia caregivers. *Current Translational Geriatrics and Experimental Gerontology Reports*, 2(1), 31–36. <https://doi.org/10.1007/s13670-012-0033-2>
- Crist, J. D., McEwen, M. M., Herrera, A. P., Kim, S. S., Pasvogel, A., & Hepworth, J. T. (2009). Caregiving burden, acculturation, familism, and Mexican American elders' use of home care services. *Research and Theory for Nursing Practice*, 23(3), 165–180. <https://doi.org/10.1891/1541-6577.23.3.165>
- Del-Pino-Casado, R., Frías-Osuna, A., Palomino-Moral, P. A., & Pancorbo-Hidalgo, P. L. (2011). Coping and subjective burden in caregivers of older relatives: a quantitative systematic review. *Journal of Advanced Nursing*, 67(11), 2311–2322. <https://doi.org/10.1111/j.1365-2648.2011.05725.x>
- Del-Pino-Casado, R., Palomino-Moral, P. A., & Frías-Osuna, A. (2015). The association of satisfaction and perceived burden with anxiety and depression in primary caregivers of dependent elderly relatives. *Research in Nursing & Health*, 38(5), 384–391. <https://doi.org/10.1002/nur.21671>
- Del-Pino-Casado, R., Palomino-Moral, P. A., Pastor-Bravo, M., & Frías-Osuna, A. (2017). Determinants of depression in primary caregivers of disabled older relatives: a path analysis. *BMC Geriatrics*, 17(1), 274. <https://doi.org/10.1186/s12877-017-0667-1>
- Del-Pino-Casado, R., Rodríguez Cardosa, M., LópezMartínez, C., & Orgeta, V. (2019). The association between subjective caregiver burden and depressive symptoms in carers of older relatives: A systematic review and meta-analysis. *PLoS ONE*, 14(5), e0217648. <https://doi.org/10.1371/journal.pone.0217648>
- Dilworth-Anderson, P., Goodwin, P. Y., Williams, S. W. (2004). Can culture help

- explain the physical health effects of caregiving over time among African American caregivers? *The Journals of Gerontology: Series B*, 59(3), S138–S145. <https://doi.org/10.1093/geronb/59.3.S138>
- Falzarano, F., Moxley, J., Pillemer, K., & Czaja, S. J. (2021). Family Matters: Cross-Cultural Differences in Familism and Caregiving Outcomes. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, gbab160. Advance online publication. <https://doi.org/10.1093/geronb/gbab160>
- Greenglass, E. R. (2002). Proactive coping and quality of life management. In: E. Frydenberg (Ed.), *Beyond coping: Meeting goals, vision, and challenges* (pp. 37-62). Oxford University Press.
- Greenwood, N., Habibi, R., Smith, R., & Manthorpe, J. (2015). Barriers to access and minority ethnic carers' satisfaction with social care services in the community: a systematic review of qualitative and quantitative literature. *Health and Social Care*, 23(1), 64–78. <https://doi.org/10.1111/hsc.12116>
- Hays, R. D., Bjorner, J. B., Revicki, D. A., Spritzer, K. L., & Cella, D. (2009). Development of physical and mental health summary scores from the patient-reported outcomes measurement information system (PROMIS) global items. *Quality of Life Research*, 18(7), 873–880. <https://doi.org/10.1007/s11136-009-9496-9>.
- Judge, K. S., Bass, D. M., Snow, A. L., Wilson, N. L., Morgan, R., Looman, W. J., McCarthy, C., & Kunik, M.E. (2011). Partners in dementia care: A care coordination intervention for individuals with dementia and their family caregivers. *The Gerontologist*, 51(2), 261–272. <http://doi.org/10.1093/geront/gnq097>.
- Kelly, K., Wolfe, N., Gibson, M., & Feinberg, L. F. (2013). Listening to family caregivers: The need to include caregiver assessment in Medicaid home and community-based service waiver programs. Washington, D.C.: AARP Public Policy Institute. Retrieved from https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/the-need-to-include-family-caregiver-assessment-medicaid-hcbs-waiver-programs-report-AARP-ppi-ltc.pdf
- Kim, J., Knight, B. G., & Longmire, C. V. (2007). The role of familism values in stress and coping processes among African American and White dementia caregivers: Effects on mental and physical health. *Health Psychology*, 26(5), 564–576. <https://doi.org/10.1037/0278-6133.26.5.564>
- Li, H. (2004). Barriers to and unmet needs for supportive services: Experiences of Asian-American caregivers. *Journal of Cross-Cultural Gerontology*, 19,

241-260. doi:10.1023/B:JCCG.0000034221.07028.9a.

- Longacre, M. L., Miller, M. F., & Fang, C. Y. (2021). Racial and ethnic variations in caregiving-related physical, emotional, and financial strain during COVID-19 among those caring for adult cancer patients. *Supportive Care in Cancer*, 29(7), 4137–4146. <https://doi.org/10.1007/s00520-020-05933-9>.
- Losada, A., Márquez-González, M., Knight, B. G., Yanguas, J., Sayegh, P., & Romero-Moreno, R. (2010). Psychosocial factors and caregivers' distress: Effects of familism and dysfunctional thoughts. *Aging & Mental Health*, 14(2), 193–202. <https://doi.org/10.1080/13607860903167838>
- Mendez-Luck, C. A., Applewhite, S. R., Lara, V. E., & Toyokawa, N. (2016). The concept of familism in the lived experiences of Mexican-origin caregivers. *Journal of Marriage and the Family*, 78(3), 813-829. <https://doi.org/10.1111/jomf.12300>
- Molina, Y., Henderson, V., Ornelas, I. J., Scheel, J. R., Bishop, S., Doty, S. L., Patrick, D. L., Beresford, S., & Coronado, G. D. (2019). Understanding complex roles of family for Latina health: Evaluating family obligation stress. *Family and Community Health*, 42(4), 254-260.
- National Academies of Sciences, Engineering, and Medicine. (2016). Families caring for an aging America. Washington, D.C.: The National Academies Press. <https://doi.org/10.17226/23606>.
- Pearlin, L. I. (1994). Conceptual strategies for the study of caregiver stress. In E. Light, G. Niederehe, & B. D. Lebowitz (Eds.). *Stress effects on family caregivers of Alzheimer's patients: Research and interventions* (pp. 3-21). Springer Publishing Company.
- Pérez-Cruz, M., Parra-Anguita, L., Lopez-Martinez, C., Moreno-Camara, Sara, & del-Pino-Casado, R. (2019). Winter and anxiety in caregivers of dependent older adult relatives. *International Journal of Environmental Research and Public Health*, 16(9), 1651. <https://doi.org/10.3390/ijerph16091651>
- Pinquant, M., & Sorensen, S. (2003). Differences between caregivers and noncaregivers in psychological health and physical health: A meta-analysis. *Psychology and Aging*, 18(2), 250-267. <https://doi.org/10.1037/0882-7974.18.2.250>
- Potter, A. J. (2018). Factors associated with caregivers' use of support services and caregivers' nonuse of services sought. *Journal of Aging & Social Policy*, 30, 155-172. doi:10.1080/08959420.2017.1414539.
- RAISE Family Caregiving Advisory Council. (2021). Recognize, Assist, Include, Support, & Engage (RAISE) Family Caregivers Act Initial Report to Congress. Retrieved from <https://acl.gov/sites/default/files/RAISE-Initial%20>

[Report%20To%20Congress%202021_Final.pdf](#)

- Reinhard, S. C., Young, H. M., Ryan, E. & Choula, R. B. (2019). The CARE Act Implementation: Progress and Promise. AARP Public Policy Institute. Retrieved from <https://www.aarp.org/content/dam/aarp/ppi/2019/03/the-care-act-implementation-progress-and-promise.pdf>.
- Reinhard, S. C., Feinberg, L. F., Houser, A., Choula, R., & Evans, M. (2019). Valuing the invaluable: 2019 update. AARP Public Policy Institute. Retrieved from <https://www.aarp.org/content/dam/aarp/ppi/2019/11/valuing-the-invaluable-2019-update-charting-a-path-forward.doi.10.26419-2Fppi.00082.001.pdf>
- Rodríguez-Pérez, M., Abreu-Sánchez, A., Rojas-Ocaña, M. J., & Del-Pino-Casado, R. (2017). Coping strategies and quality of life in caregivers of dependent elderly relatives. *Health and Quality of Life Outcomes*, 15(1), 71. <https://doi.org/10.1186/s12955-017-0634-8>
- Romero-Moreno, R., Márquez-González, M., Losada, A., & López, J. (2011). Motives for caring: relationship to stress and coping dimensions. *International Psychogeriatrics*, 23(4), 573–582. <https://doi.org/10.1017/S1041610210001821>.
- Rozario, P. A., & DeRienzi, D. (2008). Familism beliefs and psychological distress among African American women caregivers. *The Gerontologist*, 48(6), 772-780. <https://doi.org/10.1093/geront/48.6.772>
- Sayegh, P., & Knight, B. G. (2010). The effects of familism and cultural justification on the mental and physical health of family caregivers. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences*, 66(1), 3–14. <https://doi.org/10.1093/geronb/gbq061>
- Schulz, R., & Sherwood, P. R. (2008). Physical and mental health effects of family caregiving. *American Journal of Nursing*, 108(9 Suppl), 23-27. <https://doi.org/10.1097/01.NAJ.0000336406.45248.4c>.
- Sorrell, J. M. (2014). Moving beyond caregiver burden: Identifying helpful interventions for family caregivers. *Journal of Psychosocial Nursing and Mental Health Services*, 52(3), 15–18. <https://doi.org/10.3928/02793695-20140128-05>
- Vandepitte, S., Van Den Noortgate, N., Putman, K., Verhaeghe, S., Verdonck, C., & Annemans, L. (2016). Effectiveness of respite care in supporting informal caregivers of persons with dementia: A systematic review. *International Journal of Geriatric Psychiatry*, 31(12), 1277–1288. <https://doi.org/10.1002/gps.4504>

- Westat. (2018). *Outcome evaluation of the National Family Caregiver Support Program*. Retrieved from https://acl.gov/sites/default/files/programs/2018-12/Caregiver_Outcome_Evaluation_Final_Report.pdf.
- Winter, K. H., Bouldin, E. D., & Andresen, E. M. (2010). Lack of choice in caregiving decision and caregiver risk of stress, North Carolina, 2005. *Preventing Chronic Disease*, 7(2), 1-12.
- Wolff, J. L., Spillman, B. C., Freedman, V. A., & Kasper, J. D. (2016). A national profile of family and unpaid caregivers who assist older adults with health care activities. *JAMA Internal Medicine*, 176(3), 372-379. <https://doi.org/10.1001/jamainternmed.2015.7664>
- Zarit, S. H., Reever, K. E., & Bach-Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. *The Gerontologist*, 20, 649-655.
- Zebrak, K. A., & Campione, J. R. (2021). The effect of National Family Caregiver Support Program services on caregiver burden. *Journal of Applied Gerontology*, 40(9), 963-971. <https://doi.org/10.1177/0733464819901094>.

A Comfort or a Threat? How Older Italians View Home Eldercare Assistants

*Anne E. Barrett, PhD

*Pepper Institute on Aging and Public Policy, Department of Sociology
Florida State University, Tallahassee, FL*

abarrett@fsu.edu

Katia Vecchione, MS, RN

*Independent Scholar
Trento, Italy*

*Corresponding author

Acknowledgements

This research was supported by a Fulbright Senior Scholar Research Award to Anne Barrett. It also was supported by the Pepper Institute on Aging and Public Policy at Florida State University in Tallahassee, Florida, and the Department of Sociology and Social Research and the Center for the Interdisciplinary Study of Gender at the University of Trento in Trento, Italy. The authors thank the staff members at the senior center and nursing home where we conducted interviews. They generously assisted with recruiting and scheduling and found space for the interviews. We also thank Dominik Balazka for his transcription assistance and useful project suggestions. Most of all, we thank the participants in our study. Without their enthusiastic involvement, honest responses, and patience with a non-native Italian speaker, this research would not have been possible.

ABSTRACT

Increasing life expectancy has led, in many countries, to new arrangements to meet the growing need for care in later life. In Italy, with the second oldest population in the world, family members, especially women, provide the majority of care. Paid care workers, however, are increasingly filling in where families cannot. Known as “home eldercare assistants” or *badanti*, most are middle-aged women from Eastern Europe, South America, or the Philippines.

Research on this phenomenon is limited by its almost exclusive focus on care workers rather than older adults who receive their care—or may do so in the future. Our study addresses this issue using interviews with 28 older adults living in northern Italy. Participants with friends or family members who had received support from these care workers often held positive views. Most, however, also expressed negative views that resonated with cultural discourses about aging, as well as immigration. These views reflected the high value placed on independence, along with the centrality of the home as a site for decision-making and identity maintenance. Negative views also were shaped by dominant discourses that construct immigrants as threats to security, particularly regarding one's belongings. Another discourse that influenced views of home elder-care assistants centered on the construction of aging as a biomedical phenomenon that is better addressed by medical professionals in health care settings, including nursing homes. Such views influence older adults' willingness to receive help from care workers and its effectiveness—knowledge of which can improve care.

Keywords: care work, formal care, caregiving, *badanti*, Italy

¿Un consuelo o una amenaza? Cómo los italianos mayores ven a los asistentes de cuidado de ancianos en el hogar

RESUMEN

El aumento de la esperanza de vida ha llevado, en muchos países, a nuevos arreglos para satisfacer la creciente necesidad de atención en la vejez. En Italia, con la segunda población más envejecida del mundo, los miembros de la familia, especialmente las mujeres, brindan la mayor parte del cuidado. Sin embargo, los cuidadores remunerados están ocupando cada vez más los lugares donde las familias no pueden hacerlo. Conocidas como “asistentes de cuidado de ancianos en el hogar” o *badanti*, la mayoría son mujeres de mediana edad de Europa del Este, América del Sur o Filipinas. La investigación sobre este fenómeno está limitada por su enfoque casi exclusivo en los trabajadores del cuidado en lugar de los adultos mayores que reciben su atención, o pueden recibir su atención en el futuro. Nuestro estudio aborda este tema mediante entrevistas con 28 adultos mayores que viven en el norte de Italia. Los participantes con amigos o familiares que habían recibido apoyo de estos cuidadores a menudo tenían opiniones positivas. La mayoría, sin

embargo, también expresó puntos de vista negativos que resonaron con los discursos culturales sobre el envejecimiento, así como la inmigración. Estos puntos de vista reflejaban el alto valor otorgado a la independencia, junto con la centralidad del hogar como lugar para la toma de decisiones y el mantenimiento de la identidad. Las opiniones negativas también fueron moldeadas por los discursos dominantes que construyen a los inmigrantes como amenazas a la seguridad, en particular con respecto a las pertenencias de uno. Otro discurso que influyó en las opiniones de los asistentes de cuidado de ancianos en el hogar se centró en la construcción del envejecimiento como un fenómeno biomédico que es mejor abordado por profesionales médicos en entornos de atención de la salud, incluidos los hogares de ancianos. Estos puntos de vista influyen en la disposición de los adultos mayores a recibir ayuda de los cuidadores y en su eficacia, cuyo conocimiento puede mejorar la atención.

Palabras clave: trabajo de cuidados, cuidado formal, cuidado, *badanti*, Italia

舒适还是威胁？意大利老年人如何看待家庭老年护理助手

摘要

在许多国家，预期寿命的延长引起了一系列用于满足日益增长的晚年护理需求的新安排。在拥有世界第二大老年人口的意大利，家庭成员（尤其是女性）提供了绝大部分的护理。不过，有偿护理人员正越来越多地为无法自我护理的家庭提供服务。这类护理人员被称为“家庭老年护理助手”或 *badanti*，她们大多数是来自东欧、南美或菲律宾的中年妇女。关于此现象的研究有限，因为其几乎只关注护理人员，而不是接受护理的老年人或者将在今后接受护理的老年人。我们的研究通过对意大利北部的 28 名老年人进行访谈，以期研究该问题。部分参与者的朋友或家人曾经接受过这些护理人员的支持，这部分参与者通常持有积极看法。不过，大多数人也表达了消极看法，后者与关于老龄化和移民的文化话语产生共鸣。这些看法反映了对独立性的高度重视，以及家庭作为决策和身份维护场所的中心地位。负面看法也受到主流话语的影响，这些话语将移民建构为安全威胁，尤其是关于个人财物的威胁。影响对家庭老年护理助手的看法的另一话语将老龄化建构为一种生物医学现象，而医疗护理机构（包

括疗养院)的医疗专业人员能更好地应对该现象。这类看法会影响老年人在接受护理人员帮助方面的意愿以及护理有效性—了解这些能改善护理。

关键词: 护理工作, 正式护理, 护理, 家庭老年护理助手 (*badanti*), 意大利

A Comfort or a Threat? How Older Italians View Home Eldercare Assistants

Across the globe, families – and especially the women in them – provide the lion's share of care for older adults. The caregiving challenge may be particularly intense in nations that are characterized by a more family-centered model of care (Esping-Anderson, 1990; Leitner, 2003). Providing examples are the Southern European countries, including Spain, Portugal, Greece, and Italy. They contrast with others, like their northern neighbors of Sweden, Denmark, and Finland, that support older adults through a more balanced combination of family and state support (Esping-Anderson, 1990; Leitner, 2003). Italian families, however, may be stretched especially thin, given the nation's relatively high life expectancy, averaging 83 years, and its low and declining fertility

rate, averaging 1.35 children per woman (Istat, 2016; Mazzola et al., 2016; World Health Organization, 2016).

Paid immigrant care workers are increasingly filling in where Italian families cannot. They are participants in “global care chains” (Ehrenreich & Hochschild, 2004) driven by developed nations' care-provider shortage and labor market's globalization. Known in Italy as “home eldercare assistants,” or *badanti*¹ most of these care workers are middle-aged women with families of their own in Eastern Europe (e.g., Ukraine, Romania), South America (e.g., Ecuador, Peru), or the Philippines (Cvajner, 2018; Degiuli, 2016). These workers provide a variety of services, ranging from providing companionship to self-sufficient older adults to assisting those with physical or mental disabilities with tasks like bathing, dressing, and feeding (Degiuli, 2007). The work also varies by the workers' living arrangements and time commit-

1 Following Degiuli (2007: 206), we use the term “home eldercare assistant”; as she noted, “The term *badante* was first adopted by the center-right government in Law No. 189 Art. 33 July 2002 to define a ‘migrant person from a non-EEC country, who offers assistance to a person whose self-sufficiency is limited by pathologies or handicaps.’ Since its adoption the term has been contested by many because it was originally used to define, in the 1900s, people who would take care of animals.” As a term that is offensive to care providers and care recipients, various organizations have promoted the use of “home eldercare assistant.” We did, however, use the term *badante* in interviews, as it remains the more commonly used term in public discourse.

ment, with “live-in” eldercare workers residing in the care recipients’ home and providing around the clock care and “live-out” workers living in their own homes and providing care on a more fixed schedule (Degiuli, 2007).

The research examining this phenomenon focuses almost exclusively on care workers’ perspectives (e.g., Degiuli, 2007, 2010, 2011, 2016; Elrick & Lewandowska, 2008; Näre, 2009; Rugolotto, Larotonda, & van der Geest, 2017). Although some studies incorporate care recipients’ perspectives (e.g., Rugolotto et al., 2017), they provide limited insight into the perspectives of another relevant segment of the population – older adults who are not currently receiving their care, but may have considered it in the past or may seek it (or not) in the future. We know little about their perceptions of home eldercare workers, including whether they view them as desirable care providers and why they hold these views. These views are likely to be influenced by friends’ or family members’ experiences and the media’s portrayals of home eldercare providers, although we know little about their relative importance. Similarly, little is known about how they may be shaped by broad cultural narratives about aging, such as the inevitability of physical decline and importance of avoiding dependence – or narratives about immigrants, such as those centering on perceived threats to safety.

Our study addresses this issue by focusing on older Italians’ views of home eldercare assistants. It uses interviews with a sample of 28 adults between the ages of 67 and 93 living in northern

Italy. None of the participants reported having received care from home eldercare assistants; however, nearly all held strong views of these workers that were drawn from close others’ experiences or from media images. By examining these views and the social and cultural factors shaping them, our study provides insight on older adults’ likelihood of considering care from home eldercare workers and the preconceptions with which they would enter such arrangements – knowledge of which would aid in the design of more effective care scenarios.

Care Work in Italy

The Italian family’s social duty – indeed, its legal responsibility – to provide for its older members is reflected in the intergenerational coresidence and support patterns found in Italy (Albertini & Kohli, 2013; Albertini, Kohli, & Vogel, 2007; Meda, 2014; Naldini, 2003). For example, research using the Survey of Health, Ageing and Retirement in Europe found that more than half of Italians 60 and older live in a household with an adult child, a figure two to six times higher than many other European nations (Hank, 2007). It also revealed an Italian pattern of less frequent – but more intense – support (e.g., money, personal care, household help) provided by children outside the household (Albertini et al., 2007). Further indicating family’s centrality were the results of European Commission-funded survey research revealing that adult children were the most frequently mentioned persons on whom

they could rely in the case of illness – support made possible by the fact that two-thirds had children living in the same town (Gagliardi et al., 2012).

Although the family continues to be the primary care providers for older Italians (Haberkern, Schmid, & Szydlik, 2015), other sources of care, funded through private and public sources, are becoming more important (Naldini, Wall, & Le Bihan, 2013). This trend is propelled by the increasing care work demands resulting from the extension of life expectancy, the decline in family size, and the rise in women's employment – along with the state's response to these pressures (Da Roit, 2007; Naldini et al., 2013). Although more limited in Italy than many other EU nations, the state response focuses on “cash-for-care” programs, the most widely used (*Indennità di accompagnamento*) providing approximately 500 Euros a month in unrestricted funds to those needing continuous assistance (Barbabella et al., 2016; Naldini & Saraceno, 2008). The percentage of those 65 and older receiving the benefit rose over the past two decades from 6 to 13 percent – and 24 percent for those 80 and older (Barbabella et al., 2016; Gagliardi et al., 2012). Most of the funds are used to hire home eldercare assistants. Approximately 8 percent of all Italian households with older adults report hiring a home eldercare assistant, a figure much higher than elsewhere in Europe (Da Roit & Weicht, 2013).

Home eldercare assistants have been the focus of research examining this care work as a phenomenon driven

by macro-level migration processes involving globalization and inequalities, including those based on gender, race or ethnicity, and socioeconomic status (e.g., Cvajner, 2018, 2019; Parreñas, 2015). An example is Cvajner's (2018, 2019) ethnographic research examining women's experience of migration from several former Soviet republics to northern Italy. Her work historically contextualized their migration and explored how the women, most of whom became home eldercare assistants, navigated the labor market and created lives for themselves in their new home.

Another stream of research on home eldercare assistants relates more closely to the current study, as it focuses on the care work itself (e.g., Degiuli, 2007, 2010, 2011, 2016; Elrick & Lewandowska, 2008; Näre, 2009; Rugolotto et al., 2017). For example, Degiuli (2007, 2010, 2011, 2016) used participant observation and interviews with home eldercare assistants and the family caregivers who hired them, along with workers in community organizations that interfaced with these groups, to examine how the women were transformed into “ideal” home eldercare assistants, which involved the acceptance of a physically and emotionally taxing “job with no boundaries” (Degiuli, 2007, p. 193). Another example is Rugolotto and colleagues' (2017) study that used interviews with home eldercare assistants and family caregivers to examine the complex relationships involving not only positive bonds characterized by warmth and gratitude, but also negative ones characterized by subservience and exploitation.

Less is known about older adults' perceptions of home eldercare assistants; however, the literature suggests that their views are mixed. Italy's historic reliance on families for caregiving raises the possibility that non-family care providers, particularly those who are paid, are viewed negatively. This prediction is suggested by the conclusions that Rugolotto and colleagues (2017, p. 185) drew from their interviews with home eldercare assistants and the relatives of older adults who hired them:

Badanti, Italian families and older people find themselves locked in an uneasy contract: badanti because they are exploited and unable to find better, formal employment; Italian families because they are aware that they fail to render their moral duty to their aged parents and grandparents; and older people because they feel neglected and maltreated by their children.

Providing further evidence of negative views of home eldercare assistants, care workers often felt that the care recipients' family members viewed them with suspicion – as “strangers” who might swindle their loved ones. However, the study also reported that some home eldercare assistants felt that the older people for whom they cared were satisfied with the arrangements and preferred them to placement in a nursing home (Rugolotto et al., 2017).

Similarly mixed views of home eldercare workers are revealed by research conducted in other countries

(e.g., Chon, 2015; Doyle & Timonen, 2009; Porat & Iecovich, 2010; Walsh & Shutes, 2013; Yeoh & Huang, 2010). As in Italy, the patterns are gleaned from studies of care providers or (to a lesser extent) care recipients and their family members – rather than from studies of older adults who may seek such care in the future for themselves or their family members. For example, Walsh and Shutes' (2013) focus group interviews conducted in the United Kingdom and Ireland with older nursing home residents and migrant care workers, who worked in home and residential care settings, revealed complex relationships characterized not only by warm and reciprocal attachments but also by discrimination, particularly toward care workers from African countries. Mixed views of care recipient and care worker relationships also were reported in Chon's (2015) interviews conducted in Korea with home eldercare workers and care recipients' family members; however, family members tended to have more positive views than did the home eldercare workers, some of whom reported excessive demands and even sexual harassment.

Studies conducted in other countries also reveal how cultural narratives of aging influence views of home eldercare workers (e.g., Ayalon, 2009; Breitholtz, Snellman, & Fagerberg, 2012; Schröder-Butterfill & Fithry, 2014; Yeoh & Huang, 2010). A central narrative focuses on the view of care receipt, particularly in the home setting, as a threat to independence. For example, Breitholtz and colleagues' (2012) interviews with older adults receiving in-home care

in Sweden highlighted care recipients' strong desire that care workers facilitate their self-determination in the home, as an entity that symbolizes personhood. Other research draws attention to in-home care's threat to privacy, as well as safety – themes more often highlighted in studies of migrant care work. An example is Ayalon's (2009) study of older adults in Israel with live-in home care workers from the Philippines. Involving interviews with older care recipients and their family members, the study found fear of abuse or neglect to be a central concern that stemmed from concerns about having a stranger living in one's home. A similar theme is found in Schröder-Butterfill and Fithry's (2014) ethnographic study that involved interviews with all adults aged 60 and older in two rural Indonesian villages. The interviews revealed a strong reluctance to have intimate personal care provided by "non-blood" relatives.

Our study contributes to the relatively small literature – in Italy or elsewhere – examining older adults' views of home eldercare assistants. In particular, it focuses on the views of those who are not currently receiving assistance from home eldercare assistants but are likely to have perceptions of these care providers that are influenced by their friends' and family members' experiences as care recipients. Moreover, the participants' ages, which averaged 80, made it likely that they had considered the possibility of receiving assistance from home eldercare assistants. This feature of our study provides a different vantage point on Italy's home eldercare assistants.

Data and Methods

The study, which was approved by the institutional review boards at Florida State University and the University of Trento, involved interviews with 28 Italians. They were recruited from a senior center and a nursing home that were typical of such facilities in the region and were conveniently located for the researchers. The senior center was walking distance of the main piazza of a mid-sized city in northern Italy. The nursing home was located in a smaller village near the main city. In both facilities, the activities director assisted with recruitment of participants by sharing the study's details with their clients or residents. The majority of participants (71%) were recruited from the senior center. Ages ranged from 67 to 93 and averaged 80. The average age was higher among nursing home residents (83 compared with 79 years). Eighty-two percent of participants were women, and 89 percent had children. Fifty percent of participant were widowed, 25% were married, 18% were separated or divorced, and 7% were never married.

Interviews were conducted in-person at the senior center or nursing home between December 2018 and February 2019. All were conducted individually, with the exception of one married couple who was interviewed together. Written consent was obtained from all participants, with the exception of one for whom only oral consent was possible. Interviews were conducted in Italian by the authors. While the first author speaks the language at an

intermediate level, the second author is a native speaker. Most interviews were conducted with both authors present; however, the last six were conducted by the first author.

We conducted semi-structured interviews that explored the care arrangements for older adults in three broad stages of the participants' lives. Focusing on their childhood and adolescence, the first questions centered on the care provided to their great-grandparents, grandparents, or other older relatives, including their living arrangements and quality of relationships with the participants. Turning to their young adulthood and middle-age, participants were asked about the support or care provided to their own parents, in-laws, or other older relatives. Respondents were then asked about their own need for and receipt of various types of support or care from different sources, including their adult children, grandchildren, siblings or other relatives, friends, and paid caregivers. Participants, particularly those recruited from the senior center who needed little assistance in their daily lives, were asked about their desired sources of care, should they require any additional assistance in the future. All participants consented to the audio-recording of interviews, which were transcribed verbatim. The excerpts used in this paper were translated into English by the authors.

We used thematic analysis, a qualitative method that reveals overarching patterns by identifying topics and ideas found in the data (Boyatzis, 1998;

Braun & Clarke, 2006; Nowell, Norris, While, & Moules, 2017). The analysis involved several steps. We first read one-third of the transcripts to develop initial coding categories (e.g., home eldercare assistants, nursing homes, parents' later life health, care for grandparents, participants' care preferences). We then coded all transcripts using these codes, in addition to others that emerged during this more in-depth coding (e.g., home eldercare assistants' ethnicity or nationality, positive views of nursing homes, news stories about home eldercare assistants).

For the current paper, we examined all excerpts of the transcripts that included codes related to home eldercare assistants. As we examined these excerpts, we considered them in the context of the full interview to clarify participants' views. For example, contextualization of the excerpts revealed that although participants often conveyed some positive views of home eldercare assistants these sentiments were often revealed by questions that followed respondents' initial descriptions of negative views (e.g., "Do you know anyone who had a positive experience with a *badante*?"). This observation revealed that many participants' most salient view of home eldercare assistants was negative. From the analysis of all interview content related to home eldercare assistants, several key themes emerged, which became the outline for the results section of this paper.

Results

Analyses revealed that a mix of positive and negative views of home eldercare assistants, a pattern consistent with prior studies conducted in Italy and elsewhere (e.g., Chon, 2015; Doyle & Timonen, 2009; Porat & Iecovich, 2010; Rugolotto et al., 2017; Walsh & Shutes, 2013; Yeoh & Huang, 2010). Positive sentiments were especially common among participants with friends or family members who had received care from these providers. Most participants, however, also expressed negative views, especially when asked about their possible receipt of such assistance in the future. Our analyses focus on unpacking explanations for these negative views by drawing on dominant cultural discourses about aging, as well as immigration.

***Una Bravissima Donna* (Excellent Woman): Positive Views of Home Eldercare Assistants**

Some respondents conveyed positive views of home eldercare assistants, often using terms like *una bravissima donna* (an excellent woman) or *una persona meravigliosa* (a marvelous person). For example, Pina, an 87-year old woman, had only positive words to describe a neighbor's home eldercare assistant: "She comes, takes the lady out, but not outside now because it's cold. But at least downstairs for some fresh air. She talks with her and caresses her. But the *badante* looks after her like . . . better! She takes care of her as she was one of her relatives. Really, really good." Oth-

ers with positive descriptions had had personal experiences with home eldercare assistants, particularly as providers of care to their relatives. For example, 80-year-old Ida described her experience with a home eldercare assistant who had cared for her sister: "I had just retired and my brother was still working because you can't assist a person 24 hours a day. So we found this *badante*. She was really a wonderful person. We are still in touch with her despite the fact it has been thirteen years that my sister is no longer with us."

Such views, however, were often revealed only by interview questions that followed participants' initial expression of negative sentiments, an observation suggesting that the most salient views were, in fact, negative. The following excerpt from the interview with Assunta, a 68-year-old divorced woman, provides an illustration:

Interviewer: Would you consider the idea of having a *badante*?

Assunta: No. [Laughs, then laughs a bit more loudly.] No.

Interviewer: Why?

Assunta: No. No, because when you are a certain age, you are very fragile. . . . Me alone with the caregiver? No. . . . I'd almost be afraid.

[Interviewer asked about and Assunta explains the source of this feeling.]

Interviewer: Do you know anyone who has had a positive experience with a *badante*?

Assunta: Yes. Sure. Sure. My neighbors, where I live. She's a lady I still see. A very good lady. They were close, I know she treated them very well. No, no. I mean, it's my fear. It's not like I'm saying that all *badanti* are... are... but, in short... hmm...

Like Assunta, most participants could provide examples of positive experiences that others had had with home eldercare assistants, but they tended to frame them as exceptions. This observation is likely to reflect the salience of negative cultural constructions of these workers.

Una Brutta Parola (An Ugly Word): Negative Views of Home Eldercare Assistants

The interviews revealed ample evidence of negative views of home eldercare assistants, but these views were most stridently expressed when participants were asked about the idea of hiring a home eldercare assistant for themselves, should they require assistance in the future. Most participants saw it as highly undesirable. When asked to whom she would likely turn for assistance, Loretta, a 77-year-old widowed woman, indicated a preference to go to a nursing home rather than hire a home eldercare assistant because "there are only one in a thousand good ones." She expressed her position even more emphatically by adding "I told my children, I go to the bridge of the Adige and throw myself in rather than having a *badante*."

Although this response is likely to reflect dominant cultural construc-

tions of these workers, it also may stem from a more general reaction to the notion of oneself as a potential care recipient. Illustrating this possibility is the following exchange between the interviewer and Maria, a 91-year-old widowed woman:

Interviewer: Would you consider having a *badante*?

Maria: Ah... what a *brutta parola* [ugly word] – *badante* [caretaker]. Ugly.

Interviewer: In what sense "ugly"?

Maria: Yes, I don't like "*badante*," it needs to change. A lady chaperone, see how it changes? Do you need a "chaperone" for help? But "*badante*"? It's bad.

Maria's preference for a term that implies less need for assistance reflects broader discourses about aging, in particular the emphasis on preserving independence and autonomy.

Autosufficienza (self-sufficiency). Participants' attitudes toward home eldercare assistants reflected the high cultural value placed on self-sufficiency, which was perceived as threatened by home eldercare assistants' provision of care. Like Maria, who preferred the word "chaperone" over "*badante*," maintaining self-sufficiency also was important to Annamaria, an 82-year-old separated woman, for whom the amount of time home eldercare assistants spent helping indicated one's dependence. As she explained, "No, look. I wouldn't be happy. I mean, I'd be happy for them to come in the morning and do things. Either in

the morning or the afternoon. But *having it this way forever* [italics added] – no. I’m too used to being on my own. To being a little autonomous on certain things.” Annamaria’s comments revealed two factors that led participants to see their independence as imperiled by home eldercare assistants’ support – receiving it over a greater proportion of the day (and presumably night) and viewing the arrangement as permanent.

Assunta, the 68-year-old woman who indicated that she would be “afraid” to have a home eldercare assistant, also expressed a concern about its implications for her independence. As she explained, “Yes, yes, yes. They do the cleaning. Although I don’t know if I’d stand a situation . . . I don’t know. It’s not that I can say about the future, but I know I’d have a lot of trouble accepting myself in a dependency situation. Dependency.”

She continued, however, explaining that these sentiments were not limited to the idea of help from a home eldercare assistant: “Whether it’s from a *badante*, whether it’s from my daughter . . . It will be a very hard work for me to accept help from someone else.” As these comments illustrate, some of the negative sentiments regarding home eldercare assistants were not specific to paid care providers. They reflected what home eldercare assistants represented to most participants: a loss of independence, and perhaps an irreversible one.

“La casa mia” (my home). Views of home eldercare assistants were influenced by another dominant cultural

discourse about aging, one that centered on the home as a space for autonomous decision-making, thus an entity that symbolizes personhood. For some participants, the symbolic importance of the home manifested in an emphasis on the objects in it – their belongings, over which they wished to maintain control. When asked about home eldercare assistants, Luisella, a 71-year-old widowed woman, replied with the following explanation for her opposition to hiring them: “Absolutely – no, no, no. Absolutely. I am particular about who touches my things. My daughter, too. If she touches my things, she moves them . . . I say, ‘Where’s the thing? Where is it?’ But wasn’t it okay there? It has to stay there. I put it there, it’s there. When I was in the hospital [...] I couldn’t find my things anymore. Where’s the... ? All because they were put somewhere else.” Luisella’s expectation that objects remain where she places them – and not be relocated by others, even family members – illustrates participants’ strong desire to preserve their autonomous decision-making in the home.

Other participants emphasized the psychological adjustment that having an eldercare assistant would require, given their presence in the home. Anna, an 84-year-old widowed woman, described that she would find having an eldercare assistant in her home “a little difficult.” She continued, asking “Do you know why? Because you’re used to being alone and it’s hard.” Anna’s comments suggest that receiving care from a home eldercare assistant is challenging for many people because it represents a significant shift – from being complete-

ly alone in one's home to having another person present.

Anna's further explanation suggests yet another facet of participants' discomfort with the idea of home eldercare workers, and one that was shared by other participants: They are "strangers" in the home. As Anna explains, "I don't know how to say, having *a person you don't know* [italics added] inside the house is . . . I'd be a little uncomfortable, you know. I don't know. I'm going to have to accept it later, of course." Flora, an 89-year-old widowed woman, expressed a similar unease: "Look, honestly. Sincerely. As long as I'm clear-minded, I want to stay in my house. To help me with home cleaning I have my daughter-in-law. I would never want *strangers* [italics added]. I'd rather go to the nursing home. If one day I don't understand anything anymore, then throw me in the nursing home. I don't give a damn. No, no, no, no, no [to the having a home eldercare assistant]." Flora's comments, in particular, illustrate how participants' discomfort with home eldercare assistants as strangers centered on their presence in the home. Flora viewed paid care in the home as less desirable than paid care in a nursing home, although care in both settings would be provided by unfamiliar others. This observation underscores the view of paid care in the home as especially threatening.

Some participants corroborated their reluctance to having a home eldercare assistant by describing friends' or family members' experiences of care, with these descriptions often empha-

sizing a definition of these workers as strangers. An example is provided by Pia, a 75-year-old married woman, who said "I have my friends who have *badanti*. Eh, now they've adapted, let's say. It's been a while . . . A little problematic at first . . . because my son's mother-in-law didn't like her at all. I mean, having a person in the house, *stranger* [italics added], it's a little hard, huh." Nora, a 78-year-old married woman, similarly drew on her sister's experience with home eldercare assistants to explain the risk of receiving care from a stranger. She mentioned that several of the home eldercare assistants before the current one had mistreated her sister. As she explained, "[T]he others sincerely were dishonest. They filled her with medicine and they went outside, more than one. So this is what I mean, the people you take into the house you have to get to know them well, don't you?"

A factor that appeared to shape the labeling of home eldercare assistants as "strangers" was their ethnicity or national origin. Although respondents did not express overtly negative views of home eldercare assistants as immigrants, we observed that many participants mentioned this characteristic without a direct question about it. It was often the only demographic characteristic mentioned, besides gender. None of the participants, for example, referred to the age or marital status of a home eldercare assistant. When asked whether he knew anyone who had hired a home eldercare assistant, Giuseppe, a 73-year-old divorced man who lived in the nursing home, mentioned his in-laws, adding that their care pro-

vider was “a very polite lady. I think she is Ukrainian, if I’m not mistaken.” Pina, an 87-year-old woman who also lived in the nursing home, noted that she knew a home eldercare assistant who is Albanian, adding “but very nice, friendly, sweet.” Such comments alluded to home eldercare assistants as “outsiders” or “others,” contributing to the view of them as strangers in the home.

La sicurezza (security). Participants also conveyed negative views of home eldercare assistants that centered on concerns about safety. These concerns resonated with two cultural discourses – one about aging’s effect on one’s vulnerability and another about immigrants as threats to one’s safety. As Assunta, the 68-year-old divorced woman whose dialogue was presented earlier to illustrate the greater salience of negative than positive views, explained, “...when you are a certain age, you are very fragile. ... Me alone with the caregiver? No. ... I’d almost be afraid.” Another illustration is provided by Ida, an 80-year-old divorced woman who described her efforts to protect her sister from her home eldercare assistant – a role she termed a “badante for the badante.” As she explained:

Well, there are *badanti* who steal money and treat the sick badly, et cetera. So I used to go there [to her sister’s house] every day. So I’d go and see what the caretaker was doing. But I mean, as my mother used to say, “The occasion makes the thief.” If you are a poor wretch, alone, with the caretaker, better go to the

hospital. Because even if she’s good, she might think of putting a hundred euros in her pocket because you’ve got them there.

This description reflects a view of older people, particularly those in need of assistance, as vulnerable to mistreatment and a view of home eldercare assistants as care providers who may succumb to the temptation of exploiting the relationship’s power differential and the home setting’s limited oversight.

While some participants mentioned perceived threats to physical safety, most of the concerns centered instead on the objects in the home, the belongings. Describing her mother’s home eldercare assistant, Fiorenza, a 78-year-old widowed woman, said that “she was one who took away a lot of stuff, too. Because my mom was a woman who knew how to use her hands and was buying fabrics, pieces of stuff, balls of wool, and had made a full closet. That one took it all away in bags. Got it?” A more intricate scheme was described by Loretta, a 77-year-old widowed woman, who recounted a story of attempted jewelry theft by a cake-baking home eldercare assistant. The following excerpt described it:

Interviewer: Do you know the people this happened to?

Loretta: Yes. Yes. That she had gold jewelry, she was the one who had it in the cakes. And [the home eldercare assistant] said, “I make two cakes. One I make for my relatives, I make one for us.” And inside one of those she had

put the rings. So when it was time to take the cakes, she didn't remember which was which. When the older woman's relatives came in the evening, she said, "Come on, let's eat the cake." They cut the cake and things were in it. And it's true, eh.

As these examples illustrate, participants often viewed home eldercare assistants as highly undesirable care providers because they could be thieves.

This perception resulted from participants' collection of various accounts regarding home eldercare assistants, with the media an important source of them. As an illustration, Ida, who had described herself as a "badante for the badante," said, "I do not recommend it [hiring a home eldercare assistant], because every now and then you read in the newspaper, about those who live alone . . . the badante. Better go to the nursing home . . . as my mom used to say 'the opportunity'. . . that is, if she's there on her own . . . [and it's] clear that if she can, something remains in her pocket, in short [laughs]." Nunzia, 69-year-old widowed woman, also shared a story that appeared in the news. She prefaced it by saying she would not consider having a home eldercare assistant "because I have heard lots of bad stories." When asked to provide an example, she recounted the following:

Even around here, huh?! Last year . . . a gentleman down here . . . took his wife to the hospital because he was sick. He came back and never found the furniture. Eh, probably, even you

heard about it . . . Everybody on the street knew about it. And I want a *badante*? I don't think she will steal my furniture, no. But the same, with all the ones I hear. Oh, no.

The salience of these accounts, which provided rationales for participants' negative views of home eldercare assistants, may have been magnified by several factors. Their origin in a variety of sources, including family and community members' experiences and the media, may have amplified their impact. Moreover, the accounts "make sense," as they resonate with dominant cultural narratives of aging, as well as immigration. The emphasis on theft of belongings in the home reflects aging narratives that center this space as a site for self-determination, thus heightening the perceived risk of having those defined as strangers in it. The accounts' salience may have been further strengthened by their resonance with two additional narratives that intertwine to support a negative view of home eldercare assistants – an aging narrative that emphasizes older adults' vulnerability and an immigration narrative that emphasizes the workers' "otherness" and their perceived criminality.

"Preferenza per casa di riposo" (preference for nursing homes). Contrasting with their views of home eldercare assistants, participants tended to view nursing homes in more uniformly positive ways. For example, they often mentioned them as their preferred source of care should it be required

in the future – a preference that a few participants had conveyed to their children. For some, their rationale centered on the greater sense of security that nursing homes were thought to provide. As Anna, an 84-year-old widowed woman, explained, “I’ll go to the nursing home if they take me. I’m safer there [Laughs].” Moreover, she implied it was almost an inevitable, and final, transition. As she observed, “there are lot of ladies who came here [to the senior center] that went to the nursing home . . . I mean, that’s our end.” For other participants, however, nursing homes were less of an inevitability and more of a reassuring option, as a place where all their medical needs could be taken care of. In explaining her preference for a nursing home over a home eldercare assistant, Carlotta, a 67-year-old widow, said the following: “I think in a nursing home you’re much more protected, more looked after. [...] It’s like a hospital.” However, the level of care needed figured into one’s preferences, as Ida, an 80-year-old divorced woman, noted: “[I]t depends on how much you’re staying at home sick with a *badante*. It’s better to go to the nursing home: there they give you everything and more.” The focus on the availability of medical care in nursing homes reflected cultural discourses about aging that construct it as a largely biomedical phenomenon – namely a set of inevitable physiological declines that can be slowed or ameliorated with biomedical approaches (Estes & Binney, 1989). The dominance of these aging discourses contributed to participants’ negative views of home eldercare assistants, who

were seen as lacking credentials from the medical institution.

Discussion

Our study contributes to the literature on an increasingly common care arrangement in Italy and many other countries, the hiring of home eldercare assistants – typically middle-aged migrant women – to provide older adults with care that allows them to continue living at home. The study’s contribution stems from its focus on the views of these workers that are held by a segment of the population receiving relatively limited attention in prior studies – older adults who are not currently receiving their care but may have considered it in the past or may seek it (or not) in the future. Prior studies have focused instead on care providers or (to a lesser extent) current care recipients and their family members (e.g., Ayalon, 2009; Chon, 2015; Degiuli, 2016; Rugolotto et al., 2017; Walsh & Shutes, 2013; Yeoh & Huang, 2010). These studies provide much insight on the experiences of care providers and recipients and the relationships they form; however, they yield more limited insight on the views of these workers that are held by the broader population of older adults for whom the issue of their own or family members’ care needs in the future may be especially salient. Understanding their views and the social and cultural factors shaping them can help to identify and unpack preconceptions of these care providers, an exercise that could improve care and the conditions under which it is provided.

Our study, which focused on older adults in Italy, revealed a mix of positive and negative views of home eldercare assistants. This observation resonates with prior studies, conducted in Italy and elsewhere, that focused on care providers and care recipients and their family members (e.g., Chon, 2015; Doyle & Timonen, 2009; Porat & Iecovich, 2010; Rugolotto et al., 2017; Walsh & Shutes, 2013; Yeoh & Huang, 2010). Also echoing these prior studies were some of the themes that emerged from our analyses of these countervailing views, several of which reflected dominant cultural narratives of aging. This observation points to their wide-ranging influence, as they shape not only care recipient and care provider relationships but also the views of these care providers that are held by the broader population.

Our analyses indicated that participants' positive views largely stemmed from their knowledge of others' positive experiences, particularly family members' and friends' – an observation with implications for long-term care policy that extend beyond that of home eldercare. This observation resonates with prior research indicating that care recipients and their family members tend to have positive assessments of their experiences, while negative views are more common among home eldercare workers (e.g., Chon, 2015; Degiuli, 2016; Rugolotto et al., 2017). Also consistent with these studies, we found that our participants described “excellent” home eldercare assistants as those who treated the care recipients “like family,” implying that care from family is the standard

against which other types are measured. While not surprising, this observation underscores the bedrock expectation that all care recipients, regardless of the source of their care, are treated with dignity and compassion. It also highlights the importance of enhancing home eldercare assistants' ability to provide care that meets this expectation, namely through policies that make these jobs better paid, less precarious, and less physically and emotionally draining. Another policy implication is suggested by our observation that positive views largely derived from knowledge of others' favorable experiences. It suggests the potential value in facilitating this exchange, perhaps through social networks or support groups connected with the health service community – a possibility that may help counter the negative images of home eldercare assistants that are dominant in the culture.

Like the positive views of these care providers, the negative views of them also revealed values that reflect dominant cultural narratives of aging and have implications for long-term care policy, and care policies more generally. Our analyses revealed that some of the negative views stemmed from the loss of independence that care receipt – from any source – was assumed to represent. Care receipt in the home, however, gave relevance to another aging narrative, one that centers the home as a critical site for autonomous decision-making and identity preservation. These findings are consistent with prior research emphasizing the centrality of the home and the importance of preserving in-home care recipients'

self-determination (e.g., Breitholtz et al., 2012; Yeong & Huang, 2009). These findings reflected the cultural framing of “aging well” as a project centered on avoiding any sign of dependence – and continuing to reside in the home (e.g., Dillaway & Byrnes, 2009; Katz & Calasanti, 2015). This observation points to the importance of policies that assist older adults in achieving these goals.

From a more critical perspective, however, the observation suggests that alternative framings of the changes that can precipitate care receipt – from home eldercare assistants or other providers – may provide useful antidotes to the dominant cultural narratives of aging and may create more positive care experiences. One such alternative framing would place the receipt of care in later life in a broader perspective that recognizes and values individuals’ ever-shifting participation across their lives in the giving and receiving of varying levels and types of care. Such a framing could be facilitated by policy changes that minimize age as a factor used to organize the delivery of social care services and to determine eligibility for them. This reconfiguration may loosen the cultural link between care receipt and later life, which contributed in our study to participants’ negative view of care receipt. It would unpack the various elements of “long-term care” and locate them in the broader set of social and health care services, thus shifting the policy focus from age or life stage to care, including its receipt, provision, and unmet need across the life course.

Raising other policy implications are our analyses revealing that negative

perceptions of home eldercare assistants stemmed, in part, from the view of them as “strangers” in the home. This finding is consistent with other studies conducted in Italy and elsewhere (e.g., Ayalon, 2009; Degiuli, 2016; Schröder-Butterfill & Fithry, 2014). Although some of this sentiment reflected the home’s importance as a site for decision-making and identity maintenance, it also appeared to relate to these care providers’ ethnicity or nationality, which marked them as “other” to some participants. This finding underscores the importance of better understanding these views and how policies to challenge them could be designed and implemented. Insight on these views could be gained by research that examines images of home eldercare assistants found in the media and popular culture and how they influence Italians’ of all ages, views of these care providers. Such research also could incorporate an examination of how media depictions of an even more politicized and highly publicized migration process – African migrants’ harrowing journeys across the Mediterranean Sea – may influence Italians’ views of and relationships with people from other migrant groups, including many home eldercare assistants.

Another finding of our study – one that has received limited attention in the literature on home eldercare workers – suggests long-term care policy implications. We found that views of home eldercare assistants were colored by a dominant cultural narrative that constructs aging as a biomedical phenomenon requiring biomedical solutions (Estes & Binney, 1989). This ori-

entation led some participants to report a preference for nursing homes over home eldercare assistants. This finding contrasts with Rugolotto and colleagues' (2017) interviews with home eldercare assistants and family members of those receiving, which suggested that some older Italians preferred home eldercare assistants because they avoided the shame of nursing home placement by one's family. Among those receiving care from home eldercare assistants, who were the focus of their study, the typically more intensive care provided in nursing homes may be constructed as a less desirable option, given the strong cultural emphasis placed on avoiding dependence. In contrast, older adults who are not currently receiving any care – like most of our participants – may be able, through the privilege of their greater independence, to sidestep this issue altogether and focus instead on nursing homes' provision of medical care for their aging-related medical issues. Further research is needed to unpack these possibilities and explore their policy implications, which may include issues related to the training and credentialing of home eldercare assistants, as well as the framing of these care providers by the health and social service agencies with which they interface.

Although the general themes revealed in our interviews echoed those in other care work research, some findings may not extrapolate to other countries or even other regions in Italy. Our interviews were conducted in northern Italy, where family size is the smallest, incomes the highest, and elder services the most extensive (Mazzola et al., 2016).

Northern families' care work pressures, combined with their greater resources to hire help, may generate more positive views of home eldercare workers than might be found in southern Italy, where care provision exclusively by family remains a stronger norm.

Also suggesting a direction for further research is our study's inclusion of two distinct groups – senior center participants and nursing home residents. This design offers the advantage of a wider range of perspectives on home eldercare workers, although it likely influenced some of our findings. For example, nursing home residents are more exposed to a biomedical approach to aging, which may predispose them to this orientation. Moreover, their residence in a nursing home gave them a vantage point on home eldercare workers, from whom they were unlikely to ever receive care, that differed from that of the senior center participants, for whom such care was more likely. A more extensive examination of this topic could explore the views of a wider range of older Italians, including those in different regions and having different living arrangements, family networks, and physical abilities.

In sum, our study revealed that older Italians' views of home eldercare assistants are complex. Some are positive and others negative – but this complexity can be understood as a reflection of tensions between various social and cultural factors shaping these perceptions. While friends' and family members' positive care experiences contributed to positive views of these care

providers, these views were undercut by the negative views of in-home care, particularly by paid workers who may be of a different ethnic group, that pervaded the culture. Other tensions were produced by dominant narratives of aging, as well as immigration. The construction of aging as a biomedical phenomenon made nursing homes more appealing options than in-home care; however, this preference conflicted with the emphasis on the home's centrality to

one's well-being, especially in later life. Similarly, the emphasis on the home, and the symbolism of the belongings in it, sat uncomfortably with cultural discourses about immigration that constructed paid care providers in one's home as potential threats. By identifying these contradictions and suggesting policies that could alleviate them, our study can contribute to improving care experiences in Italy and beyond.

References

- Ayalon, L. (2009). Fears come true: The experiences of older care recipients and their family members of live-in foreign home care workers. *International Psychogeriatrics*, 21(4), 779-86.
- Breitholtz, A., Snellman, I., & Fagerberg, I. (2012). Older people's dependence on caregivers' help in their own homes and their lived experiences of opportunity to make independent decisions. *International Journal of Older People Nursing*, 8(2), 139-48.
- Estes, C.L., & Binney, E.A. (1989). The biomedicalization of aging: Dangers and dilemmas. *The Gerontologist*, 29(5), 587-96.
- Albertini, M., Kohli, M., & Vogel, C. (2007). Intergenerational transfers of time and money in European families: Common patterns – different regimes? *Journal of European Social Policy*, 17(4), 319-34.
- Albertini, M., & Kohli, M. (2013). The generational contract in the family: An analysis of transfer regimes in Europe. *European Sociological Review*, 29(4), 828-40.
- Barbabella, F., Chiatti, C., Rimland, J.M., Melchiorre, M.G., Lamura, G., & Lattanzio, F. (2016). Socioeconomic predictors of the employment of migrant care workers by Italian families assisting older Alzheimer's disease patients: Evidence from the Up-Tech study. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 71(3), 514-25.
- Boyatzis, R.E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: SAGE Publications.

- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Chon, Y. (2015). An exploratory qualitative study on relationships between older people and home care workers in South Korea: The view from family carers and service providers. *Ageing & Society*, 35(3), 629-52.
- Cvajner, M. (2018). *Sociologia delle migrazioni femminili: L'esperienza delle donne post-societiche*. Bologna, Italy: il Mulino.
- Cvajner, M. (2019). *Soviet Signoras: Personal and Collective Transformations in Eastern European Migration*. Chicago, IL: University of Chicago Press.
- Da Roit, B. (2007). Changing intergenerational solidarities within families in a Mediterranean welfare state. *Current Sociology*, 55(2), 251-69.
- Da Roit, B., & Weicht, B. (2013). Migrant care work and care, migration and employment regimes: A fuzzy-set analysis. *Journal of European Social Policy*, 23(5), 469-86.
- Degiuli, F. (2007). A job with no boundaries: Home eldercare work in Italy. *European Journal of Women's Studies*, 14(3), 197-207.
- Degiuli, F. (2010). The burden of long-term care: How Italian family care-givers become employers. *Ageing & Society*, 30(5), 755-77.
- Degiuli, F. (2011). Labouring lives: The making of home eldercare assistants in Italy. *Modern Italy*, 16(3), 345-61.
- Degiuli, F. (2016). *Caring for a living: Migrant women, aging citizen, and Italian families*. Oxford, UK: Oxford University Press.
- Dillaway, H.E., & Byrnes, M. (2009). Reconsidering successful aging: A call for renewed and expanded academic critiques and conceptualization. *Journal of Applied Gerontology*, 28(6), 702-22.
- Doyle, M., & Timonen, V. (2009). The different faces of care work: Understanding the experiences of the multi-cultural care workforce. *Ageing & Society*, 29(3), 337-50.
- Ehrenreich, B., & Hochschild, A.R. (2004). *Global women: Nannies, maids, and sex workers in the new economy*. New York, NY: Henry Holt and Company.
- Elrick, T., & Lewandowska, E. (2008). Matching and making labour demand and supply: Agents in Polish migrant networks of domestic elderly care in Germany and Italy. *Journal of Ethnic and Migration Studies*, 34(5), 717-34.
- Esping-Anderson, G. (1990). *The three worlds of welfare capitalism*. Princeton, NJ: Princeton University Press.

- Gagliardi, C., Di Rosa, M., Melchiorre, M.G., Spazzafumo, L., & Marcellini, F. (2012). Italy and the aging society: Overview of demographic trends and formal/informal resources for the care of older people. In J.A. Jaworski (Ed.), *Advances in sociology research* (pp. 85-104). Hauggaugue, NY: Nova Science Publishers.
- Haberkern, K., Schmid, T., & Szydlik, M. (2015). Gender differences in intergenerational care in European welfare states. *Ageing & Society*, 35(2), 298-320.
- Hank, K. (2007). Proximity and contacts between older parents and their children: A European comparison. *Journal of Marriage and Family*, 69(1), 157-73.
- Istat (2016). *Births and fertility among the resident population. Year 2015*. Retrieved from http://www.istat.it/en/files/2016/11/EN_Births_Fertility_2015.pdf?title=Birth+and+fertility+-+28+Nov+2016+-+Full+text.pdf.
- Katz S., & Calasanti, T. (2015). Critical perspectives on successful aging: Does it “appeal more than it illuminates?” *The Gerontologist*, 55(1), 26-33.
- Leitner, S. (2003). Varieties of familialism: The caring function of the family in comparative perspective. *Journal of European Societies*, 5(4), 353-75.
- Mazzola, P., Rimoldi, S.M.L, Rossi, P., Noale, M., Rea, F., Facchini, C., Maggi, S., Corrao, G., & Annoni, G. (2016). Aging in Italy: The need for new welfare strategies in an old country. *The Gerontologist*, 56(3), 383-90.
- Meda, S.G. (2014). No country for old men? Italian families facing the challenges of an aging society. *Journal of Comparative Family Studies*, 45(2), 275-92.
- Naldini, M. (2003). *The family in the Mediterranean welfare states*. London, UK: Frank Cass.
- Naldini, M., & Saraceno, C. (2008). Social and family policies in Italy: Not totally frozen but far from structural reforms. *Social Policy & Administration*, 42(7), 733-48.
- Naldini, M., Wall, K., & Le Bihan, B. (2013). The changing mix of care in six European countries. In B. Le Bihan, C. Martin, & T. Knijn (Eds.), *Work and care under pressure: Care arrangements across Europe* (pp. 171-194). Chicago, IL: University of Chicago Press.
- Näre, L. (2009). The making of “proper” homes – everyday practices of migrant domestic work in Naples. *Modern Italy*, 14(1), 1-17.
- Nowell, L.S., Norris, J.M., White, D.E., & Moules, N.J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1), 1-13.

- Parreñas, R.S. (2015). *Servants of Globalization: Women, Migration and Domestic Work* (2nd ed.). Stanford, CA: Stanford University Press.
- Porat, I., & Iecovich, E. (2010). Relationships between elderly care recipients and their migrant live-in home care workers in Israel. *Home Health Care Services Quarterly*, 29(1), 1-21.
- Rugolotto, S., Larotonda, A., & van der Geest, S. (2017). How migrants keep Italian families Italian: Badanti and the private care of older people. *International Journal of Migration, Health and Social Care*, 13(2), 185-97.
- Schröder-Butterfill, E., & Fithry, T.W. (2014). Care dependence in old age: Preferences, practices and implications in two Indonesian communities. *Ageing & Society*, 34(3), 361-87.
- Walsh, K., & Shutes, I. (2013). Care relationships, quality of care and migrant workers caring for older people. *Ageing & Society*, 33(3), 393-420.
- World Health Organization (2016). *World Health Statistics 2016. Monitoring health for the SDGs, Sustainable Development Goals*. Geneva, Switzerland: World Health Organization.
- Yeoh, B.S.A., & Huang, S. (2010). Foreign domestic workers and home-based care for elders in Singapore. *Journal of Aging & Social Policy*, 22(1), 69-88.

Residents' and Family Perspectives of Involuntary Healthcare Facility Closure and Relocation

Raven H. Weaver, PhD

Washington State University

Department of Human Development (0568)

Pullman, WA 99164-4852

raven.weaver@wsu.edu

(Corresponding author)

Karen A. Roberto, PhD

Virginia Tech

Institute for Society, Culture and Environment
& Center for Gerontology

230 Grove Lane

Blacksburg VA 24061

kroberto@vt.edu

Nancy Brossoie, PhD

Virginia Tech

Center for Gerontology

230 Grove Lane

Blacksburg, VA 24061

brossoie@vt.edu

Pamela B. Teaster, PhD

Virginia Tech

Center for Gerontology

230 Grove Lane

Blacksburg, VA 24061

pteaster@vt.edu

ABSTRACT

Older adults who receive care in a healthcare facility certified by the Centers for Medicare and Medicaid Services receive services mandated and regulated by state and federal policy to ensure that basic quality and safety standards are met. Termination of certification due to ongoing care deficiencies results in the involuntary relocation of residents receiving Medicare or Medicaid services to another healthcare facility. If a facility ultimately closes, all residents are displaced. Facility decertification happens infrequently, but when it does occur, it affects both residents and their families. Few studies have examined resident input and the role that family plays in the relocation process. The purpose of this study was to explore residents' and families' perceptions of the relocation process and its effect on residents' health and wellbeing. The study sample included 27 residents and 93 family members from two facilities that lost their certification. Semi-structured, audio-recorded interviews conducted with participants either in-person or by telephone focused on perceptions of relocation processes, relocation challenges and stressors, and physical and mental effects on residents. Interviews were transcribed verbatim and analyzed using an open coding process to identify common themes and patterns in the data. Four interrelated, overarching themes emerged from the analysis: 1) awareness of need to relocate; 2) notification of need to relocate; 3) involvement in relocation decisions; and 4) relocation stressors. Neither residents nor families were satisfied with the relocation process and offered multiple suggestions to guide policy and practice to improve their involuntary relocation experiences.

Keywords: older adults, long-term services and supports, nursing homes, qualitative methods

Perspectivas de los residentes y sus familias sobre el cierre y la reubicación involuntarios de los establecimientos de salud

RESUMEN

Los adultos mayores que reciben atención en un centro de atención médica certificado por los Centros de Servicios de Medicare y Medicaid reciben servicios exigidos y regulados por la política estatal y federal para garantizar que se cumplan los estándares bási-

cos de calidad y seguridad. La terminación de la certificación debido a deficiencias continuas en la atención da como resultado la reubicación involuntaria de los residentes que reciben servicios de Medicare o Medicaid a otro centro de atención médica. Si una instalación finalmente cierra, todos los residentes son desplazados. La descertificación de instalaciones ocurre con poca frecuencia, pero cuando ocurre, afecta tanto a los residentes como a sus familias. Pocos estudios han examinado los aportes de los residentes y el papel que desempeña la familia en el proceso de reubicación. El propósito de este estudio fue explorar las percepciones de los residentes y sus familias sobre el proceso de reubicación y su efecto en la salud y el bienestar de los residentes. La muestra del estudio incluyó a 27 residentes y 93 familiares de dos establecimientos que perdieron su certificación. Entrevistas semiestructuradas grabadas en audio realizadas con los participantes, ya sea en persona o por teléfono, centradas en las percepciones de los procesos de reubicación, los desafíos y factores estresantes de la reubicación, y los efectos físicos y mentales en los residentes. Las entrevistas se transcribieron palabra por palabra y se analizaron mediante un proceso de codificación abierta para identificar temas y patrones comunes en los datos. Del análisis surgieron cuatro temas generales interrelacionados: 1) conciencia de la necesidad de reubicarse; 2) notificación de necesidad de reubicación; 3) participación en las decisiones de reubicación; y 4) factores estresantes de reubicación. Ni los residentes ni las familias quedaron satisfechos con el proceso de reubicación y ofrecieron múltiples sugerencias para guiar las políticas y prácticas para mejorar sus experiencias de reubicación involuntaria.

Palabras clave: adultos mayores, servicios y apoyos a largo plazo, hogares de ancianos, métodos cualitativos

居民和家庭对非自愿医疗设施关闭及搬迁的看法

摘要

在联邦医疗保险和医疗补助服务中心认证的医疗机构接受护理的老年人，接受由州和联邦政策授权并监管的、用于确保满足基本医疗质量和安全标准的一系列服务。因持续存在的护理缺陷造成的认证终止会导致接受联邦医疗保险和医疗补助服务的居民非自愿搬迁到另一家医疗机构。如果医疗机构最终关闭，所有居民都会被迫迁移。医疗机构取消认证一事

很少发生，但一旦发生便会影响居民及其家人。很少有研究分析了居民的意见以及家庭在搬迁过程中发挥的作用。本研究旨在探究居民和家庭对搬迁过程的感知及其对居民健康和福祉的影响。研究样本包括27名居民和93名家庭成员，他们来自两个失去认证的医疗设施。与参与者面对面或通过电话进行的半结构化录音访谈聚焦于搬迁过程感知、搬迁挑战和压力源、以及对居民产生的身心影响。访谈被逐字转录并使用开放式编码进行分析，以确定数据中的共同主题和模式。分析发现了四个相互关联的重要主题：1) 对需要搬迁的认识；2) 需要搬迁的通知；3) 参与搬迁决策；4) 搬迁压力源。居民和家庭都对搬迁过程不满意，并提出了多项建议以指导政策和实践，以期改善其非自愿搬迁体验。

关键词：老年人，长期服务和支持，疗养院，定性方法

Older adults residing in a health-care facility certified by the Centers for Medicare and Medicaid Services (CMS) receive services mandated and regulated by state and federal policy to ensure that basic quality and safety standards are met. Federal and state agencies inspect facilities regularly; when health and fire safety standards are not met, the cited deficiencies require timely correction. In 1998, the “Special Focus Facility” (SFF) program was developed to monitor compliance history. After inspection, a minority of facilities have more deficiencies, more severe deficiencies, or a pattern of serious deficiencies that may designate them as an SFF. Anywhere from 5 to 30 facilities per state can be in the SFF program. According to CMS, “most of the nursing homes in the SFF program significantly improve their quality of care within 18-24 months after being selected, while about 10% tend to be

terminated from Medicare and Medicaid” (CMS.gov, 2021). Because facilities have ample opportunity to correct the deficiencies, thereby making termination of certification a rare event, providers often do not consider them as serious threats (Rudder, 2016). In turn, residents and families are told not worry and typically do not anticipate or plan for relocation.

Unless residents utilize another payer source, termination of certification results in the involuntary relocation of residents receiving Medicare or Medicaid services to another healthcare facility. If a facility ultimately closes, all residents, irrespective of payer source, are displaced. Facility decertification and the involuntary relocation of residents happen infrequently (Castle, 2005/2006; Li et al., 2010), as it is an action of last resort. However, when it occurs, it impacts both residents and their families. During the transition process,

residents' care needs should be of primary concern, yet few studies have examined resident input (Lee et al., 2002) or the role that family plays in the relocation process (Gaugler & Mitchell, 2021).

Federal Requirements for Facility Closure

CMS finalized its requirements for long-term healthcare facilities closure on March 19, 2013 (Department of Health and Human Services [DHHS], 2013a). Administrators are required to "provide written notification of the impending closure and a plan for the relocation of residents at least 60 days prior to the impending closure or, if the Secretary terminates the facility's participation in Medicare or Medicaid, not later than the date the Secretary determines appropriate" (p.16795, DHHS, 2013a). Subsequent public comments regarding the rule suggested including more specific and explicit requirements. In response, CMS stated,

We appreciate the commenter's suggestion; however, we do not believe it is necessary to include specific requirements for the plan in the regulation text. We want to allow each LTC facility the flexibility to develop a plan that would most effectively protect the residents' health, safety, and well-being. (p.16798, DHHS, 2013a)

A subsequent rule was finalized in September 2016, which established "national emergency preparedness re-

quirements for Medicare- and Medicaid-participating providers and suppliers to ensure that they adequately plan for both natural and man-made disasters" (p. 63860, DHHS, 2013b). To adequately meet the needs of residents during disasters and emergency situations, providers need to coordinate with federal, state, tribal, regional, and local emergency preparedness systems. DHHS maintained the need for flexibility so that regulations are neither too specific so that they become outdated over time nor too broad to be ineffective. Instead, principles set forth in the National Preparedness Cycle within the National Preparedness System guided development of the regulations (DHHS, 2013b).

Relocation Research

Understanding the effects of relocation on residents' health and wellbeing has long-been a priority among researchers and practitioners alike (e.g., see Brownie et al., 2014; Davison et al., 2021; Pino et al., 1978). A review of literature identified psychological (e.g., autonomy and control) and social factors (e.g., relationships with staff, residents, families, and friends), as well as aspects of the built environment (e.g., private and public spaces; technology) that influence nursing home residents' sense of home (Oswald & Wahl, 2005; Rijnaard et al., 2016). Other researchers have examined residents' initial response to moving to assisted living facilities (O'Hora & Roberto, 2019) and care homes (O'Neill et al., 2022). For moves to both types of facilities, study authors offered recommendations to improve

the relocation experience, emphasizing strong communication between providers, residents, and families, and consideration of contextual factors as key for a positive transition and residents' wellbeing.

For persons living with Alzheimer's disease and related dementias (ADRD), a move to a healthcare facility is often a necessity, particularly in the later stages of life (Arrighi et al., 2010; Toot et al., 2017). The literature on the consequences of relocation for persons living with ADRD on their quality of life and their family caregivers presents inconsistent findings across studies: some residents benefited from the relocation, while others experienced no changes in quality of life (Moon et al., 2017). Ryman and colleagues (2019) found a detrimental effect for persons living with ADRD who relocated with respect to mortality and morbidity; however, the extent of participation and control (i.e., involvement in decision-making) modified adverse effects of relocation.

While there is ample research focused on older adults' initial placement in healthcare facilities, there is a dearth of contemporary literature exploring subsequent planned or involuntary relocation experiences of older residents. Murphy and colleagues (2013) explored residents' perceptions of a planned relocation from one long-term care setting to another. Three themes emerged, emphasizing the importance of 1) involvement in decisions and preparation before relocation, 2) desirability of the relocation (i.e., residents' feelings and emotions), and 3) care continuity in relation to staff, fam-

ily relationships, and relationships with other residents. The authors advocated for taking a person-centered approach to identify residents' unique needs and concerns, thereby increasing the likelihood of a positive experience with relocation.

A scoping review of involuntary relocation (Weaver et al., 2020) concluded that residents experienced immediate but minimal long-term health problems; of the 28 articles identified about involuntary relocation of residents published between 1971 and 2018, four explicitly examined residents' perception of the move, two of which also included family's perceptions of the move; one additional article included the family's perspective. Findings indicated that involuntary relocation result in immediate but minimal disruptions to health, even among this highly vulnerable population; intrinsic characteristics (e.g., functional or cognitive ability; social connections), as well as extrinsic factors (e.g., preparation and communication; staff involvement) affect functional, psychological, and emotional health outcomes of residents who experience involuntary relocation (Weaver et al., 2020).

Viewed collectively, findings across relocation studies suggest the importance of preparedness, involvement in decision-making, and inclusion of family members when experiencing initial (or additional) relocation to long-term healthcare facilities. When relocation occurs, particularly when involuntarily, information about residents' and families' involvement and response remains sparse. Thus, the pur-

pose of this study was to explore residents' and family members' viewpoints concerning the relocation process and effects of relocation on the health and wellbeing of residents. We analyzed the experiences of residents and their family caregivers following a healthcare facility decertification that triggered an involuntary relocation. Recognizing the need for a person-centered approach that illuminates the voices of residents as well as their families, our primary research question is: What are residents' and family members' perceptions of the relocation process? Based on their experiences, we discuss the need to amend policy to benefit and prioritize residents and their families during involuntary relocation.

Methods

We collected resident and family perception data as part of a larger mixed-method investigation of involuntary relocation of healthcare facility residents. The study sample came from two facilities, one in a rural area and one in an urban area of Virginia that lost their Medicare and State Medicaid certification due to ongoing care deficiencies in 2013 and 2015, respectively. The rural facility was independently owned; its decertification necessitated the relocation of 53 residents. The urban facility was part of a national corporation; its decertification required relocation of 132 residents. Decertification of both facilities and subsequent resident relocations occurred within a 2-year period. Because data collection procedures were similar

across facilities, we combined and analyzed the data collectively.

Procedures

Contact information for 99 residents and 191 family members was provided directly from the Virginia Department of Medical Assistance Services (DMAS) to study authors using secure information transfer protocols following the policies and procedures of the DMAS and the Virginia Tech Institutional Review Board (#15-135). All participants provided informed consent prior to being interviewed. A research team member (including Weaver, Brossoie, and Teaster) conducted in-person interviews with the residents and either in-person or telephone interviews with families. Interviews were recorded and transcribed for the purpose of analysis. In appreciation of their time, the research team transferred \$10 into the resident's facility fund accounts, and family members received a \$10 gift card to a local retailer.

Participants

The study sample was comprised of 27 residents and 93 family members identified as responsible for monitoring a resident's care (i.e., relatives, guardians, power of attorneys). Non-participating residents were unable to be interviewed because they had cognitive impairments, were geographically inaccessible, or had died. Among the non-participating family members, 66 were lost to contact (e.g., invalid contact information, unable to contact after five attempts), and 32 family members declined an interview.

Residents interviewed ranged in age from 37 to 93, 33% identified as female, and the majority were White. Family members primarily identified as female (69%) and were either an adult child (28%) or other family member (26%); just (8%) was a spouse/partner of the resident. To preserve participant confidentiality, no other demographic or health characteristics were collected about individual study participants. However, aggregate-level (de-identified) Minimum Data Set (MDS; CMS, gov, n.d.a.) health assessment data (available from the second author) for all residents at the time of the relocation suggests that their health profiles were typical of most nursing home residents. The most prevalent diseases/disorders among the residents were heart/circulation, gastrointestinal, metabolic, neurological, musculoskeletal (e.g., pain), and psychiatric (e.g., depression, anxiety) disorders.

Interviews

Findings from the review of the scholarly literature (Weaver et al., 2020) informed the interview questions. The order of the interview questions was consistent across residents and families, with follow up questions based on the participant's role in the relocation process. Interview questions represented the following domains: general perceptions of relocation process, pre-relocation communications, relocation challenges and stressors, resident quality of life, scope of participation during relocation process, and recommendation for future relocations.

Analysis

Initially, we used an open coding process (Charmaz, 2006) to develop primary codes and secondary codes, which were applied to all interviews to generate common themes within and across the interviews (See Weaver et al., 2021 for detailed description of the initial coding process). We used the constant comparative method in which each coded response was verified by at least one other author to ensure codes were applied consistently and appropriately (Strauss & Corbin, 1990). The intensive coding approach yielded 100% agreement in the development and application of the coding scheme, which enhanced the rigor of the analysis and dependability of the findings. Data were managed using Atlas.ti (ver.7.0) software.

For the current analysis, two authors (Weaver and Roberto) revisited the initial findings to address our research question. In our second coding iteration, we gleaned nuances and commonalities across resident and family perceptions. We conducted a thematic analysis of the data (Braun & Clarke, 2012) by separating, sorting, and synthesizing the initial coding categories. Four interrelated, overarching themes, each with multiple sub-themes, emerged from the analysis of the resident and family member interviews. We used a range of participants' quotes are used to illustrate experiences and perceptions.

Results

Awareness of Need to Relocate

For many residents and families, the need to relocate was not explicitly clear, although there were signs and suspicions that something was amiss. As participants reflected on their awareness of needing to relocate, they noted changes in staffing and temporary arrangements for relocation within facilities.

Change of Staffing

Several residents commented on improper behaviors of staff and observed poor quality of care for several years preceding decertification. One resident described the nurses and CNAs as “not coming to work on time, having inappropriate conversations that [don’t] have anything to do with healthcare, [and] messing up appointments and medical records.” Residents recounted that service delivery was poor and regarded the nurses and frontline staff as “very unprofessional.” They recalled that their residential facility had been “in shambles” for several years. When a new administrator was hired after the long-time administrator and director of nursing were fired, one resident believed that “it was too late to correct the problem[s]” contributing to the facility’s decertification.

Similarly, most family members reported sensing that something was awry. They had observed changes and disarray in staff and services at the facility. Gossip circulated among staff and in the community, but staff continually denied rumors about licensing prob-

lems or closure until the time to relocate residents was imminent.

We kept asking them, “What’s going on?” We were scared that it was going to get shut down. Rumors were going around. They kept telling us, “No, we’re not going to be shut down. Nobody’s going to be losing their jobs. Don’t worry about it.” They had meetings with the residents and the staff telling them, “We were not going to get shut down” and then a week after, they came and told the residents that it was getting shut down, that they were losing their license, and that all the residents had to ship off somewhere else. It was abrupt. It was too late by the time they told us.

Other families were not surprised by the news that CMS had decertified the facility. One family member recalled, “There [was] a buzz going around since last January about it.” Another family member suggested that staff also sensed impending change. “She [a staff member] didn’t want to tell me because she wasn’t positive that they were going to make everybody get out of [facility] or what they were going to do.”

In retrospect, families interpreted the lack of communication as a means to calm family concerns during a time of uncertainty. However, families did not view it favorably.

I went and talked to the social worker. She completely denied that they were going to be shutting down and everything. I told

her, "Please let me know, I've got to make arrangements. I'm an only child, there's no one else to help. I work, and all that," and she said none of that was going to happen. About a week later it was on the news, it was going to happen.

Temporary Arrangement

In hindsight, residents noted additional clues about the forthcoming relocation. For instance, one resident recalled how residents were relocated to new rooms on different floors under the guise of remodeling rooms for short-term residents needing rehabilitation services; however, the new rooms and new residents never materialized.

They had cleared that floor, the floor that I was on, and then they started transitioning people from upstairs out of the facility. So, by the time that they had the meeting with us . . . upstairs was empty.

Similarly, the reason given one resident for moving was initially presented as temporary and within the facility due to remodeling. "But then the next thing I know they were moving me out!" Residents also noticed that when other residents were admitted to the hospital they were never readmitted to the facility.

Notification of Need to Relocate

Residents and family members rarely indicated that they received notice from the facilities about the need for relocation. It was unclear from most of our in-

terviews with residents if they were ever told or understood why they had to move. Family members learned about the impending relocation through unofficial channels and indirect statements from staff as well as their own observations that something seemed to be not right within the facilities. Often, families learned the fate of the home of their loved ones through the media.

Unofficial Notification

Only one resident reported receiving a tip from a staff member that he should start looking for a new place to live.

I knew from all the people being there, strangers being there, that something was up. I made friends with some of the nurses, and they told me, "Go ahead and tell your sister to start looking for you a place because this is not going to last." And so that's what I did. I was pretty lucky with finding this place [new health-care facility].

Several family members received a heads-up from staff or members of the community in which the facilities were located. One family member recounted, "Well, I just found out really on the QT. One of the staff who looked after mom was concerned that things were not going well." Another family found out inadvertently when she "walked into the facility and heard people talking about it." She was told about the relocation only when she spoke to office staff about moving her mother, a decision she had made before knowing anything about

the relocation plans. Word about the problems experienced by the facilities appeared to seep out to the community, as one family member indicated that a person she knew who lived in the area asked her, "Is your brother not at this nursing home?" and then proceeded to tell her "all these horrible things."

Indirect Notification

In some instances, family members reported that the residents called them to say they were in the process of moving. One family member recalled a conversation with her brother:

He called me. He said, "Look baby, this is what's going on. They're moving us. And they ain't gave us no notice, no nothing. We all gotta pack up and get outta here. They're taking us to places." He wasn't very happy about it.

When families heard about the closing for the first time through local media, they promptly called the facilities for more information.

I was absolutely not told. I found out about it on the news . . . I saw it on the news, and I did call, and I found out that they lost their license. And they told me that all the residents had to be moved . . . by a certain time.

Even after the news story broke, many families reported that staff told them that the changes would not affect their family member. One family member recalled an all-too-common exchange.

My brother had seen on the news that they were closing. So, we called—or he had contacted them and they said no, our mom would be fine, and we wouldn't have to deal with anything. It was just going to affect other patients.

Direct Notification

What and when residents were told about the relocation was unclear. As one family member explained:

He [resident] was upset. By the time I got up there, he told me, "I was mad!" And I said, "I'm sure you were." Just being caught by surprise. I found out he probably had the same amount of notice [that family member had] and having no time to really even grasp what was going on. I think that was the most difficult for him. Not having any of us talk to him to be able to explain it to him, him not knowing if we knew where he was going.

In general, residents only seemed to understand that the facility could not keep them anymore. One resident commented that some of the other residents thought they were being moved because of something they had done.

One of the men was crying, and he told the driver of the van who was taking him up there [new facility], "If you will take me back to [decertified facility], I promise I'll be good."

Residents who understood the necessity of the move tried to make some good come out of a bad situation. One resident's daughter acknowledged her mother's unhappiness with the move but explained, "There ain't nothing we can do about it." The resident agreed and tried to remain positive, concluding the move "was nobody's fault. It couldn't be helped."

When families were asked how the facilities notified them about the relocation, responses were mixed. A few recalled receiving a letter about the impending closure that "let everybody know at that time that they were shutting down and they would help people relocate, but pretty much we had to do it on our own." Other family members did not receive a letter, with one indicating "They said that I was supposedly given a letter, but I assure you if I would have received a letter that they were closing the facility, I would have known that."

At one facility, families were invited to attend a meeting during which the facility's health services staff and administrators reviewed the decertification findings and addressed attendees' concerns. One family member recalled,

A meeting was called, and I attended. At that point, [the facility] was saying that they realized that we were probably going to have to move our family members, that they had done everything they could to keep it open, but they had lost their assistance from Medicaid, Medicare, everything.

At the other facility, family members reported being notified after the resident move was arranged or in progress.

I was on my way up there [to visit her], and I got a call. And they said, "I'm moving your mother to [new facility] within 20 minutes." I said, "Twenty minutes? You didn't tell me you were moving my mother. You didn't say anything to me." Usually they'd call, but nothing.

I got this phone call late in the afternoon [from] this lady saying, "Hi, I just want to let you know that we're going to have to move [resident] to [city, state]." My words to her were, "Like hell you will." And she said, "I guess you've been reading the newspaper," and I said, "I read the newspaper every day," and she said, "Do you already know?" I said, "Know what?" And she said, "We have lost our accreditation," and she said, "We need to move rather quickly..."

A few families were given time to plan for the move, even though most were not afforded that luxury. One family member reported being satisfied with her 48-hour notice because she had a good working relationship with the social worker and had confidence that she would relocate the resident with the resident's best interest in mind.

They called me 48 hours ahead of time, and they sent a letter saying, "This is going to be the day

that she moves,” and [asked] was that day good for me, my schedule, and this is the timeframe and everything.

Lack of Notification

Some family members were concerned that residents were not told or misled about the need to move and were relocated without being prepared for it. One resident reportedly went for medical treatment only to be transferred to his new home after the appointment, without ever returning to the facility.

They shipped him from dialysis, they didn't give him a chance to go back and get his things, they didn't give him a chance to go say goodbye to anybody.

Families consistently denied receiving any formal communication, such as a letter or phone call, from the facilities about the need to relocate residents, and most did not recall receiving any notice at all. Communication with facility staff was described as “hopeless” and “ridiculous.” One family member described how she was at the facility earlier the same day that the news broke in the media, yet no one told her about it when she was there. She recalled her conversation with staff:

I was there Tuesday. So why didn't you tell me on Tuesday that 'y'all were closing'? I mean. I'm sure you knew on Tuesday that you were closing, because I found out on the news that night.

Involvement in Relocation Decisions

Residents' level of involvement in relocation decisions included no choice, limited choice, or informed choice. Families varied in how much they were involved in the relocation process. Some families took responsibility for finding a placement for residents, whereas other families were not engaged. Involvement was dependent on how much choice residents and families perceived they had in selecting a new healthcare facility for their relative.

No Choice

Residents expressed frustrations about how staff assumed they were unable to comprehend the situation and excluded them from decision-making. For example, one resident recalled her move to a new facility and explained that she never was given any information from staff or the people who transported her.

They [staff] told me that morning, “You're going to go away.” I said, “For what?” “Going away where?” They said, “Come on, you've got to go.” I said, “Go where?” Finally, I said, “Okay.” So, I went to my room and got my clothes together and then they came . . . This guy went in my room and got my bags and stuff and put them in the car. He said, “You're moving away from here.” I said, “Where am I going?” . . . “I'm not going with somebody if I don't know where I'm going. I am not going anywhere.”

He said, "Don't be afraid. Go on, baby. Go on. Go on." Then he said, "Come on. I'll tell you when we get there." I remember seeing a sign that said [name of facility], so we turned and pulled up to the front. He said, "Okay. There's your home." I said, "I'm not home." He said, "No, this is where you'll be."

Another resident came back from a doctor's appointment only to be escorted to a new facility without warning.

They didn't care. Really, they didn't. Unless you were somebody that knew your own mind and could talk for yourself, they really didn't care too much [about involving you in any decision-making]. They were just there for a job, not for the patients.

Overwhelmingly, family members did not feel like they had a choice in where to relocate residents and expressed frustrations similar to those of the residents. About one-third of family members appeared to neither understand that they had a choice in selecting a new facility nor be involved in the decision-making process. One family member recounted, "[staff] knew that place [new facility], and they knew there were beds available there, so I had no choice. After calling around, I realized that was the only place she could go to at the time."

The following experience shared by one family member was repeated throughout the interviews. "She [staff]

just said, 'He's going to this facility in this town.' She didn't give us any option even to discuss it. She said, "This is what we decided; this is where he's going."

Limited Choice

While some residents perceived limited choice in the decision-making process, the timeline for selecting a new placement and moving to it was quick, much quicker than anyone would have liked. For example, one resident noted, "First, they said that we didn't have to move. Then, all of a sudden, we had to leave and go to different facilities, and they wanted you to pack up and get ready to leave."

Some residents perceived being pressured by the staff to move to a particular facility, accept the arrangement, and trust that they had arranged the move in their best interest.

I was kind of pressured into accepting this relocation . . . They tried to make it sound like everything's in place being that I require certain needs. And when I got here, I found out it wasn't—it couldn't have been farther from the truth. They tried to make it sound like this place was almost full to capacity, and they had really just one space, and if I didn't accept it right then that it would be given away. Like I said, I found out that wasn't the case at all.

Choices were constrained by time and the ability to find an available bed even among family members who were aware of healthcare facility op-

tions and actively engaged in the relocation process. As a result, they had to make immediate decisions without the benefit of time to consider alternatives.

I didn't know what I was doing in picking a place. You knew so many people were going to be flooding the market, so to speak. I really wanted to get in one place. I wanted to make a decision quickly before there weren't any more beds. I knew there wasn't going to be a whole lot of places for her to go.

It was the bed space that was available, and if I didn't pick that, she might go somewhere 5 hours, 6 hours away . . . I had no choice. I had to take it. I had to take it and that was that.

Many families were highly critical of the discharging staff and their apparent disrespect for the inclusion of residents and family members in the relocation process.

The social worker, she was kind of helpful, but she wasn't really helpful. Like, if you were to drop the ball and say, "Okay, you just find something," she would have just sent you anywhere. Like if you didn't voice your opinion, she was just going to do what she wanted to do. I don't think she saw the need of the families, the specific need of a family.

Another family member recalled expressing her frustration to a staff member and demanding answers without a successful outcome.

They [facility] already found somewhere to place him, and I'm like, "You can't do that. You can't just place him somewhere without consulting me and let me know what was going on . . . How can you do that?"

Informed Choice

Only a few residents perceived they had an informed choice in their relocation experience. Residents able to communicate their needs often turned to their professional allies for support in finding a place to relocate.

Well, my situation's different because I'm able to articulate what my care should be. I work with my Ombudsman in my care plan meeting. She suggested that I come here. This place is pretty cool. I haven't really had a lot of problems.

Two residents who enjoyed a caring and supportive friendship resisted moving until they found a new facility that would accept both of them. Although the new location meant family were further away, they were glad they could remain together.

My friend and me have been together for a while, and there were places they would have sent me, but they wouldn't accept her. I told them I didn't want go anywhere unless they would help her also. This place would accept both of us - so that's why we're here.

Only a few families felt like they had a choice, albeit limited.

I had the choice to send her either to facility A or facility B . . . And of course, in facility B, I would never be able to get up there. That's too much driving for me because I have my own health issues. And so I considered, too, for her to go to facility A, and it was a good decision to move her to facility A because it is only 45 minutes to an hour to get there, and I can get there reasonably well.

Still, some families appreciated that facility staff coordinated and oversaw the actual move.

They did all the leg work as far as getting her moved so I have to give them credit for that because they found somewhere for her to go although there was nowhere for her to go nearby . . . I told them I really wouldn't be able to do a whole lot physically. I could make some phone calls, if necessary, but they assured me they would do their best to find a good spot for her. And I feel like they did.

Family members also recognized difficulties that the relocation placed on staff and appreciated the efforts. For example, one shared that "despite no notification, despite my obvious concerns about how it transpired, they did coordinate the move. I know there's not a lot of options when they reach that point." Another family member indicated that "they did a good job with being able to come up with as much information that

they needed to transfer the patients out in such a short time."

Relocation Stressors

Although not all residents and family members reported that the transition to the new facility was stressful, the ambiguity associated with the relocation appeared to contribute to heightened stress among most residents and their families. Regardless of how or when the relocation occurred, residents reported being worried about their transition and where they were going. They commonly reported general distress over "not knowing what you're getting into." One resident admitted that he "tried not to let on, but constantly worried about the entire situation." Other stressors included moving further away from family, moving residents and their belongings, and residents' loss of friendships and sense of community.

Increased Distance from Family

For many residents, the move away from the region meant fewer visits from family and friends, which contributed to dissatisfaction with their new location. One resident noted, "The thing I don't like is my wife can't come up that often." They also perceived opportunities for community outings when family members were able to visit and accessibility to healthcare specialists as limited.

Well, there's nothing here. [My daughter] will come up here, like, twice a month, checking me out, but there's nothing [to do] here. . . And then, well, I kept all

my doctors in [previous area] because I said, "With this weird disease I have, I'm not starting over." So, they haul me down to [previous area] when I need checkup. I'm like, I'm not starting over.

Family members also shared concerns they heard from the residents about the long-distance moves.

He was concerned because he really wants to stay in the [previous] area, and he's so far out of there. He's very concerned because in [previous area], he knows people that can come and do things for him [like run errands] . . . For them to move him some 90 miles or so outside of there, he is very unhappy about that.

Families were worried about how frequently they would be able to visit the residents at their new facilities. One family member explained, "He's still an hour and a half away from where I live, and I don't do a lot of driving that far away – especially in areas I am not familiar with." Another family member reported not being able to visit because there was no bus service to the facility. A third family member, who relied on someone else to drive, expressed frustration over the travel challenge: "Well, the hardest part is I can't visit him much because I don't drive. And the only time I can go is when my son takes me." For other families, even a move nearby was an inconvenience: "She's actually a lot further from me than she'd like to be or than I would like her to be. It's not out of town or anything, but it is a little far."

The longer distances also made it more difficult for family members to monitor the residents' care, "I would like for him to be closer to the city so I can look after him more . . . I'm not driving and to get to him I have to get someone to take me." Only a few families reported that residents were placed in a facility closer than the decertified healthcare facility. They credited the staff for keeping their location in mind.

Moving Residents and their Belongings

Families discussed the actual process of moving residents and their belongings, including physical assistance with packing resident belongings and the relocation itself. Families appreciated receiving assistance. "...all the arrangements were done for her. The girls at the facility had already packed up most of her things when I went out to pack them up." Conversely, family members were frustrated when they were expected to be responsible for the move, despite short notice.

We were off packing—actually packing up all of my husband's belongings because we were told, "He has to get out now." His brother had a large van, and we loaded a lot of his stuff into the van, but in the meantime, my daughter-in-law and my brother-in-law got on the phone and started calling nursing homes all over town to find out if they had any beds . . . I pretty much feel that all of the work—all of the phone work and leg work was

done by his family, and we didn't receive any help or support from the nursing home itself.

The staff was basically, I'm sorry to say, was useless. They didn't provide any help in packing. All they did was bring the stuff down to their room and set it there, and it was left up to the residents to get help, either from family or friends to get it, I guess, dispersed where it needed to be.

Even when staff did help prepare for the move, family members noted that most haphazardly focused on mechanics of the move and not the residents.

Oh, they had packed up all of her belongings and put them in boxes and put the boxes on her bed in front of her. But they had not bothered to give her breakfast, dress her, and clean her up from the evening before—from the nighttime. She was just sitting there in her bathrobe, looking extremely frightened and distraught.

Loss of Friendships and Sense of Community

Residents talked a lot about the losses they experienced, including friendships with other residents and staff, loss of their sense of place in the community, and loss of health. Residents often viewed the staff as family and good friends, which made it difficult for residents to see staff upset about losing their jobs. "Oh, there were so many

tears that week before we moved. You could just be going down the hall, see another employee just burst into tears."

Residents felt a strong connection and commitment to the community of residents and staff—the facility was their home. It was hard to see others leave and be left. Two residents suggested that not only was it hard to leave the facility, but also it was hard to leave the area.

I didn't want to move. I cried. I did that all week. I was born and raised in [county], but I moved to [location of decertified facility]. I am used to [location of decertified facility]. I don't like [nearby city]. I didn't want to move. I liked it at that place, and I didn't want to move. But we had to.

Although some residents reported being able to stay in touch via telephone, they shared a sense of loss over friendships with former residents and staff. Several mentioned how they missed the comradery with other residents; for one resident, the new facility had yet to fill that void in his social life. "These people, they don't know too much about [card games]." Another resident captured a sentiment shared by many,

It's very hard leaving a place that you've been at for a while; it's like leaving home. You're leaving your friends and everything. People that worked there, real good people that you got to know through the years and stuff. Everybody was crying and everything.

Moving alone to a new facility was difficult for residents. One resident recalled a time when another relocated resident recognized their face at the new facility. "He came like two or three days after I did. We were never friends in [decertified facility], but he saw me, his eyes got big and lit up. He was like someplace, somebody he recognized. Pitiful, isn't it?"

Discussion

Upon moving to a residential healthcare facility, most older adults establish a sense of personal comfort and some level of competence and control (Golant, 2011). When the need to make a change to their living environment is necessary, as in the case of involuntary relocation, older adults may struggle with the immediate stress associated with leaving a place that they identify as home (Oswald & Wahl, 2005) and feel that they belong (Oswald & Wahl, 2013). Although the discomfort for residents and their families associated with involuntary relocation should not be ignored or diminished (Capezuti et al., 2006; Oswald & Rowles, 2007), other serious concerns for residents, as well as stressors and hardships for their families, emerged from our data. Specific to the focus of this study were the facility responses to decertification. Most notably, facilities failed to support residents' autonomy and well-being during the relocation process. Little evidence from the residents emerged that their preferences were sought, much less valued, which contrasted with the

person-centered individualized care promised upon admission (CFR Title 42, Public Health § 483.21).

The lack of resident input denies residents the opportunity to make decisions about how and where they want to live, which is integral to their ability to age (Scheidt et al., 1999), age in place (Löfqvist et al., 2013), and transition into new home environments (Oswald et al., 2002). Denial and devaluation of their autonomy raises multiple questions about how and to what end individuals can expect to be involved in how they live their lives when faced with declining competencies and increasing care needs. Future studies and community dialogues should explore how the rights of vulnerable persons can be preserved to ensure that they continue to direct how and where they live.

From an implementation standpoint, neither residents nor families were satisfied with the involuntary relocation process. Their shared experiences suggest that, to hold a facility accountable, relocation requires planning prior to the relocation, a detailed action plan for seeing the residents and families through the relocation, and a strategy for follow-up to ensure that the quality care of residents is maintained. Unfortunately, facilities that experience closures are typically the worst of the worst facilities. A rule that requires them to comply with good practice, when they are in complete chaos, is unlikely to be effective. CMS decertification and subsequent closure is rare but likely occurs after a facility has been poorly run for a long time (Li et al., 2010).

When facilities agree to provide services funded by Medicare and Medicaid, they are contractually obligated to comply with standards and regulations—established by CMS to deliver quality healthcare, safety, accessibility, and affordable healthcare. Moreover, a facility agrees to communicate with residents and their families and include them in making decisions about their care. As one check on service provision, qualified health professionals are hired by each state to regularly survey facilities to determine if they are meeting required standards of care and facility operations. Yet stark inconsistencies in standards of care and enforcement penalties exist across states (Harrington et al., 2004).

Allowing flexibility for each healthcare facility seems appropriate and accommodating. Residents' health, safety, and wellbeing are a priority during an impending closure or involuntary relocation. However, once regulators determine that services a facility provides are inadequate and are thus found non-compliant, it is critical to consider whether that facility has the capacity to enact a plan that protects residents' health, safety, and wellbeing.

Policy and Practice Recommendations

Residents and family members in our study offered suggestions related to CMS policy for decertified facilities tasked with relocating residents. Below, we discuss recommendations in terms of the CMS guidelines.

Establish Timely, Specified Notification to Residents, Families, and the Larger Community

With stipulations, CMS requires that administrators “provide written notification of the impending closure and a plan for the relocation of residents at least 60 days prior to the impending closure...” (p.16795, DHHS, 2013a). Decertified facilities have a responsibility and a duty to engage in thorough, timely, and reliable communication with residents and families to deliver high-quality “effective, safe, efficient, patient-centered, equitable, and timely care” (CMS.gov, n.d.b). We suggest that it is time for the 2013 CMS policy to stipulate a defined timeline for communication to residents, family members, facility staff, and the broader community about the relocation process, including but not limited sharing information about why the facility is closing, when it is closing, and the process for closing. Our suggestions are bolstered by recommendations proffered by the residents and family members in our study:

1. Provide thorough, timely, and accurate information to residents and their families. Notify and involve families in the early stages of the relocation process; rely on multiple methods of communication when reaching out to residents and families about the relocation process, including an initial phone call, face-to-face conversations during on-site visits, and written notification (i.e., letter, website).

2. Remain transparent with all parties about the timeline for relocating residents; identify a point-person for communicating information about the relocation to residents, families, and receiving facilities.
3. Explain the current situation to residents at an appropriate level of understanding (i.e., consider their cognitive abilities). Provide residents with individual counseling to prepare them mentally and physically for the transition to their new residence.
4. Leverage the expertise of local agencies. For example, the regional long-term care ombudsman can provide insights into the unique needs of residents and facilitate communication between residents, families, facilities, and state agencies.

Expand Emergency Preparedness Requirements to Incorporate Facility Relocation

The CMS rule establishing “national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to ensure that they adequately plan for both natural and man-made disasters” (p. 63860, DHHS, 2013b) is another mechanism that should be utilized pertinent to facility closures and consequent relocations. We propose that CMS require that facilities develop and maintain a “relocation plan” analogous to mandated emergency preparedness plans. An established relocation plan can minimize disruptions in care and facilitate

the relocation process. Sanctions should be leveraged upon facilities without an established relocation plan. Proactive planning is consonant with the CMS goal of “flexibility [for each facility] to develop a plan for relocation.” Further, CMS could encourage state-level entities to offer incentives to staff/administrators who contribute to a successful relocation experience and require additional staffing to support care coordination during transitions. CMS should also mandate that decertified facilities involve residents and their families and the long-term care ombudsman early in the process and to the extent possible in relocation decision-making processes. Recommendations from residents and families in our studied further support these proposed changes to policy:

1. Engage residents and families and the long-term care ombudsman in the decision-making process with at least 30-days’ notice to make an informed decisions about their new care arrangements.
2. Involve each resident and their family and relocation staff to identify healthcare needs that affect placement options.
3. Provide residents and families with physical support for moving residents and their belongings to new facilities.

Consider How Operations and Ownership of Facilities Affect Nursing Home Relocation

The scholarly literature (e.g., Bowblis,

2011; Castle et al., 2010; Fashaw et al., 2020) suggests that nursing home owners may sell their property and/or structurally reorganize in response to the regulatory demands made of them. Importantly, when new regulations, such as those offered above are proposed, it is important to understand that their promulgation is influenced by political will and lobbying. For example, Former President Trump's administration relaxed nursing home regulations, which likely affected conduct within the facilities as well as their ownership and oversight. Also important is that the administrator and staff activities within the nursing facility also contribute to maintaining a quality environment (Amirkanyan et al., 2018; Li et al., 2019).

Facilities are required by federal law to acknowledge and act upon grievances and recommendations from residents and families (Long Term Care Community Coalition, 2021). To improve the delivery of aging services, the voices of older adults and their families, as well as the wider community in which the facility is situated, must be included (Martin et al., 2019). We urge that facilities, state-level entities, and federal policy makers consider our recommendations for policy, recommendations supported by research involving residents and families.

Limitations

This study is not without its limitations. First, the location and ownership of the facilities were different. This led to some residents relocating long distances from their previous healthcare

facility, which prohibited their participation in the study. With communication through technology becoming more commonplace (i.e., videoconferencing), future investigations will be better positioned to reach study participants regardless of their location (Archibald et al., 2019). Second, the timing of interviews differed. Inquiry into the relocation of residents from the rural facility was retrospective, while interviews with residents and families from the urban facility occurred soon after with the relocation. While concurrent inquiry is ideal, involuntary relocations are contentious, and as we learned, often happen swiftly with little advanced notice. As researchers, we cannot manipulate naturally occurring events, but the commonality of findings across sites gives us confidence that residents and family members at both facilities shared similar experiences and challenges.

Developing mutually beneficial, collaborative partnerships with state and local agencies will help position both researchers and agencies to conduct ongoing research on resident and family experiences with planned or anticipated transitions to long-term care (Gaugler et al., 2021) to quickly respond to less common involuntary transitions, and to gather data to inform policies that ultimately affect the health and well-being of vulnerable older adults and their families (Rudder, 2016). Finally, the resident sample was limited to higher functioning residents, thus, the voice of residents with cognitive and other impairments was heard only through the interviews with the family members. Implementing inno-

vative and ethically sound data collection with persons with limited capacity (e.g., Kelley et al. 2019; Phillipson et al., 2018; Sturge et al., 2021) will help future researcher gain insights from the persons most effected by relocation,

the residents themselves. Data collected and interpreted will also provide a too-often absent evidence base for making, implementing, and evaluating relevant policies and practices.

Funding

This project was funded by an interagency agreement (no. IAG-409 – Assessing the Impact of Involuntary Relocation on Nursing Home Residents) between the Virginia Department of Medical Assistance Services and Virginia Tech. However, the contents herein do not necessarily represent the policy of DMAS and should not infer endorsement by federal or state government.

Conflicts of Interest

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

References

- Amirkhanyan, A. A., Meier, K. J., O'Toole Jr, L. J., Dakhwe, M. A., & Janzen, S. (2018). Management and performance in US nursing homes. *Journal of Public Administration Research and Theory*, 28(1), 33-49. <https://doi.org/10.1093/jopart/mux003>
- Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods*, 18, 1-8. <https://doi.org/10.1177/1609406919874596>
- Arrighi, H. M., Neumann, P. J., Lieberburg, I. M., & Townsend, R. J. (2010). Lethality of Alzheimer disease and its impact on nursing home placement. *Alzheimer Disease & Associated Disorders*, 24(1), 90-95. <https://doi.org/10.1097/WAD.0b013e31819fe7d1>
- Bowblis, J. R. (2011). Ownership conversion and closure in the nursing home industry. *Health Economics*, 20(6), 631-644. <https://doi.org/10.1002/hec.1618>
- Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative,*

- qualitative, neuropsychological, and biological* (pp. 57-71). American Psychological Association. <https://doi.org/10.1037/13620-004>
- Brownie, S., Horstmanshof, L., & Garbutt, R. (2014). Factors that impact residents' transition and psychological adjustment to long-term aged care: A systematic literature review. *International Journal of Nursing Studies*, 51(12), 1654-1666. <https://doi.org/10.1016/j.ijnurstu.2014.04.011>
- Capezuti, E., Boltz, M., Renz, S., Hoffman, D., & Norman, R. G. (2006). Nursing home involuntary relocation: Clinical outcomes and perceptions of residents and families. *Journal of the American Medical Directors Association*, 7(8), 486-492. <https://doi.org/10.1016/j.jamda.2006.02.011>
- Castle, N. G. (2005). Nursing home closures and quality of care. *Medical Care Research and Review*, 62(1), 111-132. <https://doi.org/10.1177/1077558704271728>
- Castle, N. G. (2006). Characteristics of nursing homes that close. *Health Care Management Review*, 31(1), 78-88. <https://doi.org/10.1097/00004010-200601000-00011>
- Castle, N. G., Sonon, K., & Antonova, J. (2010). The impact of special focus facility nursing homes on market quality. *The Gerontologist*, 50(4), 519-530, <https://doi.org/10.1093/geront/gnq006>
- CFR Title 42, Public Health § 483.21 <https://www.law.cornell.edu/cfr/text/42/483.21>
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage Publications.
- CMS.gov. (2021, December). *Special Focus Facility ("SFF") Program*. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/NHs>
- CMS.gov. (n.d.a). *Minimum data set (MDS) 3.0 for nursing homes and swing bed providers*. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30>
- CMS.gov. (n.d.b). *Quality measures*. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures>
- Davison, T. E., McCabe, M. P., Busija, L., Martin, C., & Graham, A. (2021). Trajectory and predictors of mental health symptoms and wellbeing in newly admitted nursing home residents. *Clinical Gerontologist*, 1-14. <https://doi.org/10.1080/07317115.2021.2010154>
- Department of Health and Human Services. (2013a, March 19). Medicare and

Medicaid programs; Requirements for long-term care (LTC) facilities; Notice of facility closure. *Federal Register*, 76(53), 16795-16806. <https://www.federalregister.gov/documents/2013/03/19/2013-06276/medicare-and-medicaid-programs-requirements-for-long-term-care-ltc-facilities-notice-of-facility>

Department of Health and Human Services. (2013b, September 16). Medicare and Medicaid programs; Emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers. *Federal Register*, 81(no.180), 63860-64044. <https://www.federalregister.gov/documents/2016/09/16/2016-21404/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid>

Fashaw, S. A., Thomas, K. S., McCreedy, E., & Mor, V. (2020). Thirty-year trends in nursing home composition and quality since the passage of the Omnibus Reconciliation Act. *Journal of the American Medical Directors Association*, 21(2), 233-239, <https://doi.org/10.1016/j.jamda.2019.07.004>

Gaugler, J. E., & Mitchell, L. L. (2021). Reimagining family involvement in residential long-term care. *Journal of the American Medical Directors Association*. Advance online publication. <https://doi.org/10.1016/j.jamda.2021.12.022>

Golant, S. M. (2011). The quest for residential normalcy by older adults: Relocation but one pathway. *Journal of Aging Studies*, 25(3), 193-205. <https://doi.org/10.1016/j.jaging.2011.03.003>

Harrington, C., Mullan, J. T., & Carrillo, H. (2004). State nursing home enforcement systems. *Journal of Health Politics, Policy and Law*, 29(1), 43-73. <https://doi.org/10.1215/03616878-29-1-43>

Kelley, R., Godfrey, M., & Young, J. (2019). The impacts of family involvement on general hospital care experiences for people living with dementia: An ethnographic study. *International Journal of Nursing Studies*, 96, 72-81. <https://doi.org/10.1016/j.ijnurstu.2019.04.004>

Lee, D. T., Woo, J., & Mackenzie, A. E. (2002). A review of older people's experiences with residential care placement. *Journal of Advanced Nursing*, 37, 19-27. <https://doi.org/10.1046/j.1365-2648.2002.02060.x>

Li, Y., Cen, X., Cai, X., & Temkin-Greener, H. (2019). Perceived patient safety culture in nursing homes associated with "Nursing Home Compare" performance indicators. *Medical Care*, 57(8), 641-647. <https://doi.org/10.1097/MLR.0000000000001142>

Li, Y., Harrington, C., Spector, W. D., & Mukamel, D. B. (2010). State regulatory enforcement and nursing home termination from the Medicare and Medicaid programs. *Health Services Research*, 45, 1796-1814. <https://doi.org/10.1111/j.1365-2648.2010.02600.x>

[org/10.1111/j.1475-6773.2010.01164.x](https://doi.org/10.1111/j.1475-6773.2010.01164.x)

- Long Term Care Community Coalition. (2021, July). *Improving nursing home resident safety, dignity, & financial integrity: Recommendations for CMS*. National Center for Interprofessional Practice and Education. <https://nursinghome411.org/wp-content/uploads/2021/06/LTCCC-CMS-Recs-2021.pdf>
- Löfqvist, C., Granbom, M., Himmelsbach, I., Iwarsson, S., Oswald, F., & Haak, M. (2013). Voices on relocation and aging in place in very old age – A complex and ambivalent matter. *The Gerontologist*, 53(6), 919-927. <https://doi.org/10.1093/geront/gnt034>
- Martin, D., Long, O., Kessler, L. (2019). Planning for aging in place: Incorporating the voice of elders to promote quality of life. *Journal of Housing for the Elderly*, 33(4), 382-392. <https://doi.org/10.1080/02763893.2019.1593280>
- Moon, H., Dilworth-Anderson, P., & Gräske, J. (2017). The effects of placement on dementia care recipients' and family caregivers' quality of life: a literature review. *Quality in Ageing and Older Adults*, 18(1), 44-57. <https://doi.org/10.1108/QAOA-01-2016-0009>
- Murphy, L., McCarthy, G., & Cornally, N. (2013). Residents' perceptions of relocating from one long-term setting to another. *Nursing Older People*, 25(1), 24-29. <https://doi.org/10.7748/nop2013.01.25.1.24.s9511>
- O'Hora, K., & Roberto, K.A. (2019). Facilitating family life review during a relocation to assisted living: Exploring contextual impact on family adjustment. *Clinical Gerontologist*, 42(3), 323-333. <https://doi.org/10.1080/07317115.2017.1416508>
- O'Neill, M., Ryan, A., Tracey, A., & Laird, L. (2022). 'Waiting and wanting': Older peoples' initial experiences of adapting to life in a care home: A grounded theory study. *Ageing & Society*, 42(2), 351-375. <https://doi.org/10.1017/S0144686X20000872>
- Oswald, F., & Rowles, G. D. (2007). Beyond the relocation trauma in old age: New trends in elders' residential decisions. In H.W. von Walh & C. Tesch-Roemer (Eds.), *New dynamics in old age: Individual, environmental, and societal perspectives* (pp. 127-152). Baywood Publishing Company.
- Oswald, F., Schilling, O., Wahl, H. W., & Gäng, K. (2002). Trouble in paradise? Reasons to relocate and objective environmental changes among well-off older adults. *Journal of Environmental Psychology*, 22(3), 273-288. <https://doi.org/10.1006/jevp.2002.0255>
- Oswald, F., & Wahl, H.-W. (2005). Dimensions of the meaning of home. In G. D.

- Rowles & H. Chaudhury (Eds.), *Home and identity in late life: International perspectives* (pp. 21-45). Springer.
- Oswald, F., & Wahl, H. W. (2013). Creating and sustaining homelike places in residential environments. In G. D. Rowles & M. Bernard (Eds.), *Environmental gerontology: Making meaningful places in old age* (pp. 53-77). Springer.
- Phillipson, L., & Hammond, A. (2018). More than talking: A scoping review of innovative approaches to qualitative research involving people with dementia. *International Journal of Qualitative Methods*, 17(1), 1-13. <https://doi.org/1609406918782784>
- Pino, C. J., Rosica, L. M., & Carter, T. J. (1978). The differential effects of relocation on nursing home patients. *The Gerontologist*, 18(2), 167-172. <https://doi.org/10.1093/geront/18.2.167>
- Rijnaard, M. D., van Hoof, J., Janssen, B. M., Verbeek, H., Pocornie, W., Eijkelenboom, A., Beerens H. C., Molony, S. L., & Wouters, E. J. (2016). The factors influencing the sense of home in nursing homes: A systematic review from the perspective of residents. *Journal of Aging Research*, Article No. 6143645. <https://doi.org/10.1155/2016/6143645>
- Rudder, C. (2016). *Successful transitions: Reducing the negative impact of nursing home closures*. Washington, D.C.: The National Consumer Voice for Quality Long-Term Care.
- Ryman, F. V., Erisman, J. C., Darvey, L. M., Osborne, J., Swartsenburg, E., & Syurina, E. V. (2019). Health effects of the relocation of patients with dementia: A scoping review to inform medical and policy decision-making. *The Gerontologist*, 59(6), e674-e682. <https://doi.org/10.1093/geront/gny031>
- Scheidt, R. J., Humpherys, D. R., & Yorgason, J. B. (1999). Successful aging: What's not to like? *Journal of Applied Gerontology*, 18(3), 277-282. <https://doi.org/10.1177/073346489901800301>
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Sage Publications.
- Sturge, J., Klaassens, M., Lager, D., Weitkamp, G., Vegter, D., & Meijering, L. (2021). Using the concept of activity space to understand the social health of older adults living with memory problems and dementia at home. *Social Science & Medicine*, 288, 1-9. <https://doi.org/10.1016/j.socscimed.2020.113208>
- Toot, S., Swinson, T., Devine, M., Challis, D., & Orrell, M. (2017). Causes of nursing home placement for older people with dementia: A systematic review and meta-analysis. *International Psychogeriatrics*, 29(2), 195-208. <https://doi.org/10.1017/S1041610216001654>

- Weaver, R. H., Roberto, K. A., & Brossoie, N. (2020). A scoping review: Characteristics and outcomes of residents who experience involuntary relocation. *The Gerontologist*, 60, e20-e37. <https://doi.org/10.1093/geront/gnz035>
- Weaver R. H., Roberto, K. A., Brossoie, N. & Teaster, P. B. (2021). Experiences with involuntary nursing home relocation: The staff perspective. *Journal of Applied Gerontology*, 40(10), 1206-1214. <https://doi.org/10.1177/0733464820952253>

Why Don't Older Adults Use Senior Centers? Evidence from Adults Age 50 and Older in Massachusetts

Ceara Somerville, MS (E-mail: ceara.somerville001@umb.edu), Center for Social & Demographic Research on Aging, Gerontology Institute, University of Massachusetts Boston, Boston, MA. *Corresponding author

Nidya Velasco Roldán, MS (E-mail: nidya.velascorold001@umb.edu), Center for Social & Demographic Research on Aging, Gerontology Institute, University of Massachusetts Boston, Boston, MA.

Cindy N. Bui, MS (E-mail: cindy.bui001@umb.edu), Center for Social & Demographic Research on Aging, Gerontology Institute, University of Massachusetts Boston, Boston, MA.

Caitlin Coyle, PhD (E-mail: caitlin.coyle@umb.edu), Center for Social & Demographic Research on Aging, Gerontology Institute, University of Massachusetts Boston, Boston, MA.

Jan Mutchler, PhD (E-mail: jan.mutchler@umb.edu), Center for Social & Demographic Research on Aging, Gerontology Institute, University of Massachusetts Boston, Boston, MA.

ABSTRACT

Senior centers are crucial community resources, providing programs and services intended to meet a range of needs and interests among older adults and serving as community hubs for social connection with peers. This study aims to compare older adults who attend senior centers to those who do not and assess reasons for non-attendance. Secondary data pooled from community needs assessment surveys includes a sample of 8,573 community-dwelling adults aged 50 and older from eight communities in Massachusetts. Three-quarters of respondents reported not attending the senior center. The most common reasons selected for non-attendance are not being interested (26%) and not feeling “old enough” (27%). There are significant differences among age groups for all reasons given for non-attendance. Moreover, there are significant gender differences among most reasons given. This study suggests

that senior centers and policies supporting senior centers may increase participation by expanding outreach and marketing efforts to include older men and those aged 60-69, and by adapting programming that appeals to different age groups and changing interests of older adults. Results suggest that adjusting hours of operation may offer those aged 60-69 a better opportunity to participate at the senior center. This research indicates an opportunity for re-evaluating and updating senior center operations to reflect current interests and more effectively attract and serve an evolving older population.

Keywords: community resource, program participation, gender differences

¿Por qué los adultos mayores no usan los centros para personas mayores?: Evidencia de adultos mayores de 50 años en Massachusetts

RESUMEN

Los centros para personas mayores son recursos comunitarios cruciales, brindan programas y servicios destinados a satisfacer una variedad de necesidades e intereses entre los adultos mayores y sirven como centros comunitarios para la conexión social con sus compañeros. Este estudio tiene como objetivo comparar a los adultos mayores que asisten a los centros de mayores con los que no lo hacen y evaluar las razones de la no asistencia. Los datos secundarios recopilados de las encuestas de evaluación de las necesidades de la comunidad incluyen una muestra de 8573 adultos de 50 años o más que viven en la comunidad de ocho comunidades de Massachusetts. Tres cuartas partes de los encuestados informaron que no asistían al centro para personas mayores. Las razones más comunes seleccionadas para no asistir son la falta de interés (26 %) y no sentirse “suficientemente mayor” (27 %). Hay diferencias significativas entre los grupos de edad para todas las razones dadas para la inasistencia. Además, existen diferencias significativas de género entre la mayoría de las razones dadas. Este estudio sugiere que los centros para personas de la tercera edad y las políticas de apoyo a los centros para personas de la tercera edad pueden aumentar la participación al ampliar los esfuerzos de divulgación y mercadeo para incluir a los hombres mayores y a las personas de 60 a 69 años, y al adaptar la programación que atrae a diferentes

grupos de edad y a los intereses cambiantes de los adultos mayores. Los resultados sugieren que ajustar las horas de operación puede ofrecer a las personas de 60 a 69 años una mejor oportunidad de participar en el centro para personas mayores. Esta investigación indica una oportunidad para reevaluar y actualizar las operaciones de los centros para personas mayores a fin de reflejar los intereses actuales y atraer y servir de manera más efectiva a una población de personas mayores en evolución.

Palabras clave: recurso comunitario, participación en el programa, diferencias de género

为何老年人不使用老年中心？马萨诸塞州50岁及以上老年人提供的证据

摘要

老年中心是重要的社区资源，提供旨在满足老年人一系列需求和兴趣的计划和服務，并作为与同龄人建立社交联系的社区中心。本研究旨在将参加老年中心的老年人与未参加老年中心的老年人进行比较，并评估未参加的原因。从社区需求评估调查中收集的次级数据包括来自马萨诸塞州八个社区的8,573名50岁及以上的社区居民样本。四分之三的受访者表示没有参加老年中心。不参加的最常见原因是不感兴趣（26%）和感觉“不够老”（27%）。就一切不参加的原因而言，各年龄组之间存在显著差异。此外，大多数原因存在显著的性别差异。本研究表明，老年中心和支持老年中心的政策可以通过扩大外展活动和营销工作，将老年男性和60-69岁的人群包括在内，并通过调整那些吸引不同年龄组和老年人不同兴趣的项目，以期增加参与度。结果表明，调整营业时间可能会为60-69岁的人提供更好的机会参与老年中心。本研究表明了一项用于重新评价和更新老年中心运营活动的机遇，以期反映当前兴趣并更有效地吸引和服务不断变化的老年人口。

关键词：社区资源，项目参与，性别差异

Introduction

For decades, senior centers across the United States have served as focal points for many community-based aging services. Senior centers offer a broad array of programs and services designed to meet the interests and needs of older adults in the community and serve as the “front door” to many critical services, such as financial assistance, social services, and long-term care. Moreover, they provide vital leadership and advocacy for the older population within the community. Senior centers are an essential community resource, with many participants experiencing benefits in terms of health, wellness, and social connectedness. Despite the documented benefits of attending a senior center, many community-dwellers do not participate (both those who once participated but do no longer, and those who have never participated). Although some literature suggests that non-participants are not interested, do not have time, or do not have a need (Pardasani, 2010; Pardasani & Berkman, 2016, 2020), research has not established if factors shaping participation differ by gender or age group.

To continue meeting their mission, senior centers are tasked with maintaining service to their regular clientele while also working to bring in new participants from various socio-demographic backgrounds. The purpose of this study is to identify the reasons for non-participation at the local senior center and the individual characteristics associated with those reasons. Learning why community residents do

not participate at the senior center has implications for policy efforts, program development, and targeted outreach to widen the net for attracting older adults to the senior center. This study uses novel data from community-dwelling older adults aged 50 and older in a pooled sample of eight Massachusetts communities.

Background

Senior Centers in the Community

The passage of the Older Americans Act (OAA) of 1965 codified senior centers as focal points of aging services at the local level (Weil, 2014). The OAA was passed by Congress as an effort to improve the availability and organization of social services for older adults across the nation (ACL, 2021). Under Title I and Title II, the OAA included the establishment of a federal level agency—the Administration on Aging (AoA), now part of the Administration of Community Living (ACL)—as well as a call for state-level agencies to oversee aging services and through which filter federal funds (ACL, 2021). It was Title III of the OAA that established grants for programs and services to keep older adults independent, including senior center services, such as nutrition programs (i.e., Meals on Wheels) and other health, wellness, and supportive services (Colello & Napili, 2021). The original purpose of the OAA was to improve services for all older adults to remain independent in the community; since then, subsequent reauthorizations have included a greater focus on tar-

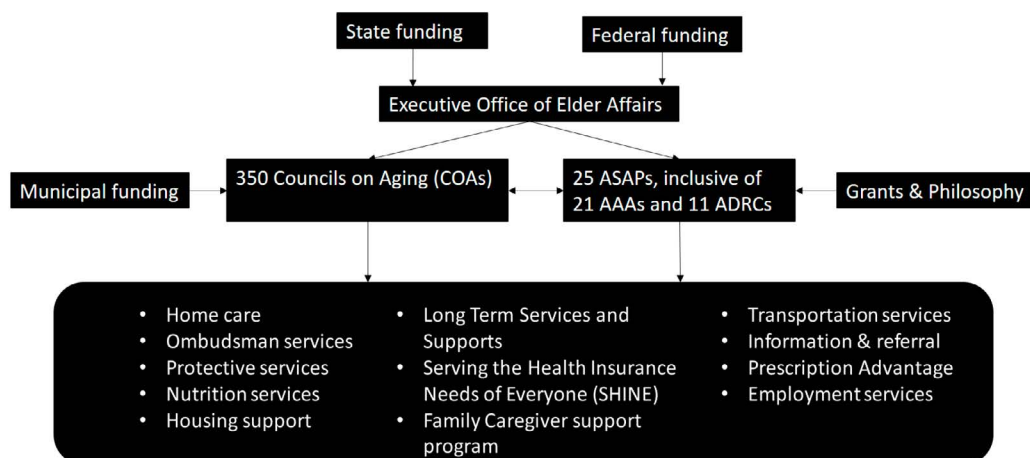
getting populations most in need (e.g., financially insecure, rural, racial, and ethnic minorities) (National Center on Law & Elder Rights, 2018).

Though they existed prior to OAA, senior centers grew in number across the nation and in breadth of offerings after 1965. Currently, about 10,000 senior centers serve nearly one million older adults across the United States (NCOA, 2020). Since the introduction of the OAA, senior centers have continued to provide socialization and recreation opportunities, while expanding to a wider array of programs and services geared toward improving health and wellness, including the provision of social, financial, and health and wellness services (ACL, 2021). There is considerable variation in the organizational structure and function of senior centers throughout the country, though most are considered multi-purpose senior centers (Pardasani & Thompson, 2012). Rather than focusing on a single aspect (e.g., nutrition sites, social clubs), multi-purpose senior centers aim to meet both the needs and the interests of older persons in the community through a variety of programs and services.

In Massachusetts, communities provide local outreach, services and information to older residents and their families through municipal agencies known as Councils on Aging (COAs). Each of the 350 COAs in Massachusetts consists of an elected or appointed Board of Residents charged with advocating for the older population and addressing important issues facing older

residents. The large majority of COAs in the state operate a senior center through which outreach, information and referral, programs, and services are provided.

Massachusetts is unique in that all COA-based senior centers are part of local governments and report to the Executive Office of Elder Affairs (EOEA), the state-wide agency that oversees all aging-related services. **Figure 1** illustrates the relationships among key organizations that fall under the jurisdiction of EOEA. All state and federal funds flow through EOEA directly to the COAs and to the Aging Service Access Points (ASAPs) across the state. Most of the ASAPs also serve as Area Agencies on Aging (AAAs) or Aging and Disability Resource Consortia (ADRC) partnerships in Massachusetts. While ASAPs operate at a regional level, COAs operate at the municipal level. In addition to state and federal funding, a major source of funding for COAs in Massachusetts comes from the municipal budget. COAs and ASAPs frequently collaborate to provide a wide range of programs and services, broadly outlined in **Figure 1**. Other non-profit and for-profit organizations (e.g., the Y, Jewish Community Centers, etc.) operate throughout the state and provide programs and services designed for older adults as well. The aging network in Massachusetts is robust, and municipal senior centers serve as the wide “front door” to that vast network. This paper focuses on municipally funded senior centers.



Adapted from the Massachusetts State Plan on Aging for 2022-2025 which can be found here:
<https://www.mass.gov/service-details/about-the-executive-office-of-elder-affairs>

Figure 1. Massachusetts Aging Services

Senior Center Participants

Several studies conducted over the last few decades have aimed to characterize those who participate at a senior center. Results suggest that older seniors (e.g., age 75+), women, those who are not currently married (e.g., widowed, never married), and older adults with a low to moderate income are more likely to attend the local senior center (Boen, 2012; Gitelson et al., 2008; Kim et al., 2011; Matsui & Capezuti, 2008; Pardasani, 2010; Schneider et al., 2014; Tang, Heo, & Weissman, 2011). Some also suggest that those who live alone and those who live in rural areas attend senior centers more than their counterparts (Pardasani, 2010).

There is limited research regarding the racial and ethnic profile of senior center attendees. Among studies that include race and ethnicity, the portion of attendees who are non-white ranges from 12% to 47% (Aday et al.,

2018; Choi, An, & DiNitto, 2020; Keyes et al., 2020; Pardasani 2010; Pardasani & Berkman, 2020). It is not clear, however, how representative of senior center population these figures are. In at least one case, sampling was conducted purposefully at senior centers that serve diverse populations (Giunta et al., 2012). The figures that do exist representing the racial/ethnic profile of senior centers are largely influenced by the geography in which the senior center is situated. As such, what is known in the literature about non-white participants is limited based on where previous studies have been conducted.

One study to date included sexual orientation as a measure of comparison between senior center attendees and non-attendees. Pardasani and Berkman (2020) showed that 15% of senior center attendees in their sample self-identified as lesbian, gay, or bisexual, compared to just 3% of the non-attendees. This data comes from a sample of New

York City senior center participants, and thus may not represent senior centers in varying types of communities. Overall, previous evidence suggests that although senior centers across the country serve many older adults, there are still large groups underrepresented within senior centers.

Benefits to Participation

Senior center participants experience a wide range of benefits, including improved outcomes related to physical and mental health, socialization, and emotional well-being. Participation in activities at a senior center has been shown to yield improvement in balance and fewer functional limitations (Gitelson et al., 2008; Orsega-Smith et al., 2020; Tang et al., 2011). Moreover, participants have reported perceived improvements in their chronic conditions as a result of participation at senior center activities, as well as improvements in self-rated health (Fitzpatrick et al., 2005; Tang et al., 2011; Taylor-Harris & Zhan, 2011). One study demonstrated that more frequent attendance at the senior center, as well as a longer history of attendance at the senior center, predict current participation in physical activity classes and continued participation in those classes (Swan et al., 2013). Among those who participated in physical activities through the senior center, most participants found the activities helpful (Turner, 2004). In their longitudinal evaluation of senior centers in New York City, Pardasani and Berkman (2016) found some improvements in self-rated physical health, self-rated mental health, and anxiety among se-

nior center participants. Additionally, self-reports of exercise suggest that senior center participants exercise more after joining and maintain or increase that level over time. In terms of health education and behavior, Pardasani & Berkman (2016) also found slightly higher percentages of senior center participants reported attending a health program in the last year compared to non-attendees, and higher shares of some senior center participants reported changes in their own behavior as a result of that health program (including “understand the importance of exercise,” “made exercise part of routine,” “became more physically active,” or “do monthly breast exams,” p.43).

Some studies have aimed to measure actual and perceived benefits from participation in nutrition programs, such as congregate meals and nutrition education courses. Based on self-reports of improvements in health and nutrition, participants recognized nutrition programs and classes as important to their own well-being and have reported high levels of agreement with their importance (Swan et al., 2016; Turner, 2006). Indeed, meals and education about nutrition can influence behavior around nutrition as well as reinforce perception that the nutrition program is beneficial to overall health. Improvements in health have been shown to be linked to the social environment of the senior center (Kim & Kim, 2019). Health-promoting group activities, such as exercise groups and congregate meals offered through the senior center, are inherently social, integrating the physical benefits with the

social and emotional benefits to participation.

Benefits to social and emotional well-being are well-documented in the literature. Senior center participants have expressed satisfaction with social engagement opportunities, including making new friends and engaging with others who have similar life experiences, and have cited these as reasons for continued attendance (Fulbright, 2010; Kim & Kim, 2019; Pardasani, 2010; Pardasani & Berkman, 2020; Vivoda et al., 2018). Indeed, some evidence suggests that senior center participants who make friends at the senior center feel less isolated (Pardasani & Berkman, 2016). Participants have reported that their attendance at the senior center has improved their own self-worth and have given purpose and meaning to their lives (Rhynes et al., 2013; Taylor-Harris & Zhan, 2011). Some research suggests that participation at the senior center increased independence and improved overall quality of life among some participants (Aday et al., 2006; Rhynes et al., 2013). Further, there is evidence that participation at the senior center can improve self-reported mental health status (Aday et al., 2006; Pardasani & Berkman, 2020; Pardasani & Berkman, 2016; Taylor-Harris & Zhan, 2011).

Current Challenges for Senior Centers

Senior centers therefore provide beneficial and vital programs and services and serve as the connection to a comprehensive network of other aging services, yet only serve a segment of the

older population. The current clientele of senior centers is old and is “aging in place” without comparable replacement of younger seniors (Markwood, 2013; Pardasani 2010). Senior centers are tasked with bringing in new generations of seniors and participants from more socio-demographically diverse backgrounds, while maintaining the programs and services that meet the needs of the current older participants. In doing so, senior centers must be creative in how they attract new participants and be careful to overcome negative stereotypes and perceptions of the senior center. They must also recognize that younger seniors, men, racially and ethnically diverse older adults, and sexual minorities may all bring different needs and interests to their engagement with the local senior center (Giunta et al., 2012; Pacey et al., 2016; Pardasani & Berkman, 2020).

Organizational and structural changes are necessary to meet the goal of increasing and diversifying their clientele. Based on results from their survey with New York senior center directors, Pardasani and Sackman (2014) make policy recommendations about senior centers in an effort to increase attendance and broadly improve aging services overall. Their recommendations center around the organization—ensuring appropriate and adequate funding, making sure staff are well-trained, and including older adults in the planning process. They recommend supporting facility renovations and remodels as well as innovative models of operation. Lastly, Pardasani and Sackman (2014) recommend creating mea-

asurable outcomes for assessment and planning, and fostering an environment for advocacy on behalf of senior center constituents. All of their recommendations aim to further the network and to support senior centers in their endeavors to remain relevant. However, input from current attendees and prospective attendees is essential to informing changes. To ultimately expand the reach of benefits to more seniors, it is critical to understand why older residents of various ages and socio-demographic backgrounds are currently not using senior centers. Understanding reasons for non-participation will inform senior centers and related policies in how to move forward in planning and outreach of their services.

Reasons for Non-Participation

Although both systematically documented and anecdotal evidence point to the benefits of participation, just an estimated 1 million older adults across the U.S.—out of over 50 million adults age 60 and older—attend programs and services at a senior center (NCOA, 2020), indicating that many are not taking advantage of the services offered. Understanding the reasons why so many older adults are not using senior centers has important policy implications. The older population across the country is large and growing, and senior centers could have greater impact on individuals and the community if more people were engaged. This topic is also an important research question; almost all research focused on senior centers has sought to characterize participants, frequency of attendance, and identify

benefits to participation (Kadowaki & Mahmood, 2018). To date, one primary researcher has sought to characterize and learn about non-participants of senior centers. Pardasani (2010) analyzes results of a survey from older adults in the northwest region of Indiana to compare participants and non-participants. Among those who do not participate at a senior center, 23% reported lack of interest, 21% reported no need for services that are offered, and 15% reported a lack of programs or services that they need. A fifth of non-participants cited a lack of transportation or impeded access to the senior center and 12% reported no volunteer opportunities as a reason for non-participation.

A similar study examining older adults in one community in Connecticut was conducted by Pardasani (2019). Of the non-participants included in the sample, 43% reported having no need and 41% reported lack of interest as reasons for their non-participation. Over a quarter reported a lack of interesting programs, while 19% reported that “senior centers are not for me.” About 13% of non-participants also cited programs or services that they *do* need are not available or cited a disability or chronic health condition as a barrier. To further contextualize the results, a focus group was conducted with non-attendees and questions were posed around reasons for non-attendance. The focus group results suggest that lack of need or interest is partially a result of there being a number of other opportunities for engagement in the community, indicating that young-older adults may already be meeting their needs elsewhere. As

well, themes of the senior center being designed for “old” people and lack of awareness of what the senior center offers emerged. For both the Indiana sample and the Connecticut sample, the top reasons for not participating at the senior center included lack of interest and lack of need, which may be partially influenced by a lack of knowledge about what the senior center provides and has available.

Pardasani and Berkman (2020) approach this possibility by further delineating their sample of non-participants from New York City between those who have never participated and those who had previously participated, but no longer do so. The most frequent reasons for those who have never participated included being too busy working and being too busy with other social activities (27% for each reason). Comparatively, among those who previously attended but are no longer participating, the most frequent reason for non-attendance was being too busy with other social activities (31%), followed by no interest or need for programs and services (23%). It is worth noting that about 27% of those never participating also reported no interest or need, which was not different from the rate for previously participated older adults. That could be a function of small sample size or could indicate that prior knowledge about the senior center does not influence the perception of interest or need.

Both the Indiana and Connecticut samples of non-participants were also asked to identify the types of programs that might be of interest to them.

Respondents in Indiana identified a wide range, including education, arts and culture, and health and wellness programs (Pardasani, 2010). Among non-participants in the Connecticut sample, the most frequently cited programs of possible interest included tax assistance, trips, hearing and vision testing, and educational classes, though no more than one third of non-participants expressed interest in each of the 60 programs listed (Pardasani, 2019).

The three studies discussed here are critical in their contributions to the senior center research literature. They highlight common reasons for not participating at a senior center from three different geographic locations. Through understanding reasons for non-attendance, we can begin to identify effective pathways for educating older persons about available resources and widening the positive impact of senior centers. This paper aims to contribute to this novel literature by adding results based on a large sample of participants and non-participants drawn from eight Massachusetts communities.

Methods

Data Source

We used secondary data from community needs assessments performed by the Center for Social and Demographic Research on Aging (CSDRA) in the Gerontology Institute at the University of Massachusetts Boston. Through the community needs assessment projects, the CSDRA helps communities identify the needs and interests of their older

population. The scope of the assessment and the age range of the population analyzed is tailored to each community. The CSDRA works directly with primary stakeholders in each community to define the goals of the project and the methods used to address them. The CSDRA also develops the instruments used to collect information; all data collection methods and instruments were approved by the UMass Boston Institutional Review Board.

For this study, we pooled survey data from eight communities in Massachusetts that conducted community needs assessment projects in collaboration with the CSDRA. The community needs assessment for each selected communities included surveys for community residents aged 50 and over; this age range is purposefully intended to capture those who currently are of an age when senior center participation is more common, as well as younger, prospective participants. Although each survey is tailored to the individual community, similar topics are included across surveys, such as housing, transportation, community and neighborhood, health, caregiving, senior center services, and demographics. Within these topics, specific questions may vary by community, though a handful of the same questions are asked across communities, including attendance at the local senior center, reasons for non-attendance, length of time living in the community, self-rated health and wellness, gender, and age—each of which is included in this analysis. The community surveys for these municipalities were conducted between 2014 and 2018.

To conduct the surveys, the CSDRA collaborates with community stakeholders to acquire a complete mailing list of residents in the target age group, from which a random sample is drawn. A postcard is sent to all sampled individuals indicating that a survey is coming and that it is in official partnership with the municipality. A printed copy of the survey is mailed a week later to the selected individuals, including a prepaid return envelope and instructions on how to complete the survey online, if desired. The online version of the survey is identical to the paper-based survey. Due to time and cost consideration, no follow-up is conducted. The response rate for the analytic sample assessed here is 31%; response rates for each community survey ranged from 27% to 34%, which is satisfactory for a mailed survey without incentive (Bourque & Fielder, 2002). Less than 10% of responses for each survey came from online submission, and online respondents tended to be younger (i.e., under age 70). CSDRA staff perform data entry and follow a strict protocol of data checking by multiple coders to ensure information is coded correctly. Information from the online and paper-based surveys is pooled in one dataset in SPSS 25 for analysis. For this study, the final sample includes 8,573 community-dwelling older adults aged 50 and over, pooled from eight Massachusetts communities.

The communities selected vary in size, from around 10,000 to 90,000 residents (ACS 2018 5-year estimates, Table B01001). About 40% of the population in these communities are age 50

and older (ACS 2018 5-year estimates, Table B01001). Among those age 50+, 39% are age 50-59, 31% age 60-69, 17% age 70-79, and 13% age 80 or older. Slightly more than half (54%) of older residents in this sample are female. As well as in other communities in Massachusetts, and the state, the proportion of older adults in these communities is expected to continue increasing. It is important to note that residents from the communities included in this study are largely homogeneous in terms of their race, ethnicity, and primary language used. Most of the older adults aged 55 and over living in these communities identify as non-Hispanic White (92% on average, ACS 2018 5-year estimates, Tables B01001 and B01001H). About 85% of the population age 65 and over in these communities speak only English (ACS 2018 5-year estimates, Table B16004). Additionally, older adults in most communities included in the study have greater financial resources compared to other communities in Massachusetts. The median household income for the population age 65 and over in Massachusetts is \$47,486. For the communities included in the analysis, the median household income ranges between \$41,500 and \$79,500 (in 2018 inflation-adjusted dollars, ACS 2018 5-year estimates, Table B19049).

Key Variables

Senior center attendance. Whether participants used their local senior center is collected with the question “How frequently do you use programs or services offered at [your local senior center]?” Participants were asked to select

a response from an array of options. Respondents were categorized as attendees if they reported visiting the local senior center anywhere between a few times a year to two or more times a week; respondents were categorized as non-attendees when they selected “Never, I do not use programs or services offered by the [local senior center]” from the response options available (coded 1 = *non-attendee*, 0 = *attendee*).

Reasons for not participating. Non-attendees were then asked “What is the reason that you do not currently use programs or services offered at [the local senior center]?” Participants could select more than one response from the reasons offered in the survey. Response options included: no interest, no time, no need, inconvenient hours, not familiar or aware, attend elsewhere, not old enough, do not identify with the word “senior,” and other. If they selected “other,” they were given the opportunity to explain further by writing the reasons for not using their local senior center. All write-in reasons for “other” were thematically coded by at least two CSDRA staff and were reviewed by the lead researcher for each community project. These qualitative responses were compared to existing response categories, and those that fit into the existing categories and were not already selected were recoded to the appropriate category (e.g., a written response of “I have no time” was recoded to the existing “no time” category if the respondent did not select that already). Other recurring themes from the “Other” write-ins that warranted separate categorization included: still working, poor

health, no transportation, and needs not met by senior center. It is important to note that only non-attendees were asked to provide reasons for not attending their local senior center.

Age. Participants selected the age group they belonged to at the time of survey. We classified the available information to create four age groups for our analysis: 50 to 59, 60 to 69, 70 to 79, and 80 and over.

Length of time in community. All respondents were asked how long they had been living in the community at the time of the survey. Response options included "Fewer than 5 years," "5-14 years," "15-24 years," "25-34 years," "35-44 years," and "45 years or longer."

Other dichotomous variables included in the analysis are gender (1 = *female*, 0 = *male*), physical health (1 = *poor/fair*, 0 = *good/excellent*), and emotional well-being (1 = *poor/fair*, 0 = *good/excellent*).

Analysis Strategy

Bivariate analyses were performed to estimate statistically significant differences in the reasons for non-attendance by age group, gender, physical health, and emotional well-being among non-attendees aged 50 and over. Specifically, contingency tables and chi-squared tests for significance were performed to estimate significant differences between groups.

Results

Sample Description

Sample characteristics are presented in **Table 1**. About 40% of respondents were in the 60-69 age bracket, with a fifth of respondents aged 50-59, about a quarter aged 70-79, and the remaining 14% aged 80 or older. Compared to the communities in which these surveys were carried out, the study sample has higher representation of people age 60-69 and age 70-79. Most of the sample (60%) is female, which is higher than the community at large (54%). About 14% reported poor or fair physical health, while 9% reported poor or fair emotional well-being. Most of the sample had lived in their communities for a long time—nearly 60% had lived in their community for 25 years or more.

A majority (75%) of the pooled sample reported not attending their local senior center. In comparison with attendees, non-attendees were more likely to be younger (ages 50-59 and 60-69), less likely to identify as female, and less frequently reported poor/fair physical health and emotional well-being. Non-attendees were also more likely to have resided in their community for shorter amounts of time, less than 34 years, compared to attendees who were more likely to live in their community for 35 years or longer.

Additional analysis (**Table 2**) suggests that within each age group, the gender distribution varies slightly. Nearly 64% of those aged 60-69 in the total sample is female, the highest proportion among age groups (see first col-

Table 1. *Sample Characteristics*

Variables (%)	Total (N = 8573)	Attendees (n = 2114)	Non-attendees (n = 6459)	χ^2 or <i>t</i>
Age				
50-59	20.1	3.5	25.5	***
60-69	40.0	31.2	42.9	***
70-79	26.1	39.2	21.8	***
80+	13.8	26.2	9.7	***
Female	60.2	69.2	57.3	***
Poor/fair physical health	13.7	18.4	12.2	***
Poor/fair emotional well-being	8.6	10.9	7.9	***
Length of time in community				
Fewer than 5 years	7.8	6.5	8.3	***
5-14 years	14.5	13.7	14.8	
15-24 years	18.2	12.0	20.2	***
25-34 years	17.2	11.8	19.0	***
35-44 years	16.8	19.4	15.9	***
45 years or longer	25.5	36.5	21.9	***

Notes. * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 2. *Sample Characteristics: Percent Female by Age and Attendance*

Variables (%)	Total (N = 8573)	Attendees (n = 2114)	Non-attendees (n = 6459)	χ^2 or <i>t</i>
Age				
50-59	53.5	64.4	47.0	***
60-69	63.8	76.2	39.1	***
70-79	59.5	66.4	44.5	***
80+	61.0	65.7	42.7	***

Notes. * $p < .05$. ** $p < .01$. *** $p < .001$.

umn). Among those aged 70-79 and 80 or older, about 60% of the sample is female, which is substantially higher than among those aged 50-59 (54%). Among attendees, nearly three-quarters of those age 60-69 are female, which compares to just 47% of non-attendees age 60-69.

Reasons for Not Participating

We examined frequencies of reasons for non-attendance, presented in **Figure 2**. Percentages will not sum to 100% since respondents could identify multiple reasons. The most frequent reasons for

non-attendance were not being old enough (26.5%), not being interested (26.3%), and not having time (20.0%). About 1 out of 10 respondents did not attend their local senior center because they did not identify with the word “senior” (13.7%), participated in programs elsewhere (11.1%), or were not familiar with or aware of programming (10.5%). A portion of non-attendees also identified another reason for non-attendance that was not included in the listed categories. Some common themes among the “other” reasons were not knowing anybody there and not having anyone to go with to start out. A number of respondents also wrote in that while they have no current need, they can foresee attending in the future (e.g., after retirement). Among “other” write-ins, less than 5% of the sample attributed their non-attendance to feeling they had no need, were still working, having poor health, not having transportation, in-

convenient hours, or their needs not being met by the senior center. Given the small portion of write-ins on “other” reasons, the Other response category was excluded from further analysis. In separate analysis, there were significant differences in reasons for non-attendance by community for all reasons except for “no transportation” and “needs not met.”

We then analyzed statistical differences in reasons for non-attendance by gender, age group and health. Differences by gender are presented in **Table 3**. Females were more likely than males to report not having time, still working, having poor health, inconvenient hours of operation, and participating in programs elsewhere as reasons for non-attendance. Males were more likely than females to say they were not interested, not familiar or aware of programming, and not old enough as reasons for their non-attendance. There was no gender

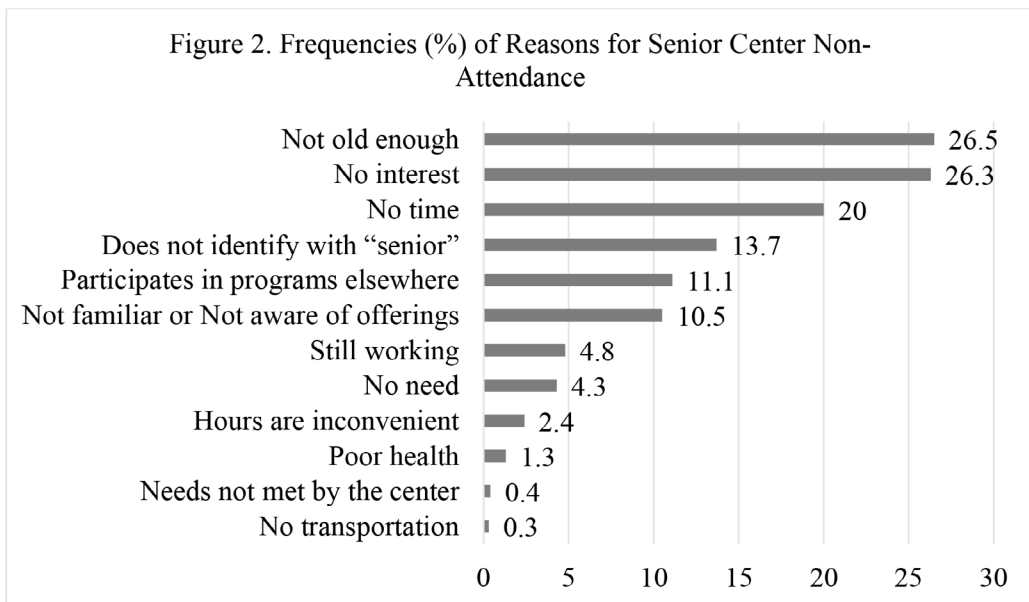


Figure 2. Frequencies of Reasons for Senior Center Non-Attendance

Table 3. *Bivariate Analysis of Reasons for Non-Attendance, by Gender*

Reason (% within gender)	Gender		χ^2
	Female	Male	
Not old enough	25.4	27.9	5.00 *
No interest	22.0	32.0	81.28 ***
No time	22.8	16.4	40.57 ***
Does not identify with “senior”	14.1	13.2	1.23
Participates elsewhere	13.5	7.9	50.14 ***
Not familiar/aware	9.2	12.3	16.27 ***
Still working	6.1	3.1	31.95 ***
No need	4.1	4.6	1.18
Inconvenient hours	3.7	0.8	54.76 ***
Poor heath	1.6	0.9	4.79 *
Needs not met by center	0.5	0.4	0.27
No transportation	0.4	0.1	3.09

Notes. $N = 6,459$ non-attendees.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4. *Bivariate Analysis of Reasons for Non-Attendance, by Age Group*

Reason (% within age group)	Age Group				χ^2
	50-59	60-69	70-79	80+	
Not old enough	57.4	22.7	8.6	2.4	1248.57 ***
No interest	20.9	25.2	31.5	33.7	63.90 ***
No time	13.3	25.6	19.3	14.8	109.83 ***
Does not identify with “senior”	23.5	13.1	8.8	1.9	238.53 ***
Participates elsewhere	3.6	9.3	19.4	20.3	256.96 ***
Not familiar/aware	11.5	12.9	7.0	5.1	56.89 ***
Still working	3.9	7.2	2.8	1.3	67.60 ***
No need	1.8	5.5	4.8	4.5	36.36 ***
Inconvenient hours	1.5	3.3	2.6	1.1	19.67 ***
Poor heath	0.2	0.5	1.6	6.8	177.71 ***
Needs not met by center	0.4	0.5	0.3	0.6	2.15
No transportation	0.0	0.1	0.3	1.7	56.42 ***

Notes. $N = 6,459$ non-attendees.

* $p < .05$. ** $p < .01$. *** $p < .001$.

difference found in feeling they had no need for the senior center, not identifying with the word “senior,” or that the senior center did not meet their needs being reported as reasons for non-attendance.

In comparing age groups (**Table 4**), all reasons except needs not being met by senior center were significantly different across groups. Younger age groups (50-59 and 60-69) were more likely to report they did not participate because they were still working (3.9% and 7.2%), were not familiar with programming offered (11.5% and 12.9%), did not feel old enough (57.4% and 22.7%), or did not identify with the word “senior” (23.5% and 13.1%). Those aged 60-69, 70-79, and 80+ all reported not needing the senior center (5.5%, 4.8%, 4.5%, respectively) at higher rates than the age group 50-59. Age groups 70-79 and 80+ were more likely than younger age groups to report no interest (31.5% and 33.7%) or participation in programs elsewhere (19.4% and 20.3%). Those in 80+ age group were significantly more likely to report poor health (6.8%) and no transportation (1.7%) as reasons for non-attendance. Additional analysis (not shown) suggests that among those who selected “Not old enough” as a reason for non-attendance, 54% of those age 50-59 were female, compared to 61% of those age 60-69, and 39% of those age 70+.

Tables 5 and 6 examined reasons of non-attendance by physical health and emotional well-being. Respondents with poor or fair physical health or emotional well-being were more likely than

their counterparts to report they did not participate because they were not familiar or aware of programming. Additionally, respondents with poor or fair physical health or emotional well-being were also more likely to identify lack of transportation as a reason for non-attendance.

Discussion

This study provides important insights about people who participate at the senior center, as well as those who do not and their reasons for not participating. Senior center attendees are older and have worse self-rated health compared to non-attendees. Attendees have lived in the community longer than non-attendees. Attendees are significantly more likely to be female than are non-attendees of the same age. The top reasons selected for non-attendance include “no time” (20%), “no interest” (26%), and “not old enough” (27%). Reasons for non-attendance differ by age, gender, physical health, and well-being of the older adult. The top reason for non-attendance among men was “no interest” (33%), while the top reason for non-attendance among women was “not old enough” (25%). Nearly a third of those aged 70 and older selected “no interest,” which was the top selected reason for that age group. This compared to 57% of those aged 50-59 most frequently selecting “not old enough,” and those age 60-69 selecting “no time.” Compared to those with better health, significantly more non-attendees with reported poor physical health and emotional well-be-

Table 5. *Bivariate Analysis of Reasons for Non-Attendance, by Physical Health*

Reason (% within physical health)	Physical Health		χ^2
	Poor/Fair	Good/Excellent	
Not old enough	14.0	28.2	72.52 ***
No interest	28.7	26.0	2.61
No time	14.1	20.9	19.82 ***
Does not identify with "senior"	7.6	14.6	28.25 ***
Participates elsewhere	8.4	11.5	6.82 **
Not familiar/aware	13.8	10.1	10.52 **
Still working	3.0	5.1	6.22 *
No need	2.8	4.5	4.9 *
Inconvenient hours	2.4	2.5	0.01
Poor health	7.2	0.5	246.12 ***
Needs not met by center	0.4	0.5	0.09
No transportation	1.1	0.2	24.08 ***

Notes. $N = 6,459$ non-attendees.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 6. *Bivariate Analysis of Reasons for Non-Attendance, by Emotional Well-Being*

Reason (% within emotional well-being)	Emotional Well-Being		χ^2
	Poor/Fair	Good/Excellent	
Not old enough	17.8	27.3	21.55 ***
No interest	26.8	26.3	0.07
No time	17.6	20.2	2.03
Does not identify with "senior"	11.5	13.9	2.21
Participates elsewhere	8.8	11.3	3.00
Not familiar/aware	16.2	10.0	19.37 ***
Still working	2.3	5.0	7.44 **
No need	2.0	4.5	7.35 **
Inconvenient hours	3.5	2.4	2.69
Poor health	6.3	0.9	106.43 ***
Needs not met by center	0.2	0.5	0.80
No transportation	1.6	0.2	33.07 ***

Notes. $N = 6,459$ non-attendees.

* $p < .05$. ** $p < .01$. *** $p < .001$.

ing identified lack of knowledge about the senior center or its programming as well as transportation issues as reasons for non-participation.

The results from this study support and further explain what has been highlighted from previous literature. To our knowledge, the sample size from this study is the largest to date that includes both participants and non-participants of senior centers. Our ability to pool data from different community needs assessments strengthened the findings. Given that senior centers are intended to represent and serve the local community, efforts to improve outreach and services should also be based on those whom the senior center serves. The results, however, also feature some reasons for non-attendance that may be more universal. These findings support what other studies have found: that non-attendees lack time, interest, or awareness of senior center programming.

This study supports that a primary reason for not participating at the senior center is lack of interest; however, it also alludes to underlying factors for non-attendance. First, a quarter of respondents reported not being old enough to participate, despite being in the appropriate age range cited by the senior center for participation. This may indicate a disconnect between who the senior center is aiming to reach, and how community-dwellers in general view the senior center (e.g., a place for old-old adults). Similarly, a sizable portion of the sample cited that they do not identify with the word "senior," which again speaks to the perception of the senior center as only serving those who

are very old and require assistance.

Comparisons by age differ slightly from some previous findings. Pardasani (2010) found that older adults younger than 70 more frequently reported no need for services or limited interest in programs compared to those age 70 or older. Among adults in this sample, however, small portions of those age 60 and older reported no need, and they reported it more frequently than those age 50-59. Similarly, the portion of non-attendees reporting "not interested" increases with each age group, from 21% among the 50-59 age group to 34% among those 80 and older.

Results from this study suggest that women do not participate at the senior center because they do not have time or they participate elsewhere, whereas men more frequently reported no interest, no awareness, and not being old enough. The finding of gender differences in "no interest" as a reason for non-participation differs from previous research. Although there were no gender differences for "lack of interest" as a reason for non-attendance from the Pardasani (2010) study, in this sample almost a third of non-attending men reported no interest, compared to 22% of women. The source of dissimilarities in findings related to gender differences of reasons for non-attendance is not immediately clear, but may stem from differences in survey wording. The survey conducted by Pardasani (2010) asked respondents to report the *most important* reasons for non-attendance; the surveys included in this study asked respondents to provide *any* reasons for non-attendance. This

difference in phrasing could be a cause for differing results around the “lack of interest” reason. Respondents to the Pardasani (2010) survey reported lack of interest as equally important by gender. When asked about any reason for non-attendance, the results from this study show that men more frequently report lack of interest than women. The difference in results between the two studies could indicate that lack of interest is not a primary reason for non-attendance, yet is more of a consideration for men than women.

Beyond differences in measurement, results regarding gender differences in non-participation may be reflective of patterns of leisure time. Some research suggests that women are more likely than men to seek out activities in later life, upon retirement or widowhood (Jaumot-Pascual, Monteagud, Kleibe, & Cuenca, 2016). Moreover, the activities that older women participate in are different than for men, with evidence suggesting that women more frequently participate in formal activities, hobbies, or social or passive activities, while men more frequently participate in physically active leisure activities (Janke, Davey, & Kleiber, 2006; Ball, Corr, Knight, & Lowis, 2007). It may be that women are busy with other role responsibilities, such as caring for grandchildren or volunteering, or participating in leisure activities elsewhere. In comparison, older men may simply not view the senior center as a place for them. The senior center may indeed provide the programs and services that interest older men, but if the male community members are not aware of them,

or have preconceived ideas of what the senior center is, does, and serves, then they are not likely to participate. Further evidence is required to elucidate any differences by age and gender for non-participation.

Implications

The traditional senior center model has served a small segment of the older population, but as the size and socio-demographics of older populations change, the offerings and the outreach of senior centers must change as well. Senior center directors, local municipalities, and policy makers must all consider the capacity to serve a larger share of the community and adjust the types of offerings provided. Results of this study indicate that older segments of the community are more likely to have time to attend senior centers, in part, because of higher rates of being retired and be in good health, which affords them the physical capability of participating in the senior center programs. However, adults age 70 and older—the most prevalent age group currently served in senior centers—more frequently reported having no need or interest in attending the senior center compared to younger non-participants.

A number of younger respondents wrote that they have no current need for the senior center but anticipate attending in the future. While this may seem promising for future senior center attendance, senior centers must also recognize that getting those adults in the door will require adapting programs and scheduling (e.g., programs at

night or on weekends). This gives senior center administrators leverage in their advocacy efforts—there is a projected interest in attending the senior center, but the senior center is not currently meeting the needs and interests of all those eligible to participate.

The results presented suggest pockets of older adults for whom targeted outreach may be beneficial. Given that men more frequently reported lack of knowledge and awareness of programs and services compared to women, gearing information or programming toward older men in the community may improve awareness and more successfully bring older men to the senior center. As well, those who reported worse physical health and emotional well-being cited transportation as a barrier to participation. Given that transportation is often an area of focus for senior centers, amplifying efforts to provide adequate transportation to the senior center to those who most need it may be a priority.

Senior centers are the “local front door” to the network of aging supports and services. As evidence from this study demonstrates, these local hubs serve as resources for community dwelling adults—particularly women and those with decent self-reported health. What the evidence in this study does not provide, however, is precisely how older adults value the senior center. Thus, increasing the visibility and the capacity of local centers to function as an information and support resource in the community could be vital to creating communities where all adults can live independent and full lives and de-

fer morbidity and disability as long as possible. Moreover, more integration between the social and quality of life enhancements offered by senior centers and the key health and human services delivered by Area Agencies on Aging (AAAs) could also strengthen and streamline individuals’ ability to leverage the aging network. For example, the Meals on Wheels program in Massachusetts is often provided through collaboration between the senior center and the regional AAA, where food and resources (financial, and sometimes volunteers) are provided by the AAA and delivery is handled by the senior center.

The results from this study are similar to what has been documented previously, thus indicating that the current challenges around increasing participation and visibility are also longstanding challenges for senior centers. While senior centers are expected to serve as a wide net to everyone in the community, they are also expected to specifically serve underserved populations defined by the Older Americans Act. From the top down, senior centers experience pressure to serve as a community resource for both those with substantial service needs and those looking for engagement and entertainment. However, evidence from non-attendees presented here suggests that senior centers are not meeting that mark, which begs the question: how do senior centers prioritize their aim and mission? Moving into the future, senior centers could remove age requirements and become more age-integrated; they could become more interest- or ser-

vice-based. Pardasani and Thompson (2012) outline a number of emerging models of senior centers from across the nation, some with targeted focuses (e.g., community centers, wellness centers, lifelong learning centers), which may serve as goals for some senior centers to transition to. However, any changes to the mission, the programs and services provided, or the target population of a senior center ought not to be made without consideration of the local community which the senior center serves. Evidence such as presented here can inform senior centers as they continue to adapt.

Limitations

This study is not without its limitations. First, the data comes from communities in Massachusetts that are quite homogeneous with respect to race and ethnicity and are also more affluent than the typical Massachusetts municipality. Each community survey was conducted as a part of a Needs Assessment project, completed in conjunction with the local Council on Aging (COA), who reached out to the research team for collaboration. COA directors who are proactively seeking research support in their planning and advocacy efforts may represent senior centers with more resources in terms of staff, funding, and space, compared to those centers that are not seeking academic research support. As such, the senior centers that were included in this study may have a more prominent role in the community, or a wider variety of offerings and marketing compared to other senior centers. The results of this study may have

differed if our data came from a different selection of communities.

Moreover, in pooling data from multiple community surveys, we were limited in the data points we could include that were comparable across all eight surveys. We only included data that came from questions phrased in the same manner across all eight surveys. In designing each community survey, the research team must strike a balance between methodological consistency and the demand for tailored information that can be used to make decisions and plans at a local level. For example, we did not have data on race and ethnicity for respondents across all surveyed communities and thus could not include that variable in this study. Although previous research suggests factors such as marital status, living arrangement, and income may predict attendance (Kadowaki & Mahmood, 2018), the scope of the pooled data did not allow for inclusion of those variables in this analysis.

Additionally, we could only include a dichotomous measure of current participation, rather than a frequency of attendance (e.g., daily, twice a week, special events only) or a measure including past attendance. Previous research suggests that those with limited participation may have different reasons for not attending compared to those who never participate (Pardasani & Berkman, 2020). Between limited covariates and our dichotomous measure, regression analyses or other techniques beyond descriptive statistics could not be performed for this study.

Conclusion

The results of this study help characterize the current challenges faced by many in the senior center network and are distinctive in highlighting the important issue in the research literature. There is limited research on this topic, and this is just the fourth study to date with attention on non-participants of senior centers. Indeed, senior center non-participation has profound policy implications for local and state aging services. The results presented here align with what has been previously documented about those who choose not to participate. Reasons for non-attendance such as lack of awareness, lack of transportation, lack of needed or interesting programs, and inconvenient scheduling are all areas in which the senior center can modify to better meet resident needs and thus attract new participants to the senior center.

An opportunity for future research includes assessing the needs, interests, and perspectives of those who do not attend senior centers and those who have stopped attending the senior center, with particular attention to individual and organizational factors that influence those perspectives. More information about how older adults view organizational attributes of the senior center that may prohibit participation—such as physical structure, staffing, depth and breadth of programs/

services offered, and the social atmosphere—could lead to actionable measures senior centers can take to better serve its clientele and to bring in new participants. Furthermore, learning from older adults about specific methods that may improve perspective and increase attendance (e.g., change the name of the center, include the senior center within a community center) is crucial to the continued success of the senior center model.

These issues are not new to senior centers; many of which are working on both maintaining and increasing participation at the local level, such as through the Community Needs Assessment projects from which the data analyzed in this paper are drawn. Some communities are actively seeking to improve the image of the senior center through naming and messaging; for example, the New York City Department for the Aging is actively working toward innovating the senior centers under its jurisdiction, starting with a suggested name change from “senior center” to “older adult center,” and pursuing input from a range of stakeholders on that change (NYC Department on Aging, 2020). Efforts to elevate the work senior centers are currently doing to a larger audience among aging service providers and the research literature could yield further research opportunities and ideas for innovation.

References

- Administration for Community Living. (ACL; 2021). *Older Americans Act*. Administration for Community Living. <https://acl.gov/about-acl/authorizing-statutes/older-americans-act>
- Aday, R. H., Wallace, B., & Krabill, J. J. (2019). Linkages between the senior center as a public place and successful aging. *Activities, Adaptation & Aging*, 43(3), 211-231. <https://doi.org/10.1080/01924788.2018.1507584>
- Aday, R., Kehoe, G., & Farney, L. (2006). Impact of senior center friendships on aging women who live alone. *Journal of Women & Aging*, 18(1), 57-73. https://doi.org/10.1300/J074v18n01_05
- Ball, V., Corr, S., Knight, J., & Lowis, M. J. (2007). An investigation into the leisure occupations of older adults. *British Journal of Occupational Therapy*, 70(9), 393-400.
- Bøen, H. (2012). Characteristics of senior centre users and the impact of a group programme on social support and late-life depression. *Norsk Epidemiologi*, 22(2), 261-269. <https://doi.org/10.5324/nje.v22i2.1574>
- Bourque, L. B. & Fielder, E. P. (2003). How to conduct self-administered and mail surveys (pp. 2-26). SAGE Publications, Inc. <https://www-doi-org.ezproxy.lib.umb.edu/10.4135/9781412984430>
- Colello, K. J., & Napili, A. (2021) *Older Americans Act: Overview and Funding*. Congressional Research Service Report. <https://crsreports.congress.gov/product/pdf/R/R43414>
- Choi, N. G., An, S., & DiNitto, D. M. (2021). Felt age among racial/ethnic minority older adults attending a senior center. *Journal of Applied Gerontology*, 40(4), 395-403. <https://doi.org/10.1177/0733464820903906>
- Fitzpatrick, T. R., McCabe, J., Gitelson, R., & Andereck, K. (2006). Factors that influence perceived social and health benefits of attendance at senior centers. *Activities, Adaptation & Aging*, 30(1), 23-45. https://doi.org/10.1300/J016v30n01_02
- Fulbright, S. (2010). Rates of depression and participation in senior centre activities in community-dwelling older persons. *Journal Of Psychiatric & Mental Health Nursing*, 17(5), 385-391. <https://doi.org/10.1111/j.1365-2850.2009.01535.x>
- Gitelson, R., Ching-hua, H., Fitzpatrick, T., Case, A., & McCabe, J. (2008). The impact of senior centers on participants in congregate meal programs. *Journal of Park & Recreation Administration*, 26(3), 136-151.

- Giunta, N., Morano, C., Parikh, N. S., Friedman, D., Fahs, M. C., & Gallo, W. T. (2012). Racial and ethnic diversity in senior centers: Comparing participant characteristics in more and less multicultural settings. *Journal of Gerontological Social Work*, 55(6), 467-483. <https://doi.org/10.1080/01634372.2011.653519>
- Janke, M., Davey, A., & Kleiber, D. (2006). Modeling change in older adults' leisure activities. *Leisure Sciences*, 28(3), 285-303.
- Jaumot-Pascual, N., Monteagudo, M. J., Kleiber, D. A., & Cuenca, J. (2016). Gender differences in meaningful leisure following major later life events. *Journal of Leisure Research*, 48(1), 83-103.
- Kadowaki, L., & Mahmood, A. (2018). Senior centres in Canada and the United States: A scoping review. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 37(4), 420-441. <https://doi.org/10.1017/S0714980818000302>
- Keyes, L., Li, Q., Collins, B., & Rivera-Torres, S. (2020). Senior center service utilization: Do social ties affect participation patterns? *Journal of Applied Gerontology* 41(2), 526-533. <https://doi.org/10.1177/0733464820975905>
- Kim, J., & Kim, J. (2021). Exploring health benefits through senior center engagement: A qualitative investigation of older Korean immigrants. *Activities, Adaptation & Aging*, 45(1), 1-13. <https://doi.org/10.1080/01924788.2019.1698121>
- Kim, H., Harada, K., Miyashita, M., Lee, E., Nakamura, Y., & Park, J. (2011). Use of senior center and the health-related quality of life in Korean older adults. *Journal of Preventive Medicine and Public Health*, 44, 149-156. <https://doi.org/10.3961/jpmph.2011.44.4.149>
- Markwood, S. (2013). Is the senior center here to stay? *Generations*, 37(4), 75-76.
- Matsui, M., & Capezuti, E. (2008). Feature article: Perceived autonomy and self-care resources among senior center users. *Geriatric Nursing*, 29(2), 141-147. <https://doi.org/10.1016/j.gerinurse.2007.09.001>
- National Center on Law & Elder Rights (2018). *Targeting Older Americans Act Services Without Means Testing: Meeting the Challenge*. Issue Brief. <https://ncler.acl.gov/pdf/Targeting-OAA%20-Services-Without-Means-Testing-Issue-Brief.pdf>
- National Council on Aging. (2020). *Senior Center Facts*. National Council on Aging. <https://www.ncoa.org/article/get-the-facts-on-senior-centers>
- Orsega-Smith, E. M., Kalksma, P. J., Harris, W., & Drazich, B. (2021). Older adults

- and Exergames Olympics: Feasibility and fun. *Activities, Adaptation & Aging*, 45(2), 118-134. <https://doi.org/10.1080/01924788.2020.1728044>
- Paceley, M. S., Keene, L. C., & Lough, B. J. (2016). Barriers to involvement in non-metropolitan LGBTQ organizations. *Journal of Gay & Lesbian Social Services*, 28(2), 117-139. <https://doi.org/10.1080/10538720.2016.1155518>
- Pardasani, M. (2010). Senior centers: Characteristics of participants and nonparticipants. *Activities, Adaptation and Aging*, 34(1), 48-70. <https://doi.org/10.1080/01924780903552295>
- Pardasani, M. (2019). Senior centers: If you build will they come? *Educational Gerontology*, 45(2), 120-133. <https://doi.org/10.1080/03601277.2019.1583407>
- Pardasani, M., & Berkman, C. (2020). New York City senior centers: Who participates and why? *Journal of Applied Gerontology*, 40(9), 985-996. <https://doi.org/10.1177/0733464820917304>
- Pardasani, M., & Sackman, B. (2014). New York City senior centers: A unique, grassroots, collaborative advocacy effort. *Activities, Adaptation & Aging*, 38(3), 200-219. <https://doi.org/10.1080/01924788.2014.935907>
- Pardasani, M., & Thompson, P. (2012). Senior centers: Innovative and emerging models. *Journal of Applied Gerontology*, 31(1), 52-77. <https://doi.org/10.1177/0733464810380545>
- Rhynes, L., Hayslip Jr, B., Caballero, D., & Ingman, S. (2013). The beneficial effects of senior center attendance on grandparents raising grandchildren. *Journal of Intergenerational Relationships*, 11(2), 162-175. <https://doi.org/10.1080/15350770.2013.782746>
- Schneider, A. E., Ralph, N., Olson, C., Flatley, A. M., & Thorpe, L. (2014). Predictors of senior center use among older adults in New York City public housing. *Journal of Urban Health*, 91(6), 1033-1047. <https://doi.org/10.1007/s11524-014-9906-3>
- Swan, J. H., Turner, K., Shashidhara, S., & Sanders, D. (2013). Increased physical activity, physician recommendation, and senior center participation. *Health*, 5(12), 8-18. <https://doi.org/10.4236/health.2013.512A002>
- Swan, J. H., Severance, J. J., & Turner, K. (2016). Senior centers and nutritional outcomes: A Texas example. *Social Work in Public Health*, 31(5), 439-452. <https://doi.org/10.1080/19371918.2015.1137506>
- Tang, F., Heo, J., & Weissman, M. (2011). Racial differences in social engagement and health status among older women. *Social Work in Public Health*, 26(1), 110-122. <https://doi.org/10.1080/10911350902986930>

- Taylor-Harris, D., & Zhan, H. J. (2011). The third-age African American seniors: Benefits of participating in senior multipurpose facilities. *Journal of Gerontological Social Work*, 54(4), 351-371. <https://doi.org/10.1080/01634372.2010.539588>
- Turner, K. W. (2004). Senior citizens centers: What they offer, who participates, and what they gain. *Journal of Gerontological Social Work*, 43(1), 37-47. https://doi.org/10.1300/J083v43n01_04
- Turner, K. (2006). Weight status and participation in senior center activities. *Family & Community Health*, 29(4), 279-287. <https://doi.org/10.1097/00003727-200610000-00006>
- U.S. Census Bureau. (2018). *2018 American Community Survey 5-year estimates* [Tables B01001, B01001H, B16004, and B19049]. U.S. Census Bureau. <https://data.census.gov/cedsci/>.
- Vivoda, J. M., & Kessler, V. (2019). Assessing Participant Satisfaction and the Impact of Senior Centers in Rural Northwestern Ohio Counties.
- Weil, J. (2014). *The New Neighborhood Senior Center: Redefining Social and Service Roles for the Baby Boom Generation*. Rutgers University Press. <https://doi.org/10.36019/9780813562964>

Mobilizing a Community to Develop a Comprehensive Master Aging Plan

Sallie D. Allgood, PhD, RN^{1,2}

sallie.allgood@duke.edu

Corresponding Author

Ryan Lavalley, PhD, OTR/L^{3,4,5}

ryan_lavalley@med.unc.edu

Cassandra Dictus, MPH, BSN, RN^{5,6}

cdictus@email.unc.edu

Janice Tyler, BA⁴

jtyler@orangecountync.gov

Cherie Rosemond, PhD⁵

crosemon@med.unc.edu

1. Center of Innovation to Accelerate Discovery and Practice Transformation (ADAPT), Health Services Research and Development, Durham VA Health Care System.
2. Duke University School of Nursing
3. Division of Occupational Science and Occupational Therapy, University of North Carolina at Chapel Hill
4. Orange County Department on Aging
5. Partnerships in Aging Program, University of North Carolina at Chapel Hill
6. School of Nursing, University of North University of North Carolina at Chapel Hill

Funding Sources:

SDA's effort was covered by a VA Office of Academic Affiliations Health Services Research -Advanced Fellow in National Clinician Scholar Program (TPH 21-000-14).

CD was supported by the Hillman Scholars Program in Nursing Innovation and the National Institute of Nursing Research of the National Institutes of Health under Award Number T32NR007091. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Hillman Foundation or National Institutes of Health

CR, RL, SDA, CD time to lead MAP initiatives and conduct program evaluation was partially supported through a contract between UNC's Partnerships in Aging Program and Orange County's Department on Aging.

ABSTRACT

Approximately 48 million older adults, aged 65+, live in the United States and this number is expected to double in the next 40 years. In response, cities and states are creating policies and programs to support older adults and the overall experience of aging. Yet there is a lack of input from older adults about which policies and programs actually meet their needs. This case example provides information about how one community in North Carolina (NC) engaged older adults in development of their community's Master Aging Plan (MAP). These MAP efforts were guided by the World Health Organization's age-friendly framework. Community members and key stakeholders participated in an assessment of community assets and needs through surveys ($n=860$), focus groups ($n=13$, with 63 participants), and key stakeholder interviews ($n=34$). A comprehensive list of community needs and assets was created from the assessment and organized using the age-friendly framework. To endorse or refine findings and establish priorities, community members provided additional input during two community-wide listening sessions. Armed with findings from the assessment, community members, organizational leaders, and governmental stakeholders came together in workgroups around each domain of the age-friendly framework to create Orange County's Master Aging Plan. Orange County, NC's experience with collaborative community engagement can serve as a guide for other communities seeking to involve community members in development of their own Master Aging Plan. Policy implications include incentive mechanisms to encourage age-friendly community planning and broad engagement of both community members and leaders.

Keywords: community planning, community engagement, age-friendly, cities

Movilización de una comunidad para desarrollar un plan maestro integral para el envejecimiento

RESUMEN

Aproximadamente 48 millones de adultos mayores, mayores de 65 años, viven en los Estados Unidos y se espera que este número se duplique en los próximos 40 años. En respuesta, las ciudades y los estados están creando políticas y programas para apoyar a los

adultos mayores y la experiencia general del envejecimiento. Sin embargo, hay una falta de aportes de los adultos mayores sobre qué políticas y programas realmente satisfacen sus necesidades. Este ejemplo de caso proporciona información sobre cómo una comunidad en Carolina del Norte (NC) involucró a los adultos mayores en el desarrollo del Plan Maestro para el Envejecimiento (MAP) de su comunidad. Estos esfuerzos de MAP fueron guiados por el marco amigable con las personas mayores de la Organización Mundial de la Salud. Los miembros de la comunidad y las partes interesadas clave participaron en una evaluación de los bienes y necesidades de la comunidad a través de encuestas (n=860), grupos focales (n=13, con 63 participantes) y entrevistas con partes interesadas clave (n=34). A partir de la evaluación se creó una lista completa de las necesidades y los recursos de la comunidad, que se organizó utilizando el marco adaptado a las personas mayores. Para respaldar o refinar los hallazgos y establecer prioridades, los miembros de la comunidad brindaron información adicional durante dos sesiones de escucha en toda la comunidad. Armados con los hallazgos de la evaluación, los miembros de la comunidad, los líderes organizacionales y las partes interesadas gubernamentales se reunieron en grupos de trabajo en torno a cada dominio del marco amigable con las personas mayores para crear el Plan Maestro para el Envejecimiento del Condado de Orange. La experiencia del Condado de Orange, NC con la participación comunitaria colaborativa puede servir como guía para otras comunidades que buscan involucrar a los miembros de la comunidad en el desarrollo de su propio Plan Maestro para el Envejecimiento. Las implicaciones políticas incluyen mecanismos de incentivos para fomentar la planificación comunitaria adaptada a las personas mayores y una amplia participación tanto de los miembros como de los líderes de la comunidad.

Palabras clave: planificación comunitaria, participación comunitaria, amigable con los mayores, ciudades

动员社区发展全面的重要老龄化计划

摘要

美国约有4800万65岁以上的老年人，这一数字预计将在未来40年翻一番。作为响应，城市和州正在制定政策和计划，以支持老年人和整体的老龄化体验。不过，老年人很少表达哪

些政策和计划真正满足其需求。本案例描述了北卡罗来纳州 (NC) 的一个社区如何让老年人参与制定社区的重要老龄化计划 (MAP)。这些MAP工作以世界卫生组织的老年友好型框架为指导。社区成员和关键利益攸关方通过参与调查 (n=860)、焦点小组 (n=13, 共63名参与者) 和关键利益攸关方访谈 (n=34), 评估了社区资产和需求。根据评估创建了一份全面的社区需求和资产清单, 并使用老年友好框架对清单加以组织。为了认可或完善调查结果并确定优先事项, 社区成员在两次社区聆听会议期间提供了额外的意见。借助评估结果, 社区成员、组织领导和政府利益攸关方建立工作组, 围绕老年友好框架的每个领域制定橙县重要老龄化计划。北卡罗来纳州橙县在协作式社区参与方面的经验可为其他社区提供参考, 帮助后者动员社区成员参与制定重要老龄化计划。政策影响包括用于鼓励老年友好型社区规划的激励机制, 以及社区成员和领导者的广泛参与。

关键词: 社区规划, 社区参与, 老年友好, 城市

Introduction

Over 52 million older adults, age 65 and older, live in the United States and population growth for older adults is more rapid than for any other age group (U.S. Census Bureau, 2019). Aging of the Baby Boomer generation (individuals born between 1946 and 1964) is spurring this growth, and by 2030, 1 of every 5 individuals in the United States will be older adults (Vespa, 2018). Creating age-friendly communities that are accessible, well-designed, and provide a wide range of services is essential to meet the current and future needs of older adults (Ball & Lawler, 2014; Van Hoof et al., 2018). Age-friendly cities and communities enhance general well-being, improve quality of life, and foster

a sense of belonging not just for older adults, but for people of all ages (Menec et al., 2011; Neiboer & Cramm, 2018). To support communities in becoming more age-friendly, the World Health Organization (WHO, 2007) developed an age-friendly framework that identifies eight domains, across social environments, physical infrastructures, and essential services, that influence livability and quality of life for older adults (Figure 1).

AARP is the U.S. affiliate of the WHO age-friendly initiative and supports a Network of Age-Friendly States and Communities in the United States. Communities that join this network have access to technical assistance provided by AARP and connections to other member communities for sharing experiences, providing feedback, and

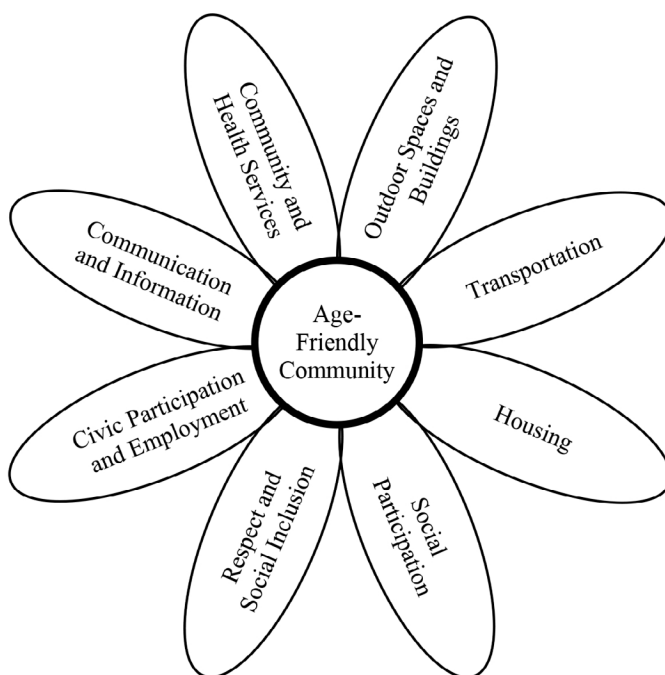


Figure 1. Eight domains of age-friendly communities identified by the World Health Organization (WHO, 2007).

sharing best practices (AARP, 2020). As members of the AARP age-friendly network, communities develop action plans that articulate strategic policies and community services agendas that will make communities more age-friendly. Development of action plans occurs over four phases: assessment, planning, implementation, and evaluation (AARP, 2020). Although the age-friendly framework provides a comprehensive overview of domains to focus on, it does not provide specific guidance on tailoring and adapting plans to the local community (Lehning & Greenfield, 2017; Plouffe et al., 2016).

To develop community-specific age-friendly plans, engagement of community members and stakeholders across sectors is needed. A recent review

of 98 age-friendly community publications concluded that taking a mix of “bottom-up” and “top-down” approaches to age-friendly community planning is more successful as this allows planners to simultaneously consider community needs and available resources (Torku, Chan, & Yung, 2020). Age-friendly community planning also needs to balance immediate needs with longer-term preventative and systemic policy changes that thoughtfully examine narratives that perpetuate ageism (Foster & Walker, 2015). Multi-stakeholder engagement requires time and resources, leading some communities to create policies and programs to support aging and older adults without feedback from the very individuals they serve (Lehning et al., 2017; Murtagh et al., 2021).

Here, we present an example of how one community broadly engaged older adults and stakeholders in co-designing its age-friendly action plan for the community. Orange County, NC's approach to engaging older adults and forging partnerships between public, private, and non-profit organizations can serve as a guide for other communities seeking to engage multi-stakeholders to develop their own age-friendly community plans.

Conceptual Model: WHO's Age-Friendly Framework

WHO's age-friendly framework can serve as a guide for assessing the current age-friendly condition of cities and communities as well as a tool to organize and document progress towards becoming an age-friendly community. The age-friendly framework is process-oriented and was developed as a tool to provide cities and communities with a list of specific areas of focus that are important for maximizing independence and active aging opportunities for all (WHO, 2007). The age-friendly framework was developed using a bottom-up approach; older adults from all continents participated in discussion groups where they described their aging experiences along with barriers and facilitators of active aging in their community. Following these discussions, the WHO identified eight age-friendly domains: outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment,

communication and information, and community and health services (Figure 1; WHO, 2007).

Orange County, NC's 2017-2022 Master Aging Plan

Orange County, NC has a 20-year history of developing 5-year Master Aging Plans (MAPs), the age-friendly community action plan for Orange County, NC. However, the 2017-2022 MAP was the first MAP developed as part of AARP's Network of Age-Friendly States and Communities and guided by the WHO age-friendly framework. As a result, the 2017-2022 Orange County MAP is steeped in the language and processes suggested by the WHO age-friendly framework. In this example, we provide details of our experience using the age-friendly framework for the *assessment* and *planning* phases. We also provide a brief overview of our experience with the *implementation* and *evaluation* phases.

Setting

In 2019, Orange County, NC had a total population of approximately 148,000, 13.4% of which are older adults (U.S. Census Bureau, 2020). By 2035, older adults are expected to make up 21% of the population (OSBM, 2021). Older adults in Orange County, NC are 84.2% White, 11.5% Black, 3.0% Asian and 2.2% Latino/a; however, residents from all age groups are more diverse (75.4% White, 11.4% Black, 7.8% Asian, and 8.4% Latino/a; U.S. Census Bureau, 2020). Thus, the older adult population is expected to become more diverse

over time. Orange County, NC has both urban and rural areas, with 68.0% of county residents residing in urban areas and 32.0% in rural parts of the county (U.S. Census Bureau, 2020).

Governance

Development of the Orange County MAP involved many players, including town government, community members, and stakeholders from across the community (Table 1). The Orange County Department on Aging is the organization charged with coordinating and facilitating the MAP process, which is inherently community driven. Funding received by the Orange County Department on Aging is unique in comparison to other communities in North Carolina. The Orange County Department on Aging is a county-level agency that receives direct appropriations from the county's budget and reports to the Orange County Board of County Commissioners, the county's elected governing body. Additional financial support for all phases of the MAP comes from a large charitable gift from a local non-profit. Advocacy for older adults across the county come, in part, from the Advisory Board on Aging, which acts as a liaison between Orange County residents, older adults, the Board of County Commissioners, and the Department on Aging. The Advisory Board on Aging advocates on behalf of older adults in the community, advising these entities on policies and practices that impact aging and older adults throughout the county. Community volunteers apply for positions on the Advisory Board on Aging and are appointed by County Commissioners.

Development of the 2017-2022 MAP used a combined "bottom-up" and "top-down" approach. This mixed approach allowed the Orange County Department on Aging to balance community priorities ("bottom-up") with organizational support and guidance for navigating systems ("top-down"). Community members were engaged throughout the MAP phases and organizational support was provided through a diverse and comprehensive network which included the (1) MAP Steering Committee, (2) MAP Leadership Committee, and (3) MAP Workgroups (Table 1). Additional details about the MAP development, including assessment tools, MAP development plans, and implementation and evaluation outcomes, are available at the Orange County Department on Aging's website (Orange County Department on Aging, 2021).

MAP Steering Committee

The MAP Steering Committee was charged with supporting the strategic vision of the MAP by providing resources and oversight of the MAP process. This committee was composed of 54 individuals, representing older adults, stakeholders, and leaders from across Orange County, NC, who represent older adult advocacy groups, county and town governments, major healthcare systems, faith-based organizations, and community-based organizations. At bi-annual meetings, organizational leaders learned about the MAP processes and results, celebrated successes toward accomplishing MAP goals, and committed, in writing, their personal and organizational resources to support the MAP.

Table 1. Roles and descriptions for organizations involved in the MAP process.

Organization	Role	Description
Orange County Board of County Commissioners	Approved the MAP	Counties in North Carolina are governed by an elected board of county commissioners. They adopt the annual county budget, regulate zoning outside of municipal boundaries, call for bond referenda, enter into contracts, etc.
Orange County Department on Aging	Charged with administrating the MAP process.	One-stop resources for older adults and caregivers. Provides leadership in planning and operating a system of integrated aging services through senior centers, serving as focal points for community, and delivering programs designed to maximize the health, well-being, community engagement, and independence of older adults at all functional levels.
Orange County Advisory Board on Aging	Provided feedback on the MAP process. Served as members of MAP Workgroups.	Charged with advising the Board of Commissioners and Department on Aging on delivery of services to Orange County's seniors. Act as a liaison between older residents and County government. Community volunteers apply and are appointed by the Board of County Commissioners.
MAP Steering Committee	Charged with providing resources, strategic vision, and oversight of the MAP process	Composed of leaders from county and town governments, major health care systems, faith-based organizations, community-based organizations, and older adult advocacy groups.
MAP Leadership Committee	Charged with guiding the MAP process (i.e., assessment, planning, implementation, and evaluation) and engaging and convening community members and stakeholders.	Leaders from Orange County Department on Aging and consultants and students from the Partnerships in Aging Program, Division of Occupational Science and Occupational Therapy, and other schools and departments at UNC-CH.
MAP Workgroups	<i>Planning phase:</i> Develop goals, objectives, strategies, and indicators within specific MAP domains. <i>Implementation & Evaluation phase:</i> Met quarterly to share information, collaborate, and report progress.	Led by members of the MAP Leadership Committee. Include members of the Advisory Board on Aging, community organizations, and community members. Organized by the age-friendly domains.

Community members	<p><i>Assessment phase:</i> Participated in a survey and focus groups.</p> <p><i>Planning phase:</i> Participated in listening sessions, workgroups, and public comments.</p> <p><i>Implementation & Evaluation phase:</i> participated in workgroups.</p>	Older adults, caregivers, and other community members interested in engaging age-friendly community work.
Community organizations	<p><i>Assessment phase:</i> Leaders of organizations participated in key informant interviews.</p> <p><i>Planning, implementation & evaluation phases:</i> Served on MAP Steering Committee and Workgroups.</p>	Organizations across the county that provide a range of services to community members of all ages.

MAP Leadership Committee

The MAP Leadership Committee, comprised of Department on Aging staff, members of the Advisory Board on Aging, and a team of interdisciplinary consultants and students from the University of North Carolina at Chapel Hill (UNC-CH), was charged with engaging and convening older adult community members and stakeholders in all phases of the MAP process (i.e., assessment, planning, implementation, and evaluation). Oversight for the MAP Leadership Committee was provided by the MAP Steering Committee; additionally, the MAP Leadership Committee regularly reported to the Orange County Board of County Commissioners and the Advisory Board on Aging. The goal of these reports was to garner feedback, support, and buy-in throughout all phases of the MAP process.

Roles of the MAP Leadership Committee varied based on the specific needs during each phase of the MAP. During the assessment and planning phases, the primary roles for the MAP Leadership Committee were to (1) engage community members and stakeholders in assessment and prioritization of community needs, (2) organize findings according to age-friendly domains, (3) facilitate a collaborative process to develop the MAP strategic plan, and (4) document the process by writing the final MAP document. During the implementation and evaluation phases, the role of the MAP Leadership Committee shifted to facilitating, guiding, and supporting the work plans detailed in the MAP.

MAP Workgroups

MAP workgroups were active during the planning, implementation, and evaluation phases and were organized based on the domains of the age-friendly framework, e.g., housing, transportation, outdoor spaces, etc. Workgroup membership included older adult community members, representatives from community organizations, social service providers, and health care organizations. The specific activities and membership of workgroups varied based on the needs during each phase of the MAP process. During the planning phase, MAP Workgroups were made up of older adult community members, organizational leaders, and government officials. Each workgroup had 20-30 members. Workgroup members were responsible, collectively, for developing MAP goals, objectives, strategies, and indicators based on the community assessment findings. During the implementation and evaluation phases, MAP Workgroup membership shifted towards a greater number of community leaders and stakeholders and included 10-40 individuals per workgroup. However, older adult community members and Advisory Board on Aging representatives continued to participate. While membership of workgroups varied somewhat between the planning and implementation phases, a core group of key participants were involved in both to ensure consistency.

Phase 1 Activities: Assessment of Community Assets and Needs

The first phase focused on assessing community assets and needs. The community assessment process was developed by the MAP Leadership Committee and Advisory Board on Aging, refined with input from the MAP Steering Committee, and co-administered by Orange County's Department on Aging and UNC-CH's Partnerships in Aging Program. The community assessment included a (1) community-wide survey, (2) focus groups with community members, (3) key informant interviews with community stakeholders, and (4) community listening sessions. The MAP process was focused on developing a MAP for Orange County, NC, and not creating generalizable knowledge; thus, this project was not submitted for Institutional Review Board approval. We are presenting our experience with community engagement to help other communities develop a tailored MAP.

Survey

The survey was developed with consultation from the Odum Institute for Research in Social Science at UNC-CH to understand older adult community members' perspectives on aging. The survey, administered through Qualtrics (Provo, UT), included 21 statements about different aspects of aging that community members might be worried about (rated on a scale of "never," "rarely," "monthly," "weekly," and "daily") and

26 statements about how Orange County is doing to address specific issues important to aging (rated on a scale of “terrible,” “fair,” “okay,” “good,” “excellent,” and “not familiar with this”). The survey also contained basic demographic questions (i.e., age range, income range, employment status, caregiver status, zip code, home ownership, home type, and urban/rural location) and space for open ended comments. The full survey is available at the Orange County Department on Aging website (2021). Surveys were distributed electronically using local listservs (e.g., Orange County Department on Aging, county government employees), advertised in public locations (e.g., notice board at libraries, senior centers, community centers), and in the local senior newspaper. Paper copies of the survey were distributed at classes and events held at area senior and community centers (e.g., early voting, congregate meals). Individuals residing in Orange County were eligible to complete the survey. Orange County residency was assessed with a one question screener, “Are you a resident of Orange County, North Carolina?” Only respondents answering “yes” could complete the survey electronically or for those completing the survey on paper, only those answering “yes” had their responses entered into the electronic database.

Focus Groups

Thirteen focus groups were conducted with older adults in public spaces in both rural and urban areas of the county. The goals of these focus groups were to (1) understand community mem-

bers’ positive and negative experiences with aging, (2) identify current gaps in aging services within the county, and (3) gather ideas about what would make Orange County the ideal location for people of all ages to live (Orange County Department on Aging, 2021). Focus groups were advertised in the county’s senior newspaper and other local media sources, through flyers posted and distributed at public spaces where focus group were held, and through the Orange County Department on Aging’s email listserv. Eleven focus groups were conducted in English, one in Mandarin, and one in Spanish (Table 2). Field notes were taken at each location by a UNC graduate student or consultant. Immediately following each focus group, the note taker and facilitator reviewed and refined field notes and these notes were used for subsequent analysis.

Key Informant Interviews

Thirty-four key informants, representing 26 organizations across the county, were conducted by the Director of the Orange County Department on Aging (Orange County Department on Aging, 2021). Between one and three individuals participated in each interview and represented organizations from a variety of sectors (Table 2). The goals of the key informant interviews were to (1) provide an overview of the work and programming of Orange County Department on Aging, (2) identify areas of concern for the aging population and generate ideas for improvements from the perspective of the key stakeholders, and (3) generate buy-in, collaboration, and an understanding about how the

work of Orange County Department on Aging intersects with that of the stakeholders. Field notes, typically compiled by a UNC-CH graduate student, cap-

tured key concepts addressed in the meeting and these notes were used for analysis.

Table 2. Assessment of community assets and needs included a survey, focus groups, and key informant interviews.

Number of Respondents	Select Characteristics of Respondents		
Survey			
<i>n</i> =860 Orange County residents	Age	Under 60	32.0% (<i>n</i> =224)
		60+	68.0% (<i>n</i> =476)
<i>n</i> ≤700 completing demographic information	Income	under \$25k	14.1% (<i>n</i> =86)
		\$25k- \$50k	22.7% (<i>n</i> =139)
		\$50k- \$75k	19.5% (<i>n</i> =119)
		\$75k- \$100k	13.9% (<i>n</i> =85)
		\$100k- \$150k	15.7% (<i>n</i> =96)
		\$150k+	14.1% (<i>n</i> =86)
		Employment status*	Full-time
	Part-time		<i>n</i> =108
	Looking for work		<i>n</i> =19
	Volunteer		<i>n</i> =71
	Retired/Not working		<i>n</i> =94
	Caregiver status	Yes	19.1% (<i>n</i> =127)
		No	80.8% (<i>n</i> =535)
	Home Ownership	Own	81.8% (<i>n</i> =567)
		Rent	13.0% (<i>n</i> =90)
		Other	5.2% (<i>n</i> =36)
	Home type	Single family	78.1% (<i>n</i> =545)
		Condominium	7.9% (<i>n</i> =55)
		Apartment	7.0% (<i>n</i> =49)
		Mobile home	1.43% (<i>n</i> =10)
		Co-housing	1.0% (<i>n</i> =7)
		Supported group home	0.7% (<i>n</i> =5)
		Other	3.9% (<i>n</i> =27)
	Location	Urban	73.1% (<i>n</i> =507)
		Rural	26.9% (<i>n</i> =187)

Focus Groups		
n=13	Language each focus group was conducted	Mandarin (n=1)
63 total participants		Spanish (n=1)
		English (n=11)
	Location for each focus group	Urban (n=8)
		Rural (n=5)

Key Informant Interviews		
n=26 interviews	Organizations represented	Town government (n=3)
1-3 individuals in each interview, for a total of 34 key informants		County government (n=3)
		Regional government (n=1)
		Public service organizations (n=7)
		Older adult advocacy group (n=2)
		Health care organizations (n=4)
		Faith organization (n=1)
		Academic organizations (n=2)

* Employment status question was select all that apply, percentages are not reported

Community Listening Sessions

Findings from the community assessment were presented in two community listening sessions for member checking and to prioritize findings based on greatest needs. Over 100 community members and stakeholders participated in two community listening sessions, one in an urban area and one in a rural area of the county. Listening sessions were held to answer the following questions about the community assessment findings: (1) Did we get it right? (2) What is missing? and (3) What do you think the biggest priority is within each domain for Orange County residents? Listening sessions provided community members with an overview of the history of previous MAPs in the county, introduced the WHO's age-friend-

ly framework, and described how the community assessment was conducted and analyzed. Community members then broke into small groups where they were presented with community assessment findings, by domain. Each small group had a facilitator and scribe who were provided a facilitation guide and a structured template for taking notes. The community assessment results were presented on a storyboard and reviewed alongside the WHO Age-Friendly Communities Checklist. Following each 5-minute presentation, group members discussed what they thought was missing from the assessment findings and which issues they believed should be a top priority to address in the 2017-2022 MAP. After each 5-minute presentation, participants

were asked to independently identify the three most important issues. Scribes summarized the main discussion points and reported these notes back to the MAP Leadership Committee.

Data Analysis

Field notes from the focus groups and key informant interviews, along with responses to the open-ended survey questions were hand sorted using Excel and Word into each of the eight domains of the age-friendly framework. Sorted data were reviewed by at least two additional members of the MAP Leadership Committee until consensus was reached. Comments within each domain were summarized to capture the breadth of ideas for community improvement and general concerns about aging. Quantitative survey data were analyzed to identify (1) aging issues respondents were most worried about personally and (2) which aging issues and services respondents thought Orange County most needed to improve in the community. Responses were also summarized by demographic (i.e., age, rurality, income) to identify differences in responses based on these criteria. Findings from the community listening session were used to amend and prioritize the community assessment findings, which would support the planning phase of the MAP process.

Phase 1 Findings: Assessment of Community Assets and Needs

Findings from the assessment of community assets and needs was based on responses from a broadly distributed survey ($n=860$), focus groups ($n=13$ focus groups, $n=63$ total participants), and key informant interviews ($n=34$ individuals representing 26 agencies, Table 2). Characteristics of respondents are shown in Table 2. Findings from the community assessment represent community needs and assets identified and prioritized by community members. We present an overview of these findings below and have organized findings by the domains of the age-friendly framework.

Outdoor Spaces and Buildings

Safety and walkability of communities were primary concerns. Respondents recommended improvements and expansion of existing sidewalk infrastructure, adjustments to pedestrian crosswalks to provide additional time to cross, and creation of pedestrian priority zones with limited or no automobile traffic in central areas of the city. Increased use of existing community resources, like senior centers, community centers, and churches, was also recommended to provide additional senior programs at more convenient locations, particularly for residents in rural communities. Recommendations for additional community resources included creating outdoor gathering spaces, community gardens, and a new community pool.

Transportation

Transportation was a major area of concern expressed by the community. The most pressing concerns from community members were centered on three key areas: (1) general infrastructure improvements, (2) transportation access for rural residents, and (3) transportation access for those with limited physical mobility. To improve the transportation infrastructure, respondents recommended an increase in frequency of routes and longer hours of operation to allow seniors to participate in evening events at senior centers. Respondents indicated the current transportation system did not provide enough direct routes connecting seniors with resources like groceries, health care, and community activities. Medical transportation was identified as an asset, but community members desired more flexibility so other needs could be met at the same time (e.g., bathroom breaks, additional stops at grocery stores). Respondents described transportation options in the rural area of Orange County as having limited access to community resources like food, health care, libraries, and community centers. Additionally, rural residents stated transportation to and from senior or community centers took too much time, thus limiting the time to participate in programming. Finally, for individuals with limited mobility, buses were a less than optimal transportation solution and door-to-door service was preferred. However, respondents stated the cost of door-to-door options was prohibitive.

Housing

Housing was another major concern across the community and was seen as particularly challenging due to the wide range of desired housing models, affordability of housing, and lack of policies requiring livable design features in new construction. Respondents stated the available housing stock in Orange County did not match with their desired housing models; for example, homes with accessory dwelling units, homes less than 1,500 square feet, and single-story homes. Some respondents stated they wanted to live in urban walkable neighborhoods. However, they noted their incomes were not always enough to make these locations affordable. Additional financial challenges identified included gentrification, rising rents, and increased property taxes. Being able to maintain their home and/or yard was the second greatest concern, with 42.6% of older adult respondents stating they worry about this at least monthly. In addition to routine up-keep of homes, accessibility, and the paucity of people and policies to perform home modifications and repairs were noted as concerns. Particularly, respondents identified eligibility barriers, wait times, and complicated navigation of service delivery processes as challenges. Respondents suggested incorporating livable design into new construction and increasing access to home modifications and repairs for existing homes, particularly rentals, to enable individuals to remain in their homes as their needs change.

Social Participation

Social isolation, loneliness, and depression were concerns for many in Orange County, and 24.8% of older adults stated they worry at least monthly about becoming socially isolated. Respondents indicated social participation was directly related to transportation difficulties, since access to adequate, frequent, and efficient transportation is necessary for many to participate in events. Respondents desired changes to community programming and supports to make them more convenient, like offering these programs at more locations across the community closer to their home (e.g., churches, gyms, or dance halls) as opposed to a central location. Participation in evening events, like cultural events in the community, was a barrier for some as evening transportation options were more limited and some did not like driving after dark. Respondents recommended providing additional educational opportunities like senior specific classes taught by retired professors and language classes. Feedback on Senior Center programming indicated respondents wanted more day trips and more night programming to accommodate the schedules of seniors who had not yet retired and could not attend programming during the day.

Respect and Social Inclusion

Respondents indicated a desire for more intergenerational programs and social opportunities. Specific ideas included intergenerational gatherings where knowledge and advice can be passed between the generations, adopt-

a-grandchild/grandparent programs, and multigenerational housing. Seniors expressed a desire to volunteer in school programs and provide information about aging, health, and life skills. Interest in sharing knowledge with young adults in the community on topics like estate planning and retirement savings was also expressed.

Civic Participation and Employment

The specific needs of older adults in the workforce were a major concern for those who want or need to work. For some respondents, employment was not optional, as they did not have enough money saved for retirement. This was reflected in survey results, with 34.6% of older adult respondents stating they worry about running out of money at least monthly. Areas of concern in the employment domain included support for finding employment, fair compensation (i.e., living wage), advocacy to address age discrimination in hiring practices, and HR policies that provide support for caregivers. Respondents wanted more resources like senior specific career counseling, paid internships, and job fairs to help seniors locate employment. Respondents also provided specific recommendations about employment supports for caregivers, including dementia friendly business training for employers, caregiving respite outside of traditional 9-5 working hours, and changes to the Family Medical Leave Act that would support caregivers who were also employed.

Communication and Information

Survey respondents indicated they did not know about many of the aging services and programs offered in the community and felt information about events was not advertised widely. To improve communication, stakeholders and community members recommended a central location to find out about community resources, services, and programming, including services offered during emergencies; improved dissemination of information to non-English speakers; increased internet access in the rural parts of the county; and in-home training and technical assistance for using computers.

Community Support and Health Services

Community support and health services was a major area of concern. This was reflected in both the survey and qualitative results. Survey respondents indicated the topics that caused the most worry fell within this domain. Out of the ten statements respondents ranked as causing the most worry, seven were from this domain. Concerns voiced in the qualitative data mirrored this and identified several key topics: (1) long-term and mental health care options, (2) care coordination, (3) respite care, and (4) community support. Access to high quality, affordable long-term and in-home care was important to respondents and perceived as lacking in the community. Respondents also wanted to see expanded and improved mental health services available across the community, particularly for indi-

viduals with dementia, as well as more dementia friendly spaces within the community. Improvements in care coordination among health care providers as well as between providers and community support services was noted as important for respondents to manage their health. Respondents recommended expansion of respite care to provide additional options outside of standard business hours, allow for more flexible scheduling, and provide more affordable options.

Respondents also wanted to see improvements to community support services to support health care access and decision-making (e.g., providing community health care advocates for single older adults living in the community, volunteers to attend medical appointments when an additional support person is required to be there during the appointment). Suggestions for improvements to community support services included identifying central points of contact community members can turn to with needs, a community helpline for general concerns, organization of neighborhood point people to organize community responses and access to resources in emergencies or disasters. Finally, respondents indicated a need for additional community support services to improve access to healthy foods in rural areas and to identify people to help with routine home maintenance (e.g., changing a light bulb, replacing batteries in smoke detectors).

Phase II: Planning

MAP Planning Workgroups were established for each of the eight age-friendly domains. Workgroups membership ranged from 20-30 individuals and included (1) “top down” experts such as stakeholders from organizations that provide relevant services and resources, (2) “bottom up” experts such as older adult community members and at least one representative from the Advisory Board on Aging, and (3) at least one facilitator from the MAP Leadership Committee. Further support was provided to each workgroup by UNC-CH public health students.

To develop the draft MAP, workgroups followed a standardized five-meeting sequence (Table 3). The initial workgroup session focused on providing information about the community assessment and understanding relevant programs and services currently available in the community. Subsequent meetings systematically built upon this information to develop solutions with defined objectives, strategies, and indicators of success as well as identifying partners who will be responsible for implementing these solutions. To share information and encourage a collaborative writing process between community members and stakeholders, planning meetings included a mix of approaches such as presentations, small group discussions and activities, and homework assignments. The final output from each workgroup was an overarching goal for each domain with a concise list of

objectives for making Orange County more age-friendly, strategies for achieving the objectives, indicators of success, and names of organizations that were primarily responsible for implementation. These objectives, strategies, indicators, and designation of responsible organizations made up the MAP draft document (Figure 2).

Once the draft MAP document was complete, it was presented to community members, stakeholders, the MAP Steering Committee, and the Advisory Board on Aging for feedback. Community members were invited to provide input through seven public forums held across the county as well as a four-week open comment period during which the draft document was posted online for review and feedback. Comments and suggestions received from community members and stakeholders were incorporated to create the final 2017-2022 MAP document. The final 2017-2022 MAP document was compiled and edited by leaders from the Department on Aging with support from a multi-disciplinary team of UNC-CH students. This document was presented to the Orange County Board of County Commissioners, who unanimously accepted the 2017-2022 Orange County MAP (Blomberg et al., 2017).

Phase III: Implementation

Key structures supporting implementation of the MAP included the creation of MAP Implementation Workgroups, developing stan-

Table 3. Overview of the MAP workgroup process for development of the 2017-2022 MAP

Meeting number	Goal of meeting	Meeting activities	Meeting outcomes
Meeting 1. Where We've Been and Where We're Going	Listening and brainstorming	<ul style="list-style-type: none"> • Orientation to MAP workgroup process • Review MAP Assessment findings 	<ul style="list-style-type: none"> • Initial list of available programs and services in Orange County • Recommendations for expanding, improving, or protecting programs and services
Meeting 2. Barriers and Facilitators to Success	Lay the groundwork for informed solution recommendations	<ul style="list-style-type: none"> • Review recommendations from prior meeting • Identify possible barriers to expansion, improvement, protection, and implementation of recommendations 	<ul style="list-style-type: none"> • Robust list of programs and services available in Orange County • Suggestions for possible solutions to identified barriers (Problems/Solutions table)
Meeting 3. Focusing on Solutions	Capture all proposed solutions and add any missing information	<ul style="list-style-type: none"> • Review and update draft of Problems/Solutions table (compiled by UNC-CH student) 	<ul style="list-style-type: none"> • Finalize Problems/Solutions table
Meeting 4. Drilling Down to Objectives	Edit and evaluate draft Objectives & Strategies with a fine-tooth comb	<ul style="list-style-type: none"> • Draft list of Objectives & Strategies (compiled by UNC-CH student) • Following the meeting, workgroup members individually prioritized each objective and associated strategies 	<ul style="list-style-type: none"> • Final list of Objectives & Strategies that were feasible in the short to medium term, and phrased appropriately
Meeting 5. Finalizing Objectives and Strategies	Finalize Objectives & Strategies	<ul style="list-style-type: none"> • Review results of Prioritization Survey • Revision of Objectives & Strategies 	<ul style="list-style-type: none"> • Final draft of Objectives & Strategies to send to MAP Leadership Committee

dard processes for workgroups to follow, and appointing workgroup leaders for each domain. Workgroup leaders were responsible for *facilitating collaboration* and *sustaining momentum* to ensure MAP goals and objectives were met. To do this, workgroup lead-

ers held quarterly workgroup meetings that served to track progress towards MAP goals, provided opportunities for collaborative planning to reach MAP goals, and allowed workgroup members to support and provide technical assistance to one another. In addition to

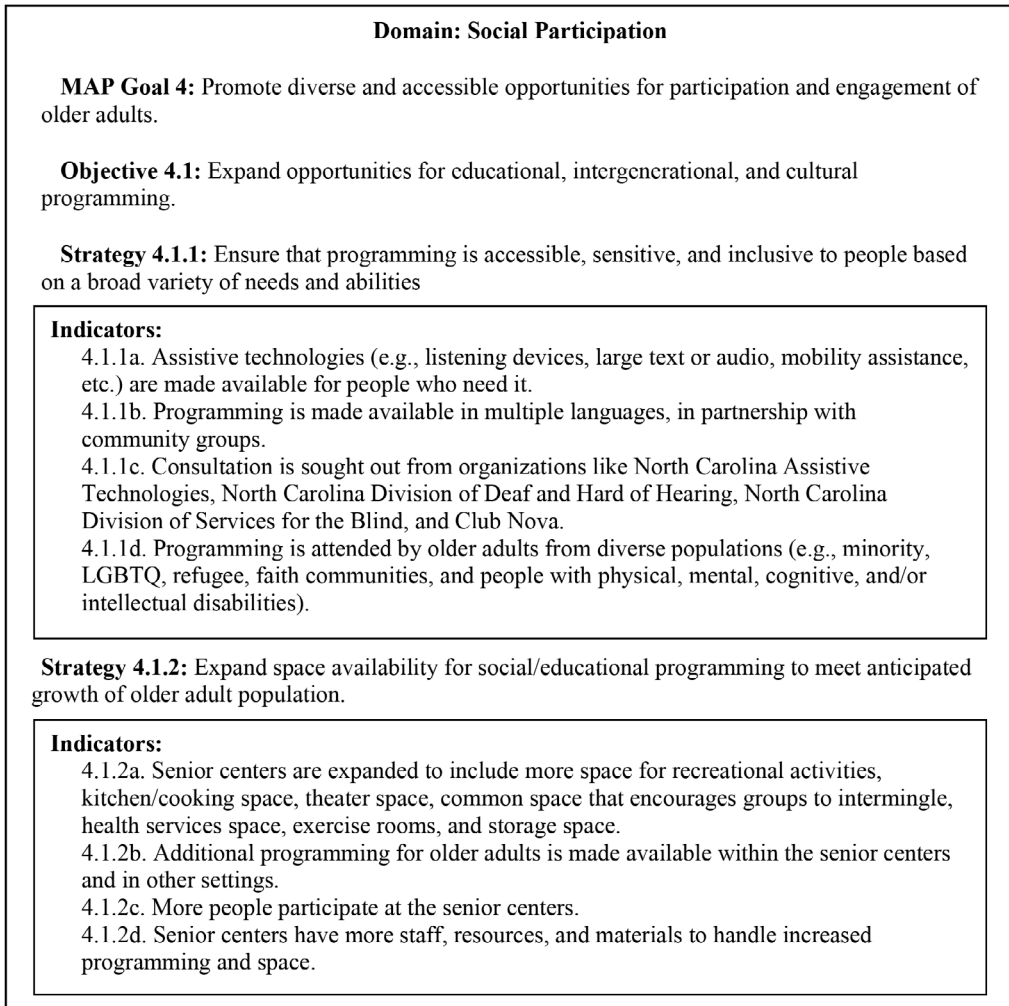


Figure 2. An excerpt of the final MAP showing the organization of this document, including overall goal of the domain, objectives, strategies, and indicators.

facilitating quarterly workgroup meetings, MAP workgroup leaders met as a team to support each other and plan for providing regular updates on the MAP process with stakeholders (e.g., MAP Steering Committee, Orange County Board of County Commissioners, and Advisory Board on Aging).

Seven workgroups, developed based on the age-friendly domains, were formed to guide and track implementation of the 2017-2022 MAP. The

domains of “social participation” and “respect and social inclusion” were combined because of overlap in stakeholders, the “housing” domain was divided into two sub-workgroups (one focused on home repair and modifications, and one focused on affordable housing priorities), and the domain “communication and information” was considered a cross-cutting theme and became the responsibility of all workgroups to explicitly address; the Communications

Manager at the Department on Aging served as the point person for this information. Workgroups were led by staff from the Department on Aging and consultants from UNC-CH's Partnerships in Aging Program.

Facilitating Collaboration

Workgroups met at least quarterly for ninety minutes. The goals of these meetings were to engage in projects and activities to reach MAP objectives, identify progress made on MAP goals, and to share information that facilitated collaboration across community organizations. In these meetings, workgroup members discussed MAP-related work conducted by their agency in the previous quarter, created collaborative plans to meet MAP objectives, learned something new relative to their age-friendly domain, and provided support to other community organizations. Community members helped ground discussions in everyday experiences, offered feedback on ideas, and identified issues important for further advocacy work. As a result, new partnerships and initiatives were forged between organizations that came together because of the MAP.

One Example of New Cross-Agency Partnerships Resulting from the MAP

Cross-agency partnerships forged during implementation of the 2017-2022 MAP had a major effect on the community. One example of partnership formation occurred through the launch of Orange County's Home Preservation Coalition, composed of a group of

stakeholders from the MAP home repair and modification sub-workgroup. This strategic MAP priority resulted directly from the community assessment findings of older adult concerns around home maintenance and difficulty finding and navigating help available in the community. Community member experience, highlighted by community outreach organizations, drove local agencies' identification of this strategic need and solution.

As part of the process, each partner organization described their scope of work, including services provided, policies, and population served, and eligibility criteria to facilitate identification of gaps and overlaps in service provision. As a result, members could (1) identify types of home repair cases best suited for their organization and (2) become more aware of services offered by others in the group. Organizations recognized that continued communication, collaboration, and data collection around homeowner needs and projects across the county would be beneficial. The group decided to shift to an ongoing coalition model and formed the Orange County Home Preservation Coalition led by the MAP Housing sub-workgroup leader, a community occupational therapist with the Orange County Department on Aging and UNC-CH's Division of Occupational Science and Occupational Therapy (Lavalley, 2020). Key goals of the coalition were to decrease redundancy and increase efficiency in the provision of home repair and modification services to older adult residents. While the Coalition was not built exclusively

to serve older adults, more than 80% of those served were over 60.

In addition to formally sharing information about home modification and repair projects and cases, the coalition sought funds to support their work through development of a database to track home preservation efforts in the county. The coalition received a capacity building grant from the Southeastern Energy Efficiency Alliance, enabling development of a database and other collaborative tools that facilitated referrals across organizations and connected clients to organizations that were most suited to meet their needs. In addition, these tools allowed the coalition to create the first and only aggregated data set related to home repair and modification services and homeowner outcomes across Orange County. This data is regularly used to inform policy development, support program development, and enable grant opportunities that facilitate access and affordability of home improvements for low-income residents of Orange County, with particular attention to older adults. Throughout, the coalition's structure and process facilitated inter-organizational partnerships that provided cost-effective, strategic, and comprehensive home improvement while supporting satisfactory wait times, safety, and home repair education for homeowners (Cooper, 2021).

Sustaining momentum

The MAP Leadership Committee met quarterly to discuss challenges and successes in each workgroup and support one another to overcome challenges.

Topics for support included providing ideas about how to facilitate large meetings, strategies for tracking the work of multiple partners, and ideas for connecting with additional partners, to name a few. The MAP Leadership Committee was also responsible for making formal presentations at the bi-annual MAP Steering Committee Meetings, Orange County Board of County Commissioners meetings, and monthly Advisory Board on Aging meetings.

Phase IV: Evaluation

To evaluate implementation of the MAP, Workgroup Leaders completed quarterly matrices, which used narrative summaries to describe progress made on each indicator. A UNC consultant was responsible for constructing the evaluation framework, inputting quarterly data, and writing the evaluation report. In addition to quarterly matrices, a 5-year planning tool was used to track progress on each indicator across each year. This tool was used to provide a snapshot illuminating indicators that had been addressed and those that still required work. Each matrix was publicly available on the Orange County Department on Aging website, and comments and participation from older adults in the community were encouraged through workgroup meetings and within individual programs (Orange County Department on Aging, 2021).

Discussion

This article provides details of how one community engaged older adult community members and stakeholders to develop a comprehensive MAP, guided by the age-friendly framework. Perspectives of older adults were particularly powerful and ensured MAP plans and activities authentically represented their ideas and needs throughout all MAP phases (i.e., assessment, planning, implementation, and evaluation). Public, private, and non-profit community organizations also supported MAP phases, and these community partnerships helped achieve MAP goals and streamlined workflow across organizations. Engagement of diverse community members and multisector stakeholders throughout all phases of age-friendly community planning is a challenge (WHO, 2018). Orange County's experience developing the 2017-2022 MAP can serve as an example for other communities seeking to engage older adults in development of their own comprehensive MAP.

In a review of the literature on age-friendly initiatives, there is consensus that age-friendly community planning should include bottom-up approaches, where the experiences of older adults are included and valued in the planning process (Lui et al., 2009). Further, engagement of older adult community members is a key driver for the development and implementation of age-friendly practices within communities (Greenfield & Reyes, 2020). Older adults enhance age-friendly community planning processes as they

bring a valuable familiarity of the community to the MAP process (Buffel, 2019). Additionally, older adults can directly benefit from engagement with the MAP, as participation may provide them with a productive outlet as they engage in efforts to make their community more age friendly (Buffel, 2019). In the case of Orange County, NC, it was important to the MAP Leadership Committee that older adults were involved at all stages, not only identifying community needs, but also developing and implementing solutions. Engagement of older adults provided important momentum for developing and setting the 2017-2022 MAP goals, and lead to continued involvement from these individuals during subsequent phases to develop and implement solutions to meet MAP goals.

The MAP Leadership Committee was also intentional in their efforts to gain input from older adults who come from diverse racial and socio-economic backgrounds. Involving diverse community members, including individuals who have historically been marginalized within the community based on race, ethnicity, age, or ability, is important to understand the full scope of community needs and assets (Greenfield et al., 2022). We sought to reach diverse community members through multimodal assessment (survey, focus groups, interviews, and listening sessions) conducted in multiple languages and locations across the county, and engaging community members of all ages. While this level of intentionality is more resource-intensive, broad community engagement centers the perspectives of

older adults, brings greater awareness to the importance of age-friendly communities, and strengthens support for policies to overcome societal and structural biases against older adults (Lehning et al., 2007).

Prior research has shown the importance of buy-in from government and community organizations to support the development and sustainability of age-friendly initiatives within communities (Neville et al., 2016; Steels, 2015). Buy-in from government agencies can help set community-wide priorities that will encourage organizations across the community to engage in age-friendly initiatives (Greenfield et al., 2015; Spina & Menec, 2015; Steels 2015). As part of Orange County's MAP assessment phase, members of the Orange County Board of County Commissioners and local town governments participated in key stakeholder interviews. These interviews afforded opportunities to inform these individuals about and promote the importance of age-friendly communities and gain support from these government agencies and elected officials. Successful development of age-friendly communities relies on leadership and coordination from local governmental authorities (Lui et al., 2009). The acceptance of the final 2017-2022 MAP document by the Orange County Board of County Commissioners contributed to their future consideration of the MAP and age-friendly initiatives when enacting policies.

The engagement of community organizations in the development of

the MAP goals and objectives provided a foundation in which stakeholders could identify a role for their organization during the implementation phase. Coordinating services across community organizations is a barrier to creating age-friendly communities (Jeste et al., 2016). Strong local leadership and identifying champions within organizations that support age-friendly practices are important to gain support for collaboration between community organizations (Menac et al., 2015). In Orange County, NC, involvement of key stakeholders throughout the process was essential and was achieved by asking representatives from organizations, the Advisory Board on Aging, and older adult community members to serve on the MAP Steering Committee and on MAP Planning and Implementation Workgroups. This broad engagement across community organizations led to increased awareness about the work of each agency and resulted in the formation of new partnerships among organizations. Having older adult experiences drive the workgroups brought energy to the meetings and helped organizations understand what it was like to age in the community. While we provided the specific example of the development of the Orange County Home Preservation Coalition, workgroups members forged many other partnerships because of their participation in the MAP process.

Limitations and Strengths

One limitation of this case example is that the replicability of this approach in other communities could be limited. While this was the first Orange County

MAP developed using the age-friendly framework, this was not the first MAP developed in Orange County, NC. The experience of developing three prior MAPs likely made the process of using the age-friendly framework in Orange County easier than it might be for communities that have never created MAPs or other age-friendly community plans. However, communities looking to create their first MAPs or improve current MAPs can use this case as an example of potential methods for how to include a broad array of perspectives in the creation of MAPs to guide local policy and innovation.

Another reason that this approach may not apply to other communities is that Orange County Department on Aging is nested in a community with strong university support (e.g., personnel, interns, expertise) and community resources (e.g., volunteers, financial support). These resources greatly supported the MAP process and may not be available to other communities. However, these are resources communities may not have considered, and leveraging the expertise available (e.g., community organizations, professional societies, colleges, and universities) can facilitate higher levels of community engagement. Additionally, if communities are unable to conduct all parts of this process due to resources, it will still be beneficial to use some of these techniques to ensure that the perspectives of older adults are a central part of the process of prioritizing services and policy during community planning activities.

Another limitation of this MAP process is that in the community assessment phase we did not track engagement by race, ethnicity, or sexual orientation. Different populations within communities have different needs, making it essential that the voices of all members are included. We have begun planning for the 2022-2027 MAP and are collecting this demographic information to guide us during the assessment phase. We strongly recommend that other communities collect such demographic information in their assessment and look at findings based on this data to identify needs requiring directed or tailored program planning.

A strength of Orange County, NC's age-friendly initiative was the comprehensive assessment of community assets and needs of local older adults. Further, findings were presented back to the community for member checking, to find out if anything was missing, to see if the findings matched older adult community members' experiences, and to identify the highest priorities for the 2017-2022 MAP. A strong partnership between the Orange County Department on Aging and a variety of schools and programs at UNC-CH strengthened support for the development and implementation of the MAP. Additionally, long term relationships between Orange County Department on Aging and community organizations provided early buy-in from stakeholders, since many had the experience of working with Orange County Department on Aging in prior MAPs.

Another strength of the 2017-2022 MAP iteration was the seamless continuation of MAP planning workgroups into the implementation phase. Workgroup members were able to create the goals, strategies, objectives, and indicators making up the plan, and were then responsible for identifying missing partners and working collaboratively to ensure MAP goals were met. Adherence to the Plan was ensured through quarterly meetings where progress was tracked for each indicator using the workgroup matrix document. Community/Strategic plans should not just sit on a shelf. They should include mechanisms for action and accountability.

Policy Implications and Recommendations

Building an age-friendly community increases livability for all, not just older adults (Menec et al., 2011; Neiboer & Cramm, 2018). Given this broad applicability, combined with growth in older adult populations, state and federal governments would benefit from considering incentive mechanisms for community planning using an age-friendly framework. Incentive mechanisms could include financial support, a formal initiative such as becoming an affiliate of the AARP age-friendly network, and adapting the design and permitting codes to be more age-friendly. One potential source for incentives is federal funding provided to Area Agencies on Aging. At the local level, Area Agencies on Aging are already leveraging federal funds to promote age-friendly com-

munity efforts ([National Association of Area Agencies on Aging, 2017](#)). However, incentive mechanisms should maintain flexibility so local communities can tailor age-friendly plans to the needs and assets of their community. Importantly, planning should employ an equity approach that ensures reach into communities with fewer resources and/or greater needs so all can benefit from age-friendly communities.

Inherent in planning for age-friendly communities is involvement from older adults and leaders from local organizations and government agencies in the community. Combining the perspectives of older adults, who are experts in living in the community, with those from leaders, who are experts in the local systems, makes age-friendly planning more comprehensive and robust (Menec & Brown, 2018; Torku et al., 2021). While this approach takes more time and effort, this intentionality is necessary for meaningful policy change. In addition, investing in seeing older adults as community resources builds community capacity to improve this work over time.

The age-friendly framework is particularly helpful in encouraging planners to look beyond the “usual suspects” of aging organizations in a community (Coyle et al., 2021). When working with organizations built around housing, transportation, and food, for example, aging leaders can promote the concept that improving the experience of aging improves the experience of living. Pulling together partners from the same area and engaging them in

strategic planning and implementation provides an opportunity for collaboration and partnership among organizations that might otherwise never cross paths. Infrastructure for collaboration and partnership among people and organizations on a micro-level should be encouraged and supported through policies and funding. The Orange County Home Preservation Coalition is just one example of how older adult perspectives were used to identify an important area for improvement in a community and, along the way, brought in external funding that increased community capacity.

Conclusion

Age-friendly communities can enhance well-being for people of all ages (Neiboer & Cramm, 2018). This case example describes Orange County's experience using WHO's age-friendly framework to develop their 5-year Master Aging Plan and provides an example of processes that can be used or adapted to other communities. Engaging older adults, community leaders, and policy makers in every phase of the process is essential to creating communities where people of all ages are supported and celebrated.

References

- AARP. (2020). *AARP network of age-friendly states and communities*. [Date retrieved July 28, 2021]. <https://www.aarp.org/livable-communities/network-age-friendly-communities/>
- Ball, M. S. & Lawler, K. (2014). Changing practice and policy to move to scale: A framework for age-friendly communities across the United States. *Journal of Aging & Social Policy*, 26(1-2), 19–32. <https://doi.org/10.1080/08959420.2014.856706>
- Blomberg, C., Chien, S., Ingawa, S., Nichols, M., Sharer, B., Hunter, M., Tyler, J. & Fraser, M. (2017). *Orange County Master Aging Plan*. Orange County Department on Aging. <https://partnershipsinaaging.unc.edu/wp-content/uploads/sites/11698/2020/10/Master-Aging-Plan.pdf>
- Buffel, T. (2019). Older coresearchers exploring age-friendly communities: An “insider” perspective on the benefits and challenges of peer-research. *The Gerontologist*, 59, 538-548.
- Cooper, M., Lavalley, R. & Rosemond, C. (2021). *Partners in home preservation program report*. Orange County Department on Aging & Partnerships in Aging Program UNC-CH. <https://orangecountync.gov/DocumentCenter/View/14540/Partners-in-Home-Preservation-Program-Report-January-2021>

- Coyle, C. E., Gleason, S. R., & Mutchler, J. E. (2022). Spillover benefits and achieving sustainability of age-friendly communities. *The Gerontologist*, 62, 29-35. <https://doi.org/10.1093/geront/gnab060>
- Foster, L., & Walker, A. (2015). Active and successful aging: A European policy perspective. *The Gerontologist*, 55, 83-90. <https://doi.org/10.1093/geront/gnu028>
- Greenfield, E. A., Oberlink, M., Scharlach, A. E., Neal, M. B., & Stafford, P. B. (2015). Age-friendly community initiatives: Conceptual issues and key questions. *The Gerontologist*, 55, 191-198. <https://doi.org/10.1093/geront/gnv005>
- Greenfield, E. A., & Reyes, L. (2020). Characterising older adults' engagement in age-friendly community initiatives: Perspectives from core group leaders in the Northeast United States of America. *Ageing & Society, First View*, 1-20. <https://doi.org/10.1017/S0144686X2000166X>
- Greenfield, E. A., Black, K., Oh, P., & Pestine-Stevens, A. (2022). Theories of community collaboration to advance age-friendly community change. *The Gerontologist*, 62, 36-45. <https://doi.org/10.1093/geront/gnab136>
- Jeste, D. V., Blazer II, D. G., Buckwalter, K. C., Cassidy, K. L. K., Fishman, L., Gwyther, L. P., Levin, S. M., Phillipson, C., Rao, R. R., Schmeding, E., Vega, W. A., Avanzino, J. A., Glorioso, D. K. & Feather, J. (2016). Age-friendly communities initiative: Public health approach to promoting successful aging. *The American Journal of Geriatric Psychiatry*, 24, 1158-1170. <https://doi.org/10.1016/j.jagp.2016.07.021>
- Lavalley, R. (2020). New Frontiers: Occupational Therapy's Role in Coordinated Community Coalitioning. *OT Practice*, 25(12), 18–21.
- Lehning, A., Chun, Y., & Scharlach, A. (2007). Structural barriers to developing 'aging-friendly' communities. *Public Policy and Aging Report*, 17(3), 15-20. <https://doi.org/10.1093/ppar/17.3.15>
- Lehning, A. J., & Greenfield, E. A. (2017). Research on age-friendly community initiatives: Taking stock and moving forward. *Journal of Housing for the Elderly*, 31(2), 178-192. <https://doi.org/10.1080/02763893.2017.1309937>
- Lehning, A. J., Smith, R. J. & Kim, K. (2017). "Friendly" initiatives: An emerging approach to improve communities for vulnerable populations. *Journal of Policy Practice*, 16(1), 46-58. <https://doi.org/10.1080/15588742.2015.1125331>
- Lui, C. W., Everingham, J. A., Warburton, J., Cuthill, M., & Bartlett, H. (2009). What makes a community age-friendly: A review of international literature. *Aus-*

tralasian Journal on Ageing, 28(3), 116-121. <https://doi.org/10.1111/j.1741-6612.2009.00355.x>

Menec, V., Bell, S., Novek, S., Minnigaleeva, G. A., Morales, E., Ouma, T., Parodi, J. F. & Winterton, R. (2015). Making rural and remote communities more age-friendly: Experts' perspectives on issues, challenges, and priorities. *Journal of Aging & Social Policy*, 27(2), 173-191. <https://doi.org/10.1080/08959420.2014.995044>

Menec, V., & Brown, C. (2018). Facilitators and barriers to becoming age-friendly: A review. *Journal of Aging & Social Policy*, 1-23. <https://doi.org/10.1080/08959420.2018.1528116>

Menec, V. H., Means, R., Keating, N., Parkhurst, G., & Eales, J. (2011). Conceptualizing age-friendly communities. *Canadian Journal on Aging/La revue canadienne du vieillissement*, 30(3), 479-493. <https://doi.org/10.1017/S0714980811000237>

Murtagh, B., Cleland, C., Ferguson, S., Ellis, G., Hunter, R., Rodriguez Añez, C. R., ... & Reis, R. S. (2022). Age-friendly cities, knowledge and urban restructuring. *International Planning Studies*, 27(1), 62-76. <https://doi.org/10.1080/013563475.2021.1920374>

National Association of Area Agencies on Aging. (2017). *Area Agencies on Aging: Local leaders in aging and community living*. <https://www.usaging.org/Files/LocalLeadersAAA2017.pdf>

Neville, S., Napier, S., Adams, J., Wham, C., & Jackson, D. (2016). An integrative review of the factors related to building age-friendly rural communities. *Journal of Clinical Nursing*, 25, 2402-2412. <https://doi.org/10.1111/jocn.13299>

Nieboer, A. P., & Cramm, J. M. (2018). Age-friendly communities matter for older people's well-being. *Journal of Happiness Studies*, 19, 2405-2420. <https://doi.org/10.1007/s10902-017-9923-5>

Office of State Budget and Management [OSBM]. (2021). County/State population projections. <https://www.osbm.nc.gov/facts-figures/population-demo-graphics/state-demographer/countystate-population-projections>

Orange County Department on Aging. (2021, August 25). *Master Aging Plan*. <https://www.orangecountync.gov/203/Master-Aging-Plan>

Plouffe, L., Kalache, A., & Voelcker, I. (2016). A critical review of the WHO age-friendly cities methodology and its implementation. In: T. Moulaert & S. Garon (Eds), *Age-friendly cities and communities in international comparison* (19-36). Springer. http://dx.doi.org/10.1007/978-3-319-24031-2_2

- Spina, J., & Menec, V. H. (2015). What community characteristics help or hinder rural communities in becoming age-friendly? Perspectives from a Canadian prairie province. *Journal of Applied Gerontology*, 34, 444-464. <https://doi.org/10.1177%2F0733464813496164>
- Steels, S. (2015). Key characteristics of age-friendly cities and communities: A review. *Cities*, 47, 45-52. <https://doi.org/10.1016/j.cities.2015.02.004>
- Torku, A., Chan, A.P.C. & Yung, E.H.K. (2021). Implementation of age-friendly initiatives in smart cities: Probing the barriers through a systematic review. *Built Environment Project and Asset Management*, 11, 412-426. <https://doi.org/10.1108/BEPAM-01-2020-0008>
- U.S. Census Bureau. (2019). *The older population in the United States: 2019*. <https://www.census.gov/data/tables/2019/demo/age-and-sex/2019-older-population.html>
- U.S. Census Bureau. (2020). 2019: ACS 5-year estimates subject tables: Orange County, NC. <https://data.census.gov/cedsci/table?q=orange%20county%20nc&tid=ACSST5Y2019.S0103>
- Van Hoof, J., Kazak, J. K., Perek-Białas, J. M., & Peek, S. (2018). The challenges of urban ageing: Making cities age-friendly in Europe. *International Journal of Environmental Research and Public Health*, 15(11), 2473. <https://doi.org/10.3390/ijerph15112473>
- Vespa, J. (2018). *The U.S. joins other countries with large aging populations*. U.S. Census Bureau. <https://www.census.gov/library/stories/2018/03/graying-america.html>
- World Health Organization. (2007). *Global age-friendly cities: A guide*. https://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf
- World Health Organization. (2018). *The global network for age-friendly cities and communities: Looking back over the last decade, looking forward to the next* (No. WHO/FWC/ALC/18.4). <https://apps.who.int/iris/bitstream/handle/10665/278979/WHO-FWC-ALC-18.4-eng.pdf>

Regional Planning for Aging in Place: Older Adults' Perceptions of Needs and Awareness of Aging Services in Washington State

Cory Bolkan, PhD

Washington State University, Vancouver, WA

bolkan@wsu.edu

Raven H. Weaver, PhD

Washington State University, Pullman, WA

raven.weaver@wsu.edu

Eunsaem Kim, PhD

Ajou University School of Medicine, Suwon, South Korea

ekim2@aumc.ac.kr

Bidisha Mandal, PhD

Washington State University, Pullman, WA

bmandal@wsu.edu

Corresponding author contact information:

Cory Bolkan, PhD, Department of Human Development

bolkan@wsu.edu

360-546-9336

Acknowledgements:

This project was funded by the College of Agricultural, Human, & Natural Resources (CAHNRS) Research Initiative in the Human Sciences at Washington State University (#125953-001). We also wish to acknowledge our collaboration and partnership with the Area Agency on Aging & Disabilities of Southwest Washington.

ABSTRACT

Aging in place (AIP), or being able to maintain independence in one's home and community, will be a big challenge for older adults in coming decades. As interest in AIP, age-friendly policies, and livable community initiatives grows, successful policy planning should be based on the perspectives of older adults, especially those from marginalized communities with limited resources. We surveyed 252 community-dwelling older adults ($M = 73.61$; $SD = 8.44$) via computer-assisted-telephone interviews about their health, support needs, access to services/supports, and awareness of the local aging services organization. Nearly one-third of participants (31%) reported having unmet support needs for their activities of daily living. The most prevalent unmet needs were related to home maintenance tasks (i.e., home repairs, yard work, housekeeping, and other services). Regression analyses revealed that poor health (physical and mental) increased risk for unmet needs, but adequate knowledge of aging services lowered the risk (all $p < 0.05$). Most participants were not familiar with the local aging services organization and nearly one-quarter did not know where to get the help they needed. Content analysis revealed four pathways of anticipated help: (1) reliance on friends/family, (2) general expectations that government, social services, or community support will be available, (3) pursuit of non-specific searches for support, and (4) referrals from medical professionals. Raising awareness about affordable community-based aging services, bolstering cross-sector engagement, and proactively investing in age-friendly community initiatives are necessary actions toward effectively planning for future support needs and addressing the comprehensive AIP needs of diverse older adults.

Keywords: community gerontology, age-friendly, home and community-based services, Area Agency on Aging

Planificación Regional para el Envejecimiento en el Lugar: Percepciones de los adultos mayores sobre las necesidades y la conciencia de los servicios para el envejecimiento en el estado de Washington

RESUMEN

Envejecer en el lugar (AIP), o poder mantener la independencia en el hogar y la comunidad, será un gran desafío para los adultos ma-

yores en las próximas décadas. A medida que crece el interés en AIP, las políticas amigables con las personas mayores y las iniciativas comunitarias habitables, la planificación de políticas exitosas debe basarse en las perspectivas de los adultos mayores, especialmente aquellos de comunidades marginadas con recursos limitados. Encuestamos a 252 adultos mayores que viven en la comunidad ($M = 73,61$; $SD = 8,44$) a través de entrevistas telefónicas asistidas por computadora sobre su salud, necesidades de apoyo, acceso a servicios/apoyos y conocimiento de la organización local de servicios para el envejecimiento. Casi un tercio de los participantes (31 %) informaron tener necesidades de apoyo insatisfechas para sus actividades de la vida diaria. Las necesidades insatisfechas más prevalentes estaban relacionadas con las tareas de mantenimiento del hogar (es decir, reparaciones del hogar, trabajo en el jardín, limpieza y otros servicios). Los análisis de regresión revelaron que la mala salud (física y mental) aumentaba el riesgo de necesidades insatisfechas, pero el conocimiento adecuado de los servicios para personas mayores reducía el riesgo (todos $p < 0,05$). La mayoría de los participantes no estaban familiarizados con la organización local de servicios para personas mayores y casi una cuarta parte no sabía dónde obtener la ayuda que necesitaban. El análisis de contenido reveló cuatro vías de ayuda anticipada: (1) confianza en amigos/familiares, (2) expectativas generales de que el gobierno, los servicios sociales o el apoyo comunitario estarán disponibles, (3) la búsqueda de apoyo no específico y (4) referencias de profesionales médicos. Crear conciencia sobre los servicios asequibles para personas mayores basados en la comunidad, reforzar la participación intersectorial e invertir de manera proactiva en iniciativas comunitarias amigables con las personas mayores son acciones necesarias para planificar de manera efectiva las futuras necesidades de apoyo y abordar las necesidades integrales de AIP de diversos adultos mayores.

Palabras clave: gerontología comunitaria, servicios adaptados a las personas mayores, en el hogar y en la comunidad, Agencia del Área sobre el Envejecimiento

关于就地养老的区域规划：华盛顿州老年人的需求感知和对养老服务的认识

摘要

就地养老（AIP）、或能够在家庭和社区中保持独立，这将

是未来几十年老年人面临的一大挑战。鉴于越来越多的兴趣聚焦于AIP、老年友好型政策和宜居社区倡议，成功的政策规划应基于老年人的视角，尤其是来自资源有限的边缘化社区的老年人。我们通过计算机辅助电话采访，对 252 名居住在社区的老年人（ $M = 73.61$ ； $SD = 8.44$ ）进行调研，了解了他们的健康状况、支持需求、服务/支持的获取机会以及对当地养老服务组织的认识。近三分之一的参与者（31%）报告称，他们日常生活的支持需求未得到满足。未满足的最普遍需求有关于家庭维护任务（即家庭维修、庭院工作、家政服务和其他服务）。回归分析显示，健康状况不佳（身体和精神）会增加未满足需求的风险，但对养老服务的充分了解会降低该风险（所有 $p < 0.05$ ）。大多数参与者不熟悉当地的养老服务组织，近四分之一的人不知道从哪里获得他们需要的帮助。内容分析揭示了预期帮助的四种途径：（1）依赖朋友/家人，（2）对“可供使用的政府服务、社会服务或社区支持”的普遍期望，（3）寻求非特定支持，（4）医疗专业人员的转介。提高对可负担的、基于社区的养老服务的认识，加强跨部门参与，并积极投资老年友好型社区倡议，是有效规划未来支持需求和解决不同老年人的综合AIP需求的必要行动。

关键词：社区老年学，老年友好，基于家庭和社区的服务，地区老龄化机构

Aging in place (AIP), or being able to maintain independence in one's home and community, will be a big challenge for older adults in coming decades (Binette, 2021). People are living longer with chronic conditions; approximately 60% of older adults experience at least one chronic condition and 40% have at least two (Administration on Aging, 2021; U.S. Centers for Disease Control & Prevention, n.d.). Living with chronic conditions will likely require daily self-management routines and may result in potentially complex health care inter-

actions and increased need for support. At the same time, most people express a preference for AIP (Binette, 2021; Binette & Vasold, 2018), which will necessitate a wide range of services/supports available in communities. Addressing the needs of an increasingly diverse older population (e.g., by race/ethnicity, urban/rural-dwelling, socioeconomic status) will require unique AIP solutions. Rather than relying primarily on policymakers or clinicians' views, AIP initiatives should incorporate older adults' perspectives, experiences, and input, especially individuals from his-

torically marginalized or underserved communities with limited resources (Finlay & Finn, 2020; Greenfield, 2015; Phillipson & Buffel, 2020) and individuals who may not have adequate and/or available family support (Greenfield & Reyes, 2015).

Age-Friendly Policies and Aging in Place

The global age-friendly movement (World Health Organization, 2007), livable community initiatives (AARP, n.d.), and the concept of aging in place (U.S. Centers for Disease Control and Prevention, 2009) all reflect the ever-growing importance of policies to promote the abilities of adults to remain living in their homes and communities as they age. Environmental gerontologists have long argued that the residential and community environments in which older adults live can support or hinder one's ability to age optimally (Greenfield, 2012; Kan et al., 2020). Policymakers and service providers have also become increasingly aware of the importance of providing age-friendly services to older people (e.g., considerations for housing, transportation, open spaces, access to services, social inclusion), which has fostered greater discussion about innovating age-friendly/AIP strategies and practices. Overall, the development and implementation of age-friendly policy strategies, such as engaging stakeholders from across sectors and taking a community-planning approach (Greenfield et al., 2015; Scharlach & Lehning, 2016), represents an important new component of public policy and ultimately supports AIP be-

cause it leads to enhancing physical, social, and service environments through local community engagement (Phillipson & Buffel, 2020).

Initial efforts to conceptualize and define AIP primarily focused on the physical health needs of older adults, within the context of their changing environments. For example, Lawton and Nahemow's (1973) foundational work described how individuals balance demands—or environmental press—in their lives (e.g., steep stairs up to a residence) with their available level of personal competence and resources (e.g., decreased stamina or mobility). This person-environment model is useful for understanding AIP interventions because it proposes a scaffolding process, where modification of one's environment can increase personal adaptation. In ideal settings, features of one's environment should operate to accommodate changes in one's functioning, especially as personal resources and abilities may change with age. An important pathway to enhancing personal adaptation for AIP is through the service environment and provision of adequate home and community-based long-term services and supports (LTSS).

Home and Community-based Long-Term Services & Supports

Access to home and community-based LTSS is an important domain of age-friendly and livable cities that facilitates older adults' abilities for AIP. Older adults easily identify barriers to AIP and may not have the resources to access the services and supports they need (Brim et al., 2021). More specif-

ically, Medicaid is the primary payer for a range of LTSS because Medicare only provides limited LTSS, and these services and supports are often unaffordable through private insurance markets (Reaves & Musumeci, 2015). If older adults proactively seek help for ongoing care needs, they may not qualify for Medicaid-funded LTSS if they are not yet considered functionally or financially in need. Furthermore, there are significant variations across states in how they provide services and supports within Medicaid (Friedman et al., 2019). As a result, older adults' utilization of home- and community-based LTSS remains low due to limited awareness of and barriers to using services (Brossoie et al., 2011; Casado et al., 2011; Lindquist et al., 2018). Issues with accessing LTSS, continuity of care, and efficiency of health care delivery (Regan & Wong, 2009) continue to contribute to health disparities and disrupt the potential for individuals to age in place.

The national network of over 600 Area Agencies on Aging (AAA) serves as an invaluable community-based resource equipped to meet older adults' AIP needs in their homes and communities. AAAs exist to specifically promote and coordinate an array of home and community-based services and supports, such as chronic disease self-management, in-home health care, transportation services, nutrition programs, information and referral, and more (Brewster et al., 2018; Kunkel, 2019). AAAs also have expertise in routinely addressing both the complex social and functional health needs of older

adults, but agencies may need to adapt or expand services to better address variability in older adults' social determinants of health needs (Weaver et al., 2021). Prioritizing community-based services that support AIP is advantageous because it enables older people to maintain independence, autonomy, and connection to social support, and helps to avoid high-cost institutional care (Martin et al., 2019; Stones & Gullifer, 2016; Wiles et al., 2012). The majority of AAAs across the nation are also actively involved in age-friendly and livable community activities and initiatives (National Association of Area Agencies on Aging, 2017; 2020). In addition, investment in age-friendly policies, programs, and services to support AIP not only benefits the current population of older adults, but also future generations who are likely to experience significantly longer lives.

Policy Planning within a Community Gerontology Framework

In response to an increasing focus on age-friendly community development and a more informed understanding of the challenges of AIP (e.g., complexities of diverse contexts, political environments, and marginalized populations), scholars have argued for community gerontology perspectives on person-environment exchanges in later life. For example, Greenfield and colleagues (2019) proposed an ecological community gerontology framework in which aging is understood at the meso-level (i.e., within the community), while simultaneously being part of the

micro- (i.e., contexts most proximal to individuals) and macro- (i.e., broader social systems) levels. More specifically, micro-level influences on aging may include individuals' health status, chronic conditions, and socio-economic status, while meso-level influences on aging can be understood as individuals' awareness of supports in the community, their openness or receptiveness to using services, or the geographic region in which they are located. Macro-level influences on aging can be comprised of the local, state, and national social and policy systems of services and supports. Overall, bioecological approaches that integrate micro-, meso-, and macro-level contexts can be useful for understanding the influence of the broader social context of population aging. It is unclear whether existing policies, programs, and services will meet the projected needs of a burgeoning aging population, underscoring the need for further work at the community development level.

Current Study

For communities to develop and implement a broad array of responsive organizational policies and practices that meet the demands of a diverse aging society and support AIP, intentional efforts to understand the challenges and changes that will occur due to population aging and to identify unmet needs in the community are needed. We take a community-based lens in our analyses that explores community contexts to sustain efforts supporting AIP. Although use of LTSS can support AIP safely, awareness of available services,

affordability issues, and various social determinants of health can be common barriers to accessing services. In this study, we explored older adults' perspectives of AIP held by older adults across a five-county region in south-west Washington state by asking the following research questions: (1) What AIP needs and supports do older adults expect? (2) Do older adults feel they are receiving adequate health services and what factors are associated with adequate support and services? (3) How aware are older adults of current aging services/supports in their community and what are their anticipated sources of support?

Methods

Guided by community-based participatory research principles, we partnered with AAA in Washington State to develop an interview protocol. We surveyed a probability sample of community-dwelling older adults via computer-assisted telephone interviews. From a sampling frame of approximately 10,000 phone numbers (obtained from Survey Sampling International) based in the five-county region covering the study area, trained interviewers relied on random digit dialing to contact households. All respondents were initially screened to determine study eligibility (i.e., identify a resident aged 60+ in the household or a person under 60 who was a caregiver). There were 7,219 eligible phone numbers from which 363 individuals ($n = 252$ older adults; $n = 111$ caregivers) either fully or partially

completed the survey during the open study period between April and June of 2016. While the overall response rate based on the larger sampling frame was just over 5%, this reflects similar national trends consistent with phone surveys (Kennedy & Hartig, 2019). When an eligible and voluntary participant was identified, interviewers continued with the phone interview. A typical interview lasted 30 minutes. For the current study, we aimed to center the voices of older adults themselves and thus only included adults aged 60+ living in the community ($n = 252$) who fully or partially completed the phone survey.

Participants

The average age of participants was 74 years ($SD = 8.4$, $range = 60-94$ years). Almost two-thirds of participants were women ($n = 164$) and the majority (81%, $n = 204$) were White, which reflected the racial demographic of the region. Over one-third of participants were widowed (37.8%; $n = 85$) and another 28.4% ($n = 64$) were married/partnered. Slightly more than half of participants ($n = 132$) resided in rural areas and nearly 20% ($n = 50$) had annual household incomes less than \$20,000. See Table 1 for additional sociodemographic information of the participants.

Table 1. *Participant Characteristics and Summary of Outcome and Independent Variables*

Variables	% (n) or Mean (SD)
Outcome variables	
Access to sufficient health services	80.00 (200)
Number of unmet I/ADL support needs	
None	68.65 (173)
One unmet I/ADL support need	17.46 (44)
Two unmet I/ADL support needs	5.95 (15)
Three unmet I/ADL support needs	3.97 (10)
Four or more unmet I/ADL support needs	3.97 (10)
Most prevalent unmet I/ADL support needs	
Heavy housework	11.11 (28)
House repairs	9.13 (23)
Yard work	15.48 (39)
Other services (e.g., wheelchair repairs, assistive devices, dental care)	8.73 (22)
Independent and control variables	
Self-rated health conditions	
Good or excellent	71.89 (179)
Neutral	14.46 (36)
Very bad or bad	13.65 (34)

Any chronic disease	53.17 (134)
Depressive symptoms (PHQ-2 scores range 0-6)	0.86 (1.46)
Awareness of where to get help if needed	76.95 (187)
Number of AAA services ever used (range 0-10)	0.26 (0.86)
Knowledge of six or more AAA services	23.02 (58)
Age (range from 60-94)	73.61 (8.44)
Gender	
Women	71.93 (164)
Men	28.07 (64)
Education	
More than high school degree	73.41 (185)
Income	
More than \$20,000	46.43 (117)
Less than or \$20,000	19.84 (50)
Did not report	33.73 (85)
Married	25.40 (64)
White, non-Hispanic	80.95 (204)
Rural residency	52.38 (132)
Type of health insurance	
Public insurance	69.44 (175)
Private insurance	30.56 (77)

Note: Most variables are categorical; there are only three continuous variables: (1) level of depressive symptoms, (2) number of AAA services ever used, and (3) age. Mean and standard deviation (in parentheses) are shown for the continuous variables.

Measures

The interview survey included both closed and open-ended questions to assess participants' AIP needs related to home and community-based services. It was developed in collaboration with AAA leaders, administrators, and management teams to reflect the types of services and programs available to the community and with the goal to identify gaps in service needs within the community. For more information on the survey, please contact the first author.

Outcome variables. We examined six outcomes, all related to health service access or unmet needs. First, we examined whether participants felt they had *access to sufficient health services*. This was measured via a one-item, dichotomous question: "Do you have sufficient health care services to meet all your medical needs including physical, mental, dental, and specialty health care (e.g., geriatrician, cardiologist, psychiatrist, or nephrologist)?" Participants responded yes/no, but were also provided an opportunity to expand on their responses in an open-ended format.

Next, we examined the number of *unmet instrumental/activities of daily living (I/ADL) support needs*. I/ADL support needs were measured via participant self-report of receiving help or needing help (new or additional help beyond their current support) in any of the following established I/ADL areas (Lawton & Brody, 1969): meal preparation, personal care tasks, getting in and out of bed/chair, walking, shopping, managing medications or money, using a telephone, light or heavy housework, yard work, interior or exterior house repairs, transportation, assistance with a computer, or any other service. The four most prevalent I/ADL needs were *heavy housework, home repairs, yard work, and other services* (e.g., wheelchair repairs, changing oxygen tanks, assistive devices such as magnifiers, access to dental care, access to exercise programs, financial support for bills, and assistance with general errands). We examined each of these four variables as an outcome separately.

Independent variables. The predictor variables of interest included a set of physical and mental health indicators, several variables pertaining to awareness/knowledge of services, and an indicator of community support services utilization. *Self-rated physical health* was reported on a five-point Likert-scale from 1 = very bad to 5 = excellent. We recoded this into a three-point scale as very bad or bad (13.6% participants), neutral (14.5% participants), and good or excellent (71.9% participants). Participants also indicated whether they had *any chronic condition*, which we

recoded into a binary variable (yes = at least one, no = none). Approximately 53% of participants reported having at least one chronic condition. To measure *level of depressive symptoms*, the Patient Health Questionnaire (PHQ-2) was used as a depression screener and inquired about the degree to which an individual experienced depressed mood and anhedonia over the prior two weeks. The PHQ-2 has been validated in previous studies and demonstrates sensitivity (Gilbody et al., 2007). The PHQ-2 scores ranged from 0 to 6, with higher scores indicating greater distress. Approximately 64% scored a 0, while 2.8% scored a 6. We used this as a continuous variable in the analyses, and the average score was 0.86.

Three predictor variables were included to measure awareness of community supports: awareness of where to get help, knowledge of AAA services, and whether AAA services were ever used. Participants began by answering a series of questions regarding their daily I/ADL needs (e.g., “Are you currently receiving help preparing meals?”, “Are you currently receiving help managing medications?”) and for which activities they would like help or more help. Participants were then asked about their *awareness of where to get help* based on a dichotomous (yes/no) question, “Do you know where to get the help you may need for daily activities?” The next variable focused more specifically on recognition of the local AAA, which provides a host of local programs and aging support services in the community. First, participants were asked whether they were aware of services provided

by AAA (e.g., family caregiver support, transportation, senior health and wellness, senior meal sites, home delivered meals, farmers market vouchers, personal care services, case management, care coordination, or information and assistance services). We then created a composite variable called *knowledge of AAA services* by sum scoring their responses to reflect the level of awareness of these ten AAA services. Participant scores ranged from 0 to 10 (*mean* = 2.81); because most participants (57.9%, *n* = 149) were not aware of a single AAA service, this resulted in a skewed distribution. Consequently, we used the top quartile as a cut-off to distinguish between participants with more, versus less, knowledge of available AAA services. This variable was then dichotomized so that scores ranging between 0-6 were considered “less knowledgeable” and scores ranging between 7-10 were considered “more knowledgeable.” Finally, participants who endorsed recognition of the AAA organization were asked if they had *ever used services*.

Control variables. Information related to age, gender, education, income, marital status, race/ethnicity, rural residency, and type of health insurance coverage were controlled for in all analyses. Given the age of the participants and that most were out of the labor force, we did not control for employment status in our analyses. Based on the sample distribution, household income was dichotomized into above and below the lowest household income quartile (\$20,000). This low-income threshold was also selected in accordance with the Center on Budget and Policy Prior-

ities (CBPP) report that 25% of retiree households live on less than \$20,000 (Romig, 2019). Participants with household incomes of less than \$20,000 per year were classified as low income and those with household incomes of \$20,000 or more per year were classified as higher income. Additionally, many participants did not disclose household income information, and we created a separate income category of ‘did not report’ to avoid large loss of data points. Due to our smaller sample size, types of health insurance were categorized into two mutually exclusive groups: those with public insurance coverage and those with private insurance coverage only. The public insurance category could include any variation of participants with Medicaid only, Medicare only, both Medicaid and Medicare, both Medicaid and private health insurance, both Medicare and private health insurance, or Medicaid, Medicare, and private insurance. While it is common for older adults to purchase a Medicare or Medicaid supplement, their primary health insurance is typically the public insurance option, which was our rationale for this dichotomization.

Given the sample size, we minimized the categories within each variable to preserve degrees of freedom. For instance, marital status was coded ‘1’ for married or partnered individuals and ‘0’ for otherwise. The latter category included divorced, separated, widowed, or single individuals; including each of these categories separately would have resulted in small cell size per category. All outcome, independent, and control variables are summarized in Table 1.

Open-ended questions. Finally, we also explored participants' *anticipated sources of support*. All participants were asked an open-ended question regarding their knowledge of where to get any help they may need and to identify that source: "Do you know where to get the help you may need? Please tell me where you would get help." The majority of respondents (77%) reported that they knew where to get the help they would need, and the research team qualitatively analyzed and coded their responses to this question.

Data Analysis

The computer-assisted telephone interview survey was programmed into Voxco software to facilitate the interview process and data collection. The computer-assisted telephone interviewing procedures resulted in minimal missing data; all available data were used in each analysis. We conducted basic descriptive (mean, standard deviation, and chi-square) and regression analyses using SPSS version 26 software. Logistic regression models were fitted to examine access to sufficient health services and the four outcome variables related to needing more help with specific tasks. These five outcome variables were binary indicator variables. Odds ratios (OR) are reported in Table 2 for access to sufficient health services and in Table 4 for the other four outcome variables on unmet I/ADL needs. Poisson regression modeling was used to examine the connection between I/ADL support needs and sociodemographic/health factors. Because support needs were based on a count of number of needs reported,

they are not reflective of a normal distribution. Thus, the advantage of relying on a count model, versus a linear model, is that it accounts for skewness of the outcome variable because a normal distribution of this variable is not assumed. Further, counting the number of unmet I/ADL support needs enabled us to determine how sociodemographic and health factors influenced the degree of perceived unmet I/ADL support needs and provided more context to the logistic regression analyses which are based on binary I/ADL outcomes. Incidence rate ratios (IRR) from the Poisson regression model are shown in Table 3. All statistical tests were two-tailed and to contextualize findings, significance level thresholds are reported at $p < 0.05$, though we note meaningful trends toward significance at $p < 0.10$ (Betensky, 2019; Thiese, Ronna, & Ott, 2016).

Anticipated Sources of Support. Lastly, for qualitative data from the open-ended survey questions, researchers independently read each response multiple times and generated an inductive coding scheme for content analysis (Hsieh & Shannon, 2005; Thomas, 2006) based on participants' reported sources for seeking support. Additional codes were developed, and the coding scheme was revised and refined, yielding several distinct themes related to how participants planned to meet their AIP needs. Two authors independently applied the final coding scheme and discrepancies were discussed until 100% agreement was achieved.

Table 2. *Logistic Regression Analysis: Access to Sufficient Health Services*

Variable	Odds ratio (SE)	p-value	95% CI
Self-rated health conditions: Very bad or bad	0.62 (0.42)	0.48	[0.17, 2.33]
Self-rated health conditions: Good or excellent	1.28 (0.73)	0.66	[0.42, 3.92]
Levels of depressive symptoms	0.72* (0.10)	0.02	[0.55, 0.94]
Any chronic disease	0.51 (0.26)	0.19	[0.19, 1.38]
Awareness of where to get help	1.44 (0.69)	0.45	[0.56, 3.69]
Adequate knowledge of AAA services	2.05 (1.17)	0.21	[0.67, 6.25]
Number of AAA services ever used	1.33 (0.45)	0.40	[0.68, 2.57]
Women	0.56 (0.29)	0.26	[0.20, 1.55]
Rural residency	0.45 [†] (0.20)	0.08	[0.18, 1.10]
Age	0.98 (0.03)	0.57	[0.93, 1.04]
White, non-Hispanic	2.68 (1.74)	0.13	[0.75, 9.55]
Has more than HS degree	0.76 (0.38)	0.58	[0.28, 2.02]
Married	1.48 (0.89)	0.51	[0.46, 4.81]
Income: more than \$20,000	3.72* (1.96)	0.01	[1.33, 10.44]
Income: did not report	1.38 (0.74)	0.55	[0.48, 3.97]
Private health insurance or self-pay	0.47 (0.29)	0.22	[0.14, 1.56]
Sample size	214		
R ²	0.25		

Note. Standard errors are shown in parentheses. * $p < 0.05$; ** $p < 0.01$. *** $p < 0.001$ reflect statistical significance; [†] $p < 0.10$ reflects trend toward significance.

Results

Access to Sufficient Health Services

Most (80%) of the participants reported having sufficient access to health services. All independent and control variables were included in the logistic regression analysis (see Table 2). While the association between each of these variables and the outcome variable was in the expected direction, estimated coefficients for three of the factors were statistically significant. Individuals from higher income households were more likely to report sufficient

access to health services (OR = 3.72 (SE = 1.96), $p = 0.01$) when compared to households with less than \$20,000. Thus, individuals in higher income households were almost at four times greater odds of reporting access to sufficient health services, compared to individuals in lower income households. When compared with participants who did not disclose their household income information, those in higher income households were still at almost three times greater odds of reporting access to sufficient health services (OR = 2.70 (SE = 1.96), $p = 0.06$). In contrast, individuals with higher levels of

Table 3. *Poisson Regression Analyses: Number of Unmet I/ADL Support Needs*

Variables	IRR (SE)	95% CI
Access to sufficient health services	0.78 (0.16)	[0.52, 1.17]
Self-rated health: Very bad or bad	1.63 [†] (0.45)	[0.95, 2.81]
Self-rated health: Good or excellent	1.14 (0.30)	[0.67, 1.91]
Level of depressive symptoms	1.27 ^{***} (0.07)	[1.15, 1.41]
Any chronic disease	2.04 ^{**} (0.47)	[1.29, 3.22]
Awareness of where to get help	0.87 (0.17)	[0.59, 1.27]
Knowledge of AAA services	0.49 ^{**} (0.13)	[0.29, 0.83]
Number of AAA services ever used	1.17 [†] (0.10)	[0.99, 1.37]
Women	1.41 (0.31)	[0.92, 2.17]
Rural residency	0.86 (0.17)	[0.58, 1.25]
Age	1.01 (0.01)	[0.98, 1.03]
White, non-Hispanic	1.23 (0.45)	[0.60, 2.52]
More than HS degree	1.51 [†] (0.33)	[0.99, 2.31]
Married	1.48 [†] (0.29)	[1.11, 2.18]

Note. Standard errors shown in parentheses. Incidence ratios from Poisson regression model are shown for the first outcome variable

^{*} $p < 0.05$; ^{**} $p < 0.01$. ^{***} $p < 0.001$ reflect statistical significance; [†] $p < 0.10$ reflects trend toward significance.

depressive symptoms (OR = 0.72 (SE = 0.10), $p = 0.02$) were less likely to report access to sufficient health services. Each unit increase on the PHQ-2 scale of depressive symptoms was associated with a decrease in the odds of reporting access to sufficient health services by a factor of 1.4. In other words, those with depressive symptoms were 38% less likely to report sufficient health service compared to those without depressive symptoms. Finally, there was also a trend for individuals from rural areas to be less likely to report access to sufficient health services (OR = 0.45 (SE

= 0.20), $p = 0.08$). Rural residency was associated with 55% less likelihood of reporting sufficient health service.

Unmet I/ADL Support Needs

Nearly one-third (31%) of participants reported unmet I/ADL support needs. All independent and control variables were included in Poisson regression analyses (see Table 3), as was access to sufficient health services in this and the next four logistic regression models (see Table 4). Among the health variables, self-rated poorer health was trending in a direction to be mean-

ingly associated with greater unmet needs ($IRR = 1.63$ ($SE = 0.45$), $p = 0.08$). That is, the incident rate for individuals with self-rated health status of very bad or bad was 1.6 times the incident rate for individuals with neutral self-rated health. Similarly, the incident rate for individuals with at least one chronic condition was twice that for individuals without any chronic conditions ($IRR = 2.04$ ($SE = 0.47$), $p = 0.002$). Mental health was also a significant factor and for every unit increase in depressive symptoms, incident rate of number of unmet needs increased by 27% ($IRR = 1.27$ ($SE = 0.07$), $p < 0.001$). In terms of knowledge of local aging services (i.e., AAA), the incident rate for those with more knowledge of AAA services was two times lower than those with limited knowledge ($IRR = 0.49$ ($SE = 0.13$), $p = 0.008$). This indicated that those with more knowledge of AAA services reported fewer unmet I/ADL needs. For every unit increase in number of AAA services ever used, incident rate of number of unmet needs increased by 17% ($IRR = 1.17$ ($SE = 0.10$), $p = 0.06$). This finding was trending toward significance but may also reflect the need for correcting for endogeneity; it is likely that those with more unmet needs might also have greater needs and higher utilization of community services in general. Finally, married individuals ($IRR = 1.48$ ($SE = 0.29$), $p = 0.05$) were significantly more likely to report greater unmet needs and those who were higher educated ($IRR = 1.51$ ($SE = 0.33$), $p = 0.06$) were substantially more likely to report greater unmet needs.

Most prevalent unmet I/ADL support needs. There were four I/ADL needs that were most frequently reported. All were related to home maintenance-related tasks: needing more help with heavy housework, home repairs, yard work, or other services. To explore key factors associated with whether the four most prevalently reported needs were met or not, we conducted a series of logistic regressions. While significantly associated factors varied with each outcome, poorer mental health was a common, significant variable across most of these unmet I/ADL support needs. The findings are described below and portrayed in Table 4.

Regarding unmet needs associated with heavy housework, those with good or excellent self-rated health reported fewer unmet needs ($OR = 0.22$ ($SE = 0.16$), $p = 0.04$). Women, and higher educated individuals, however, were both more likely to report having unmet heavy housework needs. The odds of women reporting unmet heavy housework were 4.4 times the odds of men reporting the same.

In terms of house repairs, 27.8% of participants reported they did not have the financial means to make modifications necessary to remain in their homes. Those who were married were more likely to report unmet needs. More specifically, the odds of married individuals reporting unmet house repair needs were 3.5 times higher compared to the reference group ($OR = 3.54$ ($SE = 2.24$), $p = 0.05$).

For the final two most prevalent unmet needs (yard work and other

Table 4. Logistic Regression Analyses: Four Most Frequently Reported Unmet I/ADL Needs

Variables	Heavy housework			House repairs			Yard work			Other services		
	OR (SE)	95% CI		OR (SE)	95% CI		OR (SE)	95% CI		OR (SE)	95% CI	
Access to sufficient health services	0.40 (0.25)	0.11, 1.39		0.74 (0.51)	0.19, 2.87		0.87 (0.46)	0.30, 2.47		2.71 (2.26)	0.53, 13.87	
Self-rated health: Very bad/bad	1.06 (0.79)	0.24, 4.60		0.80 (0.70)	0.14, 4.46		0.69 (0.47)	0.18, 2.62		1.62 (1.57)	0.24, 10.85	
Self-rated health: Good/excellent	0.22 ^{**} (0.16)	0.05, 0.90		0.66 (0.48)	0.16, 2.74		0.50 (0.28)	0.17, 1.51		2.06 (1.79)	0.38, 11.25	
Level of depressive symptoms	1.15 (0.20)	0.82, 1.62		1.37 [†] (0.26)	0.95, 1.98		1.42 ^{**} (0.21)	1.06, 1.89		1.64 ^{**} (0.31)	1.12, 2.38	
Any chronic disease	2.29 (1.55)	0.60, 8.67		1.16 (0.72)	0.34, 3.90		1.24 (0.60)	0.48, 3.20		1.80 (1.27)	0.45, 7.21	
Awareness of where to get help	1.66 (1.10)	0.45, 6.07		1.10 (0.68)	0.32, 3.72		1.01 (0.48)	0.40, 2.56		0.12 ^{***} (0.07)	0.04, 0.39	
Knowledge of AAA services	0.93 (0.65)	0.23, 3.69		0.75 (0.52)	0.20, 2.88		0.38 (0.24)	0.11, 1.30		0.76 (0.59)	0.17, 3.48	
Number of AAA services ever used	0.94 (0.31)	0.50, 1.79		1.04 (0.28)	0.62, 1.75		1.08 (0.25)	0.68, 1.72		0.93 (0.27)	0.52, 1.64	
Women	4.26 [*] (3.25)	0.95, 19.02		1.85 (1.18)	0.53, 6.46		0.99 (0.46)	0.39, 2.47		0.70 (0.44)	0.20, 2.39	
Rural residency	1.95 (1.14)	0.62, 6.13		0.42 (0.24)	0.14, 1.30		0.93 (0.40)	0.40, 2.15		0.23 ^{**} (0.16)	0.06, 0.89	
Age	1.01 (0.04)	0.93, 1.08		1.02 (0.04)	0.95, 1.10		1.01 (0.03)	0.96, 1.07		0.97 (0.04)	0.89, 1.05	
White, non-Hispanic	3.58 (4.44)	0.31, 40.75		0.82 (0.73)	0.15, 4.64		1.63 (1.44)	0.29, 9.18		0.17 [†] (0.17)	0.02, 1.25	

More than HS degree	3.44* (2.50)	0.83, 14.31	1.63 (1.12)	0.43, 6.23	1.61 (0.80)	0.61, 4.26	0.34 (0.23)	0.09, 1.25
Married	1.98 (1.27)	0.56, 6.99	3.54** (2.24)	1.02, 12.23	0.76 (0.40)	0.27, 2.12	0.56 (0.46)	0.11, 2.75
Income: more than \$20,000	2.23 (1.61)	0.54, 9.17	0.68 (0.49)	0.16, 2.83	2.28 (1.33)	0.73, 7.16	0.32 (0.23)	0.08, 1.32
Income: did not report	0.45 (0.42)	0.07, 2.78	0.48 (0.42)	0.09, 2.62	2.13 (1.36)	0.61, 7.48	0.29 (0.26)	0.05, 1.60
Private health insurance	1.00 (0.74)	0.24, 4.27	0.92 (0.70)	0.21, 4.07	0.52 (0.34)	0.14, 1.90	0.45 (0.43)	0.07, 2.90
Sample size	214		214		214		214	
R ²	0.24		0.11		0.11		0.30	

Note. Standard errors shown in parentheses. Odds ratios from logistic regression models are shown for remaining outcome variables.

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$ reflect statistical significance; † $p < 0.10$ reflects trend toward significance.

services), more depressive symptoms were significantly associated with both. In fact, the only significant variable associated with unmet yard work needs was depressive symptoms (OR = 1.42 (SE = 0.21), $p = 0.02$). Odds of reporting unmet needs related to other services (e.g., wheelchair repairs, access to dental care, assistive devices, access to exercise programs) increased by a factor of 1.6 with each unit increase in depressive symptoms (OR = 1.64 (SE = 0.31), $p = 0.01$). On the other hand, the odds of reporting unmet needs related to other services were eight times lower among those with awareness of where to get help compared to those with limited awareness (OR = 0.12 (SE = 0.07), $p < 0.001$). Finally, individuals living in rural areas (OR = 0.23 (SE = 0.16), $p = 0.03$) were also less likely to report unmet needs related to other services.

Anticipated Sources of Support

Despite being long-time community residents and potentially eligible for community-based services and supports, over half ($n = 127$) of the participants were completely unaware of available AAA services, and nearly three-quarters of participants ($n = 186$) had never used any AAA services. Of those who were aware of AAA ($n = 114$), 57.9% ($n = 66$) reported they had used a range of AAA services. When participants were queried in an open-ended question about where they would seek help if needed in the future, their responses aligned with four general themes: (1) reliance on friends/family, (2) general expectations that government, social services, or community support will be available,

(3) pursuit of non-specific searches for support, and (4) referrals from medical professionals. Many reported a combination of these four avenues of support.

The understanding that family, friends, or neighbors would be available for support was commonly reported (36% of all responses). A typical response was, "I call my granddaughter or daughter." While some expected help from people they lived with—"my wife helps me do just about everything"—others expected help from more distal sources, including their "network of friends and neighbors" or "several friends in town who help."

The second most prevalent response (32%) was related to an expectation that government supported programs or community-based social services would be readily available. Most of these responses were vague in nature but revealed a belief that services would be accessible to them in their local community. For example, one participant stated: "I would go through the state or human services agency" and another reported, "I'll just find local social services or use the senior center."

Approximately 29% of the responses featured non-specific or general searches for support including, "I would search the internet, phone books, or Craigslist" or "I've got a phonebook." Other participants had an impression that support was available but were uncertain about specific names of organizations or location of services. For example, "I think they have a building for where you can get support for different things if you needed it" or "I know we

have some places that can have people that can come and help." Many participants also asserted their independence and ability to "figure it out" on their own (e.g., "I talk to myself and I will get it done," "I can just have somebody come in and help me," and "I'm pretty independent so I can find my way").

Finally, 20% of the responses identified the medical community, primarily doctors or insurance providers, as a source of information and referral. Many stated, "I'd call my doctor" or "contact my doctor's office and they would guide me to who I need." Others reported that "there are things available in the community and you can get access to some of those things through your doctor" or "social workers in the doctor's office - they have access to a lot of things we don't think we may need." While participants expressed confidence that they could find the support they needed through their providers, many were still unclear on what types of supports would be available to them. For example, one participant stated, "my doctor could probably get me a lot of help through social services at the hospital, but I don't know exactly what is available." Another shared that they would "get a hold of my insurance people" when seeking help.

Discussion

We orient our findings within a community gerontology framework (Greenfield et al., 2019) that encourages consideration on how community-level change at the

meso-level can facilitate change at the micro- and larger macro-level contexts related to aging. In addition, leveraging the lived experiences of older adults can inform AIP policy and program initiatives (Carver et al., 2018), which in turn can potentially reduce health and social inequalities at the local level. By interviewing community residents about their current health, access to services, and AIP needs, community-based aging services organizations are better equipped to identify service gaps, understand local needs of older adults to inform policy, and better plan for interventions to support AIP. This approach also highlights the importance of connecting efforts at a local level to broader advocacy around national policy programs and funding streams that will be necessary to meet the demand of a rapidly increasing aging population.

Reports of Good Health, Despite Existing Support Needs

A relatively high percentage of participants reported being in good health, in spite of a simultaneously high prevalence of reported chronic conditions. This is consistent with other surveys (Lucas & Benson, 2018; Tam, 2020; Tkatch et al., 2017) and while this could be a possible indication of efforts to optimize later life health via earlier detection of disease indicators and management of chronic conditions, it may also reflect ways in which older adults conceptualize health. For many, health can be understood more broadly than simply the absence of illness or chronic conditions, especially for individuals

who feel their chronic conditions are manageable. While this positive trend of high self-rated health in later life helps to debunk common myths and declinist age stereotypes, it is important to recognize that many older adults will still likely need additional supports in later life. This reflects the growing importance of educating the public more broadly about the critical need to prepare and plan for aging and future care.

Study findings revealed several subgroups of older adults with distinct needs, underscoring the significance of targeting efforts to high-risk populations. For example, access to sufficient health services was worse among individuals living in rural areas, with greater depressive symptoms, and with potentially lower incomes, which included both those who reported household incomes of \$20,000 or less and those who did not disclose household income. Having fewer financial resources to address ongoing unmet needs negatively affects individuals' health and wellbeing. Rural-dwelling individuals historically have worse health, limited income, and restricted access to adequate services/supports compared to their urban counterparts (Hash et al., 2014); in turn, rural-dwelling individuals have increased risk of premature mortality (Weaver et al., 2018; Hoffman & Holmes, 2017). Translating these findings into practical insights for policymakers is critical for several reasons: the socioeconomic gap continues to widen (Singh et al., 2017) and a disproportionate share of the aging population growth is occurring in rural areas (Jensen et al., 2020; Lang, 2013).

The risk of having greater unmet I/ADL support needs was higher among individuals with poor self-rated health, more chronic conditions, and depressive symptoms. As for most prevalent unmet I/ADL support needs, having more depressive symptoms was associated with unmet needs related to yard work, house repairs, and other services. Health policy has traditionally focused on physical health, where services and supports are primarily targeted to address physical health needs; however, our results support provision for the explicit integration of services and supports for socioemotional health. This is especially essential in the context of research on social determinants of health (e.g., food insecurity, housing instability, transportation needs) and the significant influence that social and emotional needs have on health risks and outcomes (Greysen et al., 2014; Hood et al., 2016; Hu et al., 2014; Sattler et al., 2015; Thornton et al., 2016). Thus, early identification and intervention support for individuals with underlying mental and physical health issues, as well as limited financial means, can facilitate reduction of existing health disparities.

While the most prevalent unmet needs were related to home maintenance tasks (e.g., heavy housework, home repairs, yard work, other services) that would enable older adults to remain living in their own homes, nearly one-third reported not having the financial means to make home modifications to support AIP. This aligns with growing recognition that 90% of the nation's housing structures are unprepared to accommodate AIP (Vespa et

al., 2020). For older adults specifically, growing evidence indicates that meeting social determinant of health needs, such as housing stability, can improve health (Gottlieb et al., 2013) and reduce medical care costs (Taylor et al., 2016). Conversely, having home maintenance concerns may cause stress and anxiety (Coleman et al., 2016). Furthermore, AAAs are well equipped to address and ameliorate social determinants of health because they have strong community networks and are knowledgeable about local resources that specifically address social and environmental obstacles affecting individuals' overall health and wellbeing (Kunkel et al., 2018).

Planning for Future Support amidst a Lack of Awareness about Resources

Planning for future support needs is a critical issue for older adults, their families, and the communities in which they live. LTSS are expensive for individuals, as well as for local, state, and federal entities, and yet more than 70% of older adults will eventually need some type of support (Administration for Community Living, 2020). Advanced preparation can also reduce stress in families and prevent planning in the context of health crises. Nonetheless, most people do not anticipate they will ever need help with their care needs and relatively few adults intentionally plan for, or actively contemplate, their future care needs (Gould et al., 2017). In the current study, participants revealed a similar naiveté regarding how they would plan to seek support when needed,

which illuminated several important findings.

Many participants anticipated relying on family and friends, a perception confirmed in the literature (Roberto et al., 2001; Stolee et al., 2014), while other participants expected to turn to formal caregiving via social services or community supports, a typical alternative to informal caregiving. It is unknown whether study participants already had conversations with their loved ones about their caregiving support expectations or whether they could financially afford formal caregiving services, but prior research indicates this may be unlikely (The Assistant Secretary for Planning and Evaluation, 2019). With increased longevity, families are aging together longer and there is a need to help promote and facilitate the often difficult conversations that older adults and their families need to have in order to prepare for future needs to remain at home. Those who are proficient at using proactive coping skills to plan for and anticipate future challenges tend to have higher socioeconomic status (i.e., income and education level) in comparison to their less-resourced counterparts (Ouwehand et al., 2009). We found that higher educated and married individuals reported greater support needs, which may reflect the social privilege of recognizing an increase in care needs. Thus, there remains a gap in community outreach and education efforts that raises public awareness of available community supports for older adults and family caregivers in preparing for later life needs and changes, especially among potentially vulnerable

individuals with fewer resources or no available family members.

Beyond relying on family members or hiring formal caregivers, the other pathways of support that participants identified appeared inadequate and often inaccurate (i.e., plans to pursue non-specific searches for support; reliance solely on referrals from medical professionals). Unforeseen challenges can arise when there is an inaccurate expectation that supports will be available. For example, individuals may not be eligible for Medicaid-funded programs until they spend-down their financial assets and have greater functional need. As an alternative, individuals could turn to community-based resources like AAAs to receive in-home health, social support, and information/referral to community resources. However, individuals may not be aware of such resources. Although AAAs have been established for almost fifty years, they still tend to be under-recognized and under-utilized in communities, despite the breadth of services and supports they provide to older adults and adults of all ages with disabilities. In this study, despite being potentially eligible for services, over half the participants had not even heard of the AAA organization and importantly, we found that those with inadequate knowledge of AAA services were also more likely to report some unmet I/ADL needs. This finding in particular underscores an important gap for advocacy and targeted outreach to increase community knowledge of these available supports for adults as they anticipate aging in their homes and communities. Another

er potential barrier exists for reaching individuals living in rural areas, who were less likely to report some unmet needs. This finding aligns with a typical narrative describing many rural-dwelling individuals as self-sufficient and hesitant to allow support from outsiders. During the global pandemic, AAAs played a critical role in meeting the needs of older adults and their caregivers. AAAs needed to adapt delivery of their services/supports in order to support individuals during the height of physical distancing (Gallo & Wilber, 2020; Pendergrast, 2021; Wilson et al., 2020). Moving forward, AAAs should continue to evolve in ways that maintain connection with hard-to-reach populations.

Building collaborative, community-based, cross-sector partnerships is one promising avenue for targeted outreach and increasing community knowledge of supports. We found that individuals who had adequate knowledge about services were less likely to report unmet I/ADL support needs. Utilizing primary care sites and clinical partnerships with AAAs can be especially useful for reaching individuals who may not have family members, who live in rural communities, or who are experiencing mental and physical health challenges. Clinicians function as a key information source for older adults; in our study, at least 20% of participants planned to rely on their medical providers for information, resources, and referral for AIP support. However, health care professionals often lack sufficient knowledge of community resources that best serve their patients'

social needs (Lincoln, 2019; Ploeg, et al., 2017; Siegel et al., 2018; Siegler et al., 2015), which further highlights the importance of promoting a higher degree of clinical-community partnerships. There is increasing evidence that when local AAAs maintain partnerships with healthcare organizations, those communities experience significant benefits that translate to reduction in hospital readmission rates, lower health care use, and lower spending, in comparison to counties without these programs and partnerships (Brewster et al., 2018; Brewster et al., 2020). These findings indicate that investment in health and aging services partnerships, via AAAs, is a viable pathway to both reducing health care costs while simultaneously supporting older adults' AIP needs. Incentivizing these partnerships at the policy level (i.e., financial reimbursement) will be necessary to build sustainable practices that benefit and support vulnerable adults to age in their homes and communities (Weaver et al., 2021; WHO, 2015). Further, there are opportunities to consider additional, innovative community partnerships beyond the clinical sector that raise awareness of AIP needs. We provided examples of ways in which formal supports (e.g., aging network, health care clinics) can work more collaboratively in community settings, however, exploring informal support networks may also be necessary. For example, identification and development of innovative paid or volunteer intergenerational approaches for meeting the needs of an older population (Hoffman et al., 2020).

Limitations and Future Directions

The results should be interpreted in light of several limitations. The measures used in this study were based on participants' self-reported perceptions. Thus, we acknowledge that some of the predictors and outcomes are potentially jointly determined and that outcomes may not be causal. For instance, it is possible that some participants were aware of certain services because they needed that support or that participants were depressed as a result of their needs not being met. Due to data limitations, we lacked sufficient exogenous instruments to identify causality and to correct for endogeneity; future studies should incorporate both objective and subjective health measures, as well as a longitudinal design that can capture data over time. Nonetheless, there is still value in relying on self-reported measures as this reflects the lived experiences and perceptions of older adults related to their AIP abilities. In addition, we recognize that caution should be used when relying on any single-item measures, as this may affect measurement reliability and validity; however, some scholars (Bergkvist, 2015) also argue that for simple, concrete constructs, a single item can be sufficient.

The representative sampling from the community and opportunity to hear directly from older adults in the broader community are strengths of this study. The response rate was consistent with other national studies using phone interview methodologies. While response rates have been declining nationally and could signal higher

risk of error, researchers who have examined the effect of low response on data quality have generally found that response rates may not be a reliable metric of accuracy and can still yield reliable data (Davern et al., 2010; Kennedy & Hartig, 2019). Nonetheless, the lower response rate may indicate that some older adults' perspectives were not reflected in this study, most likely those who may be the most vulnerable and least resourced. For example, on average, the participants in this study reported better health, were more highly educated, and were primarily White. Finally, while our sample was representative of the community residents local to the study area, it did not reflect a national perspective, and thus the needs of older adults from different geographical regions may differ. Based on other national studies, however, we argue that the limited attention to planning and preparing for aging from both an individual and community perspective is a universal challenge. Additional needs assessments that incorporate, and possibly oversample for, more diverse perspectives are still needed to adequately plan for AIP, especially for racially minoritized older adults. In a post-pandemic era, in which social and racial inequities have been further exacerbated (Shippee et al., 2020), vulnerable adults may have unique needs that differ from those reflected in this study.

Finally, we acknowledge that there are many challenges within the aging network and that some of our recommendations may not apply universally. AAAs across the U.S. can vary

significantly in terms of services and supports provided, especially for those who are not Medicaid eligible. This highlights an ongoing challenge of the aging network and the continued advocacy need for better alignment of services/supports, along with expansion of supports for near-risk individuals who are proactive in seeking support, but not income eligible (Weaver & Roberto, 2019). Another related challenge of the AAAs is not just the inconsistency in availability of services/supports, but also in the naming of AAAs across regions; the terminology “area agency” may also be unclear to community members. National efforts to rebrand and market AAAs with a more universal, recognizable name—that is also more in line with emerging initiatives to reframe aging—may promote more interest, awareness of, and access to the valuable programs and services they can provide to communities.

Conclusions

Policymakers are often encouraged to advocate for preventive solutions that assist individuals before needs become unmanageable. A focus on age-friendly and AIP initiatives that can benefit all generations can help meet this goal. In terms of policy and planning, however, many issues compete for the attention of policymakers. Conveying to policymakers the extensive influence population aging will have on communities and how individuals need to proactively plan for their own aging continues to be challenging. With the ever-shifting political

landscape, it is important to have policy solutions at the ready.

Investing in age-friendly community initiatives and policies is in line with a community gerontology framework, in which community-level changes have the potential to enhance health at the individual micro-level, but also have influence on macro-level aging policies. Thus, increased community engagement between researchers, policymakers, citizens, and practitioners to address functional and socioemotional health is needed in order to collaboratively prepare for future aging care needs. Many adults avoid planning and anticipating future care needs; our findings highlight the need for raising awareness about available community-based aging services so individuals can seek preventive services/supports and engage in future planning. More than ever before, there is a need for increased cross-sector, multidisciplinary engagement and for multiple stakeholders to work together in supporting communities as a fundamental context for promoting population health, equity, and wellbeing across the lifespan. AAAs are central to serving older adults in their homes and communities and can serve a vital community role by supporting individuals’ goals to age in place and to prepare for future needs. In addition, it is important to acknowledge and recognize that older adults are also valuable community resources who can make community contributions via volunteerism, peer support, and mutual aid. Collectively, we need to continue to intentionally incorporate the perspectives and experiences of older adults,

as well as draw on their strengths and shape, and strengthen the communities resilience, regarding how to invest in, in which we all strive to age in place.

References

- AARP. (n.d.). *AARP livable communities*. <https://www.aarp.org/livable-communities/>
- Administration for Community Living. (2020, February 18). *How much care will you need? Long-Term Care*. <https://acl.gov/ltc/basic-needs/how-much-care-will-you-need>
- Administration on Aging. (2021, May). *2020 Profile of Older Americans*. U.S. Department of Health & Human Services. <https://acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans>
- The Assistant Secretary for Planning and Evaluation. (2019, May 14). *Assessing the out-of-pocket affordability of long-term services and supports*. HHS Office of the Assistant Secretary for Planning and Evaluation [ASPE] Research Brief. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//189396/OoPAfford.pdf
- Bergkvist, L. (2015). Appropriate use of single-item measures is here to stay. *Marketing Letters*, 26, 245-255. <https://doi.org/10.1007/s11002-014-9325-y>
- Betensky, R. A. (2019). The *p*-value requires context, not threshold. *The American Statistician*, 73(1), 115 – 117. <https://doi.org/10.1080/00031305.2018.1529624>
- Binette, J. (2021). *Home and community preference survey: A national survey of adults age 18-plus*. AARP Research. <https://doi.org/10.26419/res.00479.001>
- Binette, J., & Vasold, K. (2018). *2018 Home and community preferences: A national survey of adults' age 18-Plus*. AARP. <https://doi.org/10.26419/res.00231.001>
- Brewster, A. L., Kunkel, S., Straker, J., & Curry, L. A. (2018). Cross-sectoral partnerships by Area Agencies on Aging: Associations with health care use and spending. *Health Affairs*, 37(1), 15-21. <https://doi.org/10.1377/hlthaff.2017.1346>
- Brewster, A. L., Wilson, T. L., Frehn, J., Berish, D., & Kunkel, S. R. (2020). Linking health and social services through Area Agencies on Aging is associated with lower health care use and spending: An examination of the potential health impacts of establishing partnerships between hospitals and Area Agencies on Aging. *Health Affairs*, 39(4), 587-594. <https://doi.org/10.1377/hlthaff.2019.01515>

- Brim, B., Fromhold, S., & Blaney, S. (2021). Older adults' self-reported barriers to aging in place. *Journal of Applied Gerontology*, Advance online publication. <https://doi.org/10.1177/0733464820988800>
- Brossoie, N., Roberto, K. A., Willis-Walton, S., & Reynolds, S. (2011). *Report on baby boomers and older adults: Information and service needs*. Virginia Polytechnic Institute and State University, Center for Gerontology. <http://hdl.handle.net/10919/46989>
- Buffel, T., Handler, S., & Phillipson, C. (2018). Age-friendly cities and communities: A manifesto for change. In T. Buffel, S. Handler, & C. Phillipson (Eds.), *Age-friendly cities and communities: A global perspective* (pp. 273-288). Policy Press.
- Carver, L. F., Beamish, R., Phillips, S. P., & Villeneuve, M. (2018). A scoping review: Social participation as a cornerstone of successful aging in place among rural older adults. *Geriatrics*, 3(4), 75. <https://doi.org/10.3390/geriatrics3040075>
- Casado, B. L., van Vulpen, K. S., & Davis, S. L. (2011). Unmet needs for home and community-based services among frail older Americans and their caregivers. *Journal of Aging and Health*, 23(3), 529-553. <https://doi.org/10.1177/0898264310387132>
- Coleman, T., Kearns, R. A., & Wiles, J. (2016). Older adults' experiences of home maintenance issues and opportunities to maintain ageing in place. *Housing Studies*, 31(8), 964-983. <https://doi.org/10.1080/02673037.2016.1164834>
- Davern, M., McAlpine, D., Beebe, T.J., Ziegenfuss, J., Rockwood, T., & Call, K. T. (2010). Are lower response rates hazardous to your health survey? An analysis of three state telephone health surveys. *Health Services*, 45(5), 1324-1344. <https://doi.org/10.1111/j.1475-6773.2010.01128.x>
- Finlay, J. M., & Finn, B. M. (2020). Geography's blind spot: The age-old urban question. *Urban Geography*, 42(8), 1061-1078. <https://doi.org/10.1080/02723638.2020.1742468>
- Friedman, C., Caldwell, J., Rapp Kennedy, A., & Rizzolo, M. C. (2019). Aging in place: A national analysis of home-and community-based Medicaid services for older adults. *Journal of Disability Policy Studies*, 29(4), 245-256. <https://doi.org/10.1177/1044207318788889>
- Gallo, H. B., & Wilber, K. H. (2021). Transforming aging services: Area Agencies on Aging and the COVID-19 response. *The Gerontologist*, 61(2), 152-158. <https://doi.org/10.1093/geront/gnaa213>
- Gilbody, S., Richards, D., Brealey, S., & Hewitt, C. (2007). Screening for depression

- in medical settings with the Patient Health Questionnaire (PHQ): A diagnostic meta-analysis. *Journal of General Internal Medicine*, 22(11), 1596-1602. <https://doi.org/10.1007/s11606-007-0333-y>
- Gottlieb, L., Sandel, M., & Adler, N. E. (2013). Collecting and applying data on social determinants of health in health care settings. *JAMA Internal Medicine*, 173(11), 1017-1020. <https://doi.org/10.1001/jamainternmed.2013.560>
- Gould, O. N., Dupuis-Blanchard, S., Villalon, L., Simard, M., & Ethier, S. (2017). Hoping for the best or planning for the future: Decision making and future care needs. *Journal of Applied Gerontology*, 36(8), 953-970. <https://doi.org/10.1177/0733464815591213>
- Greenfield, E. A. (2012). Using ecological frameworks to advance a field of research, practice, and policy on aging-in-place initiatives. *The Gerontologist*, 52(1), 1-12. <https://doi.org/10.1093/geront/gnr108>
- Greenfield, E. A. (2015). Healthy aging and age-friendly community initiatives. *Public Policy & Aging Report*, 25(2), 43-46. <https://doi.org/10.1093/ppar/prv002>
- Greenfield, E. A., Black, K., Buffel, T., & Yeh, J. (2019). Community gerontology: A framework for research, policy, and practice on communities and aging. *Gerontologist* 59(5), 803-810. <https://doi.org/10.1093/geront/gny089>
- Greenfield, E. A., Oberlink, M., Scharlach, A. E., Neal, M. B., & Stafford, P. B. (2015). Age-friendly community initiatives: Conceptual issues and key questions. *The Gerontologist*, 55(2), 191-198. <https://doi.org/10.1093/geront/gnv005>
- Greenfield, E. A., & Reyes, L. (2015). Continuity and change in relationships with neighbors: Implications for psychological well-being in middle and later life. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 70(4), 607-618. <https://doi.org/10.1093/geronb/gbu084>
- Greysen, R. S., Hoi-Cheung, D., Garcia, V., Kessell E., Sarkar, U., & Goldman, L. (2014). "Missing pieces" – Functional, social, and environmental barriers to recovery for vulnerable older adults transitioning from hospital to home. *Journal of American Geriatric Society*, 62(8), 1556-1561. <https://doi.org/10.1111/jgs.12928>
- Hash, K. M., Jurkowski, E. T., & Krout, J. (2014). *Aging in rural places: Programs, policies, and professional practice*. Springer.
- Hood, C. M., Gennuso, K. P., Swain, G. R., & Catlin, B. B. (2016). County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine*, 50(2), 129-135. <https://doi.org/10.1016/j.amepre.2015.08.024>

- Hoffman, G. J., Webster, N. J., & Bynum, J. P. (2020). A framework for aging-friendly services and supports in the age of COVID-19. *Journal of Aging & Social Policy*, 32(4-5), 450-459. <https://doi.org/10.1080/08959420.2020.1771239>
- Hoffman, A., & Holmes, M. (2017, August). *Regional differences in rural and urban mortality trends*. NC Rural Health Research Program, UNC Sheps Center. https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2017/08/Regional-Differences-in-Urban-and-Rural-Mortality-Trends.pdf
- Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277-1288. <https://doi.org/10.1177/1049732305276687>
- Hu, J., Gonsahn, M., & Nerenz, D. (2014). Socioeconomic status and readmissions: Evidence from an urban teaching hospital. *Health Affairs*, 33(5), 778-785. <https://doi.org/10.1377/hlthaff.2013.0816>
- Jensen, L., Monnat, S. M., Green, J. J., Hunter, L. M., & Sliwinski, M. J. (2020). Rural population health and aging: Toward a multilevel and multidimensional research agenda for the 2020s. *American Journal of Public Health*, 110(9), 1328-1331. <https://doi.org/10.2105/AJPH.2020.305782>
- Kan, H. Y., Forsyth, A., & Molinsky, J. (2020). Measuring the built environment for aging in place: A review of neighborhood audit tools. *Journal of Planning Literature*, 35(2), 180-194. <https://doi.org/10.1177/0885412220903497>
- Kennedy, C., & Hartig, H. (2019, February 27). *Response rates in telephone surveys have resumed their decline*. Pew Research Center. <https://www.pewresearch.org/fact-tank/2019/02/27/response-rates-in-telephone-surveys-have-resumed-their-decline/>
- Kunkel, S. R. (2019). Building on the past, securing the future: Area Agencies on Aging and Older Americans Act reauthorization. *Public Policy Aging Rep* 29(2), 52-55. <https://doi.org/10.1093/ppar/prz009>
- Kunkel, S. R., Lackmeyer, A. E., Straker, J. K., & Wilson, T. L. (2018, November). *Community-based organizations and health care contracting: Building and strengthening partnerships*. Miami University, Scripps Gerontology Center. <https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6280/Kunkel-Community-Based-Organizations-and-Health-Care-Contracting.pdf>
- Lang, S. S. (2013, July 3). *Graying of rural America has policy implications*. Cornell Chronicle. <http://news.cornell.edu/stories/2013/07/graying-rural-america-has-policy-implications>
- Lawton, M. P., & Brody, E. M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist*, 9(3), 179-

186. https://doi.org/10.1093/geront/9.3_Part_1.179

- Lawton, M. P., & Nahemow, L. (1973). Ecology and the aging process. In C. Eisdorfer & M. P. Lawton (Eds.), *The psychology of adult development and aging* (pp. 619-674). American Psychological Association. <https://doi.org/10.1037/10044-020>
- Lincoln, K. D. (2019). The role of social determinants and why community-based programming works: Social needs often are not met during healthcare visits, but HCBS can fill that gap. *Generations (Supplement #3)*, 13-18.
- Lindquist, L. A., Ramirez-Zohfeld, V., Forcucci, C., Sunkara, P., & Cameron, K. A. (2018). Overcoming reluctance to accept home-based support from an older adult perspective. *Journal of the American Geriatrics Society*, 66(9), 1796-1799. <https://doi.org/10.1111/jgs.15526>
- Lucas, J. W., & Benson, V. (2018). *Tables of summary health statistics for the U.S. population: 2017 National Health Interview Survey*. National Center for Health Statistics. <https://www.cdc.gov/nchs/nhis/SHS/tables.htm>.
- Martin, D., Long, O., Kessler, L. (2019). Planning for aging in place: Incorporating the voice of elders to promote quality of life. *Journal of Housing for the Elderly*, 33(4), 382-392. <https://doi.org/10.1080/02763893.2019.1593280>
- National Association of Area Agencies on Aging. (2017). National survey of area agencies on aging: Serving America's older adults. Washington, D.C.
- National Association of Area Agencies on Aging. (2020). National survey of area agencies on aging: Meeting the needs of today's older adults. Washington, D.C. Available from <https://www.usaging.org/2020aaasurvey>
- Ouwehand, C., de Ridder, D. T., & Bensing, J. M. (2009). Who can afford to look to the future? The relationship between socio-economic status and proactive coping. *The European Journal of Public Health*, 19(4), 412-417. <https://doi.org/10.1093/eurpub/ckp047>
- Pendergrast C. (2021). "There was no 'That's not my job'": New York Area Agencies on Aging approaches to supporting older adults during the COVID-19 pandemic. *Journal of Applied Gerontology*, 40(11), 1425-1436. <https://doi.org/10.1177/0733464821991026>
- Phillipson, C., & Buffel, T. (2020). Age-friendly cities and communities: Policy opportunities and challenges. *Journal of Elder Policy*, 1(1), 137-154. <https://doi.org/10.18278/jep.1.1.7>
- Ploeg, J., Denton, M., Hutchison, B., McAiney, C., Moore, A., Brazil, K., Tindale, J., & Lam, A. (2017). Primary care physicians' perspectives on facilitat-

ing older patients' access to community support services: Qualitative case study. *Canadian Family Physician*, 63(1), e31-e42.

- Reaves, E. L., & Musumeci, M. (2015, December). *Medicaid and long-term services and supports: A primer*. Kaiser Family Foundation. <https://files.kff.org/attachment/report-medicaid-and-long-term-services-and-supports-a-primer>
- Roberto, K. A., Allen, K. R., & Blieszner, R. (2001). Older adults' preferences for future care: Formal plans and familial support. *Applied Developmental Science*, 5(2), 112-120. https://doi.org/10.1207/S1532480XADS0502_6
- Romig, K. (2019, July 19). *Social Security lifts more Americans above poverty than any other program*. Center on Budget and Policy Priorities. Center on Budget and Policy Priorities. <https://www.cbpp.org/sites/default/files/atoms/files/10-25-13ss.pdf>.
- Sattler, E. L., Lee, J. S., & Young, H. N. (2015). Factors associated with inpatient hospital (re)admissions in Medicare beneficiaries in need of food assistance. *Journal of Nutrition Gerontology and Geriatrics*, 34(2), 228-244. <https://doi.org/10.1080/21551197.2015.1031601>
- Schariach, A. E., & Lehning, A. J. (2016). *Creating aging-friendly communities*. Oxford University Press.
- Shippee, T. P., Akosionu, O., Ng, W., Woodhouse, M., Duan, Y., Thao, M. S., & Bowblis, J. R. (2020). COVID-19 pandemic: exacerbating racial/ethnic disparities in long-term services and supports. *Journal of Aging & Social Policy*, 32(4-5), 323-333. <https://doi.org/10.1080/08959420.2020.1772004>
- Siegel, B., Erickson, J., Milstein, B., Pritchard, K. E. (2018). Multisector partnerships need further development to fulfill aspirations for transforming regional health and well-being. *Health Affairs*, 37(1), 30-37. <https://doi.org/10.1377/hlthaff.2017.1118>
- Siegler, E. L., Lama, S. D., Knight, M. G., Laureano, E., & Carrington Reid, M. (2015). Community-based supports and services for older adults: A primer for clinicians. *Journal of Geriatrics*, vol. 2015, pp. 1-7. <https://doi.org/10.1155/2015/678625>
- Singh, G. K., Daus, G. P., Allender, M., Ramey, C. T., Martin, E. K., Perry, C., De Los Reyes, A. A., & Vedamuthu, I. P. (2017). Social determinants of health in the United States: addressing major health inequality trends for the nation, 1935-2016. *International Journal of MCH and AIDS*, 6(2), 139-164. <https://doi.org/10.21106/ijma.236>
- Stolee, P., Zaza, C., & Sharratt, M. T. (2014). Later life care planning conversations

- for older adults and families. *Journal of Applied Gerontology*, 33(6), 710-736. <https://doi.org/10.1177/0733464813500712>
- Stones, D., & Gullifer, J. (2016). 'At home it's just so much easier to be yourself': Older adults' perceptions of ageing in place. *Ageing & Society*, 36(3), 449-481. <https://doi.org/10.1017/S0144686X14001214>
- Tam, T. (2020, December). *Aging and chronic diseases: A profile of Canadian seniors*. Public Health Agency of Canada. https://www.canada.ca/content/dam/hc-sc/documents/services/publications/diseases-and-conditions/aging-chronic-diseases/canadian-seniors-report_2021-eng.pdf
- Taylor, L. A., Tan, A. X., Coyle, C. E., Ndumele, C., Rogan, E., Canavan, M., Curry, L. A., & Bradley, E. H. (2016). Leveraging the social determinants of health: What works? *PloS One*, 11(8), Article e0160217. <https://doi.org/10.1371/journal.pone.0160217>
- Thiese, M.S., Ronna, B., & Ott, U. (2016). P value interpretations and considerations. *Journal of Thoracic Disease*, 8(9), 928-931. <http://dx.doi.org/10.21037/jtd.2016.08.16>
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, 27(2), 237-246. <https://doi.org/10.1177/1098214005283748>
- Thornton, R., Glover, C., Cené, C., Glik, D., Henderson, J., & Williams, D. (2016). Evaluating strategies for reducing health disparities by addressing the social determinants of health. *Health Affairs*, 35(8), 1416-1423. <https://doi.org/10.1377/hlthaff.2015.1357>
- Tkatch, R., Musich, S., MacLeod, S., Kraemer, S., Hawkins, K., Wicker, E. R., & Armstrong, D. G. (2017). A qualitative study to examine older adults' perceptions of health: Keys to aging successfully. *Geriatric Nursing*, 38(6), 485-490. <https://doi.org/10.1016/j.gerinurse.2017.02.009>
- U.S. Centers for Disease Control and Prevention. (2009, October 15). *Healthy places terminology*. <https://www.cdc.gov/healthyplaces/terminology.htm>
- U.S. Centers for Disease Control and Prevention. (n..d.) *About chronic diseases*. National Center for Chronic Disease Prevention and Health Promotion. <https://www.cdc.gov/chronicdisease/about/index.htm>
- Vespa, J., Engelberg, J., & He, W. (2020, May 15). *Old housing, new needs: Are U.S. homes ready for an aging population?* U.S. Census Bureau. <https://www.census.gov/content/dam/Census/library/publications/2020/demo/p23-217.pdf>

- Wilson, T.L., Scala-Foley, M., Kunkel, S.R., & Brewster, A.L. (2020). Fast-track innovation: Area Agencies on Aging respond to the COVID-19 pandemic. *Journal of Aging and Social Policy*, 32(4-5), 432-438. <https://doi.org/10.1080/08959420.2020.1774313>
- World Health Organization. (2007). *Global age-friendly cities: A guide*. https://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf
- Weaver, R. H., & Roberto, K. A. (2019). Effects of long-term services and supports on survival of poor, highly vulnerable older adults. *The Gerontologist*, 59(5), 936-946. <https://doi.org/10.1093/geront/gny040>
- Weaver, R. H., Roberto, K. A., & Blieszner, R. (2018). Older adults in rural Appalachia: Preference and expectations for future care. *The International Journal of Aging and Human Development*, 86(4), 364-381. <https://doi.org/10.1177/0091415017720891>
- Weaver, R. H., Bolkan, C., Robbins, S. L., Benton, B., Kim, E., Ensey, M., & Kelly, D. (2021). Caring beyond healthcare: Lessons learned from a community-based partnership to reduce hospital readmission among high-risk adults. *Journal of Community Engagement and Scholarship*, 14(1), pp. 1-15.
- Wong, S. T., & Regan, S. (2009). Patient perspectives on primary health care in rural communities: effects of geography on access, continuity and efficiency. *Rural and Remote Health*, 9(1), Article 1142. <https://doi.org/10.22605/RRH1142>
- World Health Organization. (2015). *World Report on Ageing and Health*. <https://apps.who.int/iris/handle/10665/186463>
- Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. (2012). The meaning of “aging in place” to older people. *The Gerontologist*, 52(3), 357-366. <https://doi.org/10.1093/geront/gnr098>

Anchored Yet Displaced: Affordable Housing and Aging in a Gentrifying Place

Brian N. Sweeney, Ph.D.

Long Island University

Brian.Sweeney@liu.edu

ABSTRACT

In an era of urban gentrification and rising economic inequality, how can policies better address the needs of older city residents who wish to age in place? Drawing on qualitative data from in-depth interviews and participant observation, as well as US census data from 2010 to 2020, this study explores the perceptions and experiences of older adult residents of two affordable housing complexes in the Manhattan borough of New York City. These residents have aged in place while their surrounding community has grown wealthier and, in some respects, younger. While benefiting from housing security and numerous on-site services targeting the aged-in population, the residents nonetheless experience feelings of alienation and estrangement as their surrounding community undergoes physical, social, and cultural changes. This paper theorizes aging in place as an ongoing process of social integration and meaning making to explore issues of identity, housing, and community and to consider how policy can better address the needs of older adults aging within rapidly gentrifying urban contexts.

Keywords: Aging, Aging in Place, Gentrification, Displacement

Anclados pero desplazados: vivienda asequible y envejecimiento en un lugar en proceso de gentrificación

RESUMEN

En una era de gentrificación urbana y creciente desigualdad económica, ¿cómo pueden las políticas abordar mejor las necesidades de los residentes mayores de la ciudad que desean envejecer en el lugar? Basándose en datos cualitativos de entrevistas en profundidad y observación participante, así como datos del censo de EE. UU. de 2010 a 2020, este estudio explora las percepciones y experiencias

de los adultos mayores residentes de dos complejos de viviendas asequibles en el distrito de Manhattan de la ciudad de Nueva York. Estos residentes han envejecido en el lugar mientras que la comunidad que los rodea se ha vuelto más rica y, en algunos aspectos, más joven. Si bien se benefician de la seguridad de la vivienda y numerosos servicios en el lugar dirigidos a la población de edad avanzada, los residentes experimentan sentimientos de alienación y extrañamiento a medida que la comunidad que los rodea experimenta cambios físicos, sociales y culturales. Este documento teoriza el envejecimiento en el lugar como un proceso continuo de integración social y creación de significado para explorar cuestiones de identidad, vivienda y comunidad y considerar cómo las políticas pueden abordar mejor las necesidades de los adultos mayores que envejecen dentro de contextos urbanos que se están gentrificando rápidamente.

Palabras clave: Envejecimiento, Envejecimiento en el lugar, Gentrificación, Desplazamiento

安置却又流离失所：绅士化地区的可负担住房与养老

摘要

在城市绅士化和经济不平等加剧的时代，政策如何能更好地满足希望就地养老的老年城市居民的需求？基于从深度访谈和参与者观察中得出的定性数据以及2010至2020年美国人口普查数据，本研究探究了纽约市曼哈顿区两个可负担住房小区的老年居民的感知和经历。这些居民就地养老，同时其周边社区变得更加富有，并且在某些方面变得更为年轻。虽然受益于住房保障和针对老年人口的众多现场服务，但随着周边社区经历物理变化、社会变化和文化变化，老年居民仍然感到被疏远。本文将就地养老理论化为一个持续的社会融合和意义创造的过程，用于探究认同、住房和社区问题，并衡量了政策如何能在迅速绅士化的城市情境中更好地满足老年人的养老需求。

关键词：老龄化，就地养老，绅士化，搬迁

Aging in Place

Defined as “the ability to live in one’s own home and community safely, independently, and comfortably, regardless of age, income, or ability level” (CDC, 2017), “aging in place” is popular concept among policymakers and older adults alike. Under ideal circumstances, remaining in one’s home is associated with myriad benefits related to individual well-being, including higher levels of independence and autonomy, feelings of attachment, security, and belonging, and continued connections to social support (Lawler, 2001). Aging in place typically costs less than retirement communities or nursing homes, making it appealing to both individuals and policymakers (Thorslund & Silverstein, 2009)

In his extensive research on aging and place, Rowles (Rowles, 1983, 1990; Rowles & Ravdal, 2002) has developed the concept of “place attachment,” a bond developed over time that leads to feelings of “insideness” on physical, social, and autobiographical dimensions of place. Our sense of being in place—especially our sense of feeling in the *right* place—is a blend of action (our routine ways of moving and interacting in a space), knowledge (what we intimately know about a place and the meanings we ascribe to it), and emotion (our feelings about a place, positive and negative). Place attachment is self-affirming in conscious and pre-conscious ways. Attachments increase self-esteem and enhance feelings of security and belonging (Wiles et al., 2012). Place attachment may also enhance resilience

in the face of developmental challenges in the later stages of life: “As older adults engage in the process of life review, places that have been ascribed personal meaning help them link life course events together and integrate sense of self in old age” (Rowles, 1983).

Staying in place, however, is not a panacea to the challenges of aging. Age-related changes in individuals may alter their experience of their environment, while changes in the environment may create new challenges for individuals. Research like that of Oswald et al. (2011) has advanced empirical understandings of the person-environment exchange by exploring multiple dimensions of environments (e.g., the physical and social aspects of neighborhoods) and exploring objective and *subjective* experiences of older adults in relation to important developmental outcomes like independence, identity, and well-being.

In a similar vein, Rosenwohl-Mack et al (2020)Embase, PsycINFO, CINAHL, Web of Science, Sociological Abstracts developed a “Dynamic-Tension” model from a meta-analysis of qualitative studies on experiences of aging in place. In this model, “agency” is continuously balanced with “threats” on dimensions of identity, place, and connectedness. Those aging in place seek to maintain a positive sense of self (*identity*) both by continuing valued roles and responsibilities and by successfully altering their mindsets to accommodate changing circumstances. *Place* refers to both homes and the surrounding environs. These spaces have literal aspects

and metaphorical ones, like the comfort of daily routines or fond memories of hosting family gatherings and raising children. *Connectedness* refers to positive social connections, such as regular contact with family, participation in productive activities (whether paid or unpaid), and being integrated into various social circles and community. Importantly, this model recognizes that aging in place can be experienced as a choice enabled by resources (agency) or an imposition because of restrictions (threats).

Those aging in place want control over their circumstances—a sense of agency—especially in large decisions like where to live. On each dimension, the aging individual may find that they are well resourced, leading to positive feelings of agency, belongingness, and attachment. At the same time, there are always potential threats that might undermine agency and lead to feelings of uncertainty, dislocation, and isolation. People and places are always changing, leading to a constantly shifting balance of agency and threats. To date, research has mostly focused on changing individuals rather than changing places.

Gentrification

Gentrification is one of many ways that aging people may find their environments changing. Caused by an influx of wealthier people into an existing urban area, gentrification in the United States often includes demographic shifts toward whiter, more highly educated residents who live in

smaller households (Le Gates, 1986; Lees et al., 2008). Existing residential areas are renovated to maximize rental value or converted from rental to owner-occupied units. Former industrial areas are redeveloped into high-end housing or mixed-use commercial-residential districts (Freeman & Braconi, 2004). Gentrification is often associated with the displacement of existing residents, especially those who are marginalized economically, socially, and politically (Lees et al., 2008; Schlichtman et al., 2018).

Among those at risk of gentrification-induced displacement are older adults. The work of Henig (1981) and Singelakis (1990) have empirically documented the risk of involuntary relocation older adults face because of gentrification. Inner city areas typically have high concentrations of older adults, especially economically vulnerable ones who, if forced to relocate, have limited options for new housing. Older adults typically live on fixed incomes, and compared to their younger peers spend a higher proportion of their income on housing, making forced relocation a particularly serious threat. In addition to examining migration patterns and housing costs, Singelakis (1990) administered a questionnaire in senior centers in a heavily gentrifying area. A striking 65.5% of those surveyed said, if forced to relocate, they did not know where they would go, while 7% said they would be homeless. To date, most research has focused on older adults' risk of displacement, rather than on the outcomes and experiences of older adults who remain in place.

The changes caused by gentrification likely present both challenges and benefits to those who age in place. On one hand, lower crime rates and improved maintenance of property and infrastructure are obvious benefits that would allow older adults greater mobility and increased access to community resources. Rising property values would benefit homeowners, who gain equity. On the other hand, rising costs of goods and services would strain already tight budgets, as would rising rents for non-homeowners. Out-migration would disrupt community ambience, important social connections, and routine neighborly interactions. Other changes are less easily categorized as cost or benefit. New residents bring their own cultural affiliations, worldviews, habits, and preferences (Atkinson, 2015). Established residents could welcome such changes, or find them economically, socially, and culturally marginalizing.

Some studies have explored the costs and benefits to older adults of remaining in a gentrifying place. Smith et al. (2018), for example, examined the effects of gentrification on older adults' self-reported mental and physical health. They found that economically vulnerable adults in gentrifying areas reported better health than those living in low-income areas, but both high income and economically vulnerable older adults in gentrifying areas reported higher rates of anxiety and depression than those in more affluent areas. Overall, the authors conclude, their mixed results point to the importance of more research on older adults and gentrifica-

tion that attends to both individual and community levels.

The voices and experiences of those aging in gentrifying places are seldom included in research. A notable exception is Buffel and Phillipson's (2019) qualitative study of older adults aging in a gentrifying neighborhood of Manchester, England. The study included focus groups and in-depth interviews, and a compelling "peer-research" approach that empowered local older adults to collect the data themselves. Some responding residents expressed unease and a sense of loss at the neighborhood changes, while others showed enthusiastic commitment to the neighborhood in its new state. Some welcomed the changes: new residents brought new ideas, resources, and amenities that benefited everyone, they believed. While the researchers uncovered "exclusionary pressures" experienced by the older adults in the community, they also identified "strategies of control," or small, agentic ways that older residents responded the changes.

In another study highlighting the views and experiences of older adults in a gentrifying Manchester, Lewis and Buffel (2020) challenge the assumption that aging in place leads to increased attachment and feelings of security and belonging. The two neighborhoods they studied over four years were undergoing significant "urban regeneration." One respondent found his changed community "unfamiliar and threatening" (p. 6), especially in the context of his declining health, while another felt dislocated by the physical and social changes around

her home, where she had lived for more than forty years and hoped to stay. Yet another remained quite happy, despite the changes around her and in her own life. Her long-lasting and robust social networks supported her family connections and community involvement, providing a model for the kind of resilience and *reintegration* into place older adults likely need as they age in (changing) places.

People and places are mutually constitutive, as place is a “multi-layered, dynamic, historically and spatially contextualized process that both shapes and is shaped by the lives and experiences of older people” (Andrews et al., 2007, p. 158). In this sense, aging in place is characterized by individuals’ ongoing adaptation, reintegration, and meaning making. Identities, personal and communal, are forged from these interactions of person and environment, of self and society. In this paper I heed the call to highlight the perspectives and experiences of those aging in gentrifying places. Drawing on observation and interview data, I specifically explore the effects of gentrification on residents in two fixed income communities embedded in larger, gentrifying areas of Midtown Manhattan. I employ Rosenwohl-Mack’s Dynamic-Tension model of aging in place to discuss the perpetual balancing of agency and threats in relation to place, connectedness, and identity. How can policy help older adults remain agentic and well-resourced as they age in their chosen, changing communities? From the perspectives and experiences of the residents themselves, what seems to be working, and what is not?

Study Methods, Participants, and Location

The research presented here comes from a larger project on social networks and aging in apartment communities with high numbers of adults 65 years and older. I received Institutional Review Board (IRB) approval to collect ethnographic data in two residential complexes known to have unusually high numbers of long-term residents who had aged in place. I aimed to use a cultural and organizational lens to explore issues of community and connection among these older adult residents. In the original project, I asked: How do social networks and social support facilitate healthy aging? How do older adults get connected and stay connected as they age in place? And what neighborhood and community features might shape social connection in ways that enhance successful aging? Gentrification and the many ways it had shaped the neighborhoods studied emerged as a consistent, dominant theme in the data collected.

In total I conducted over 70 hours of observation in these communities, conducted 36 formal one-to-one interviews, and had many other informal conversations in hallways, on benches, and while walking around outside. I interviewed and observed 18 “primary” study participants (see Table 1 for demographic characteristics of primary participants) and collected detailed data on their social connectedness, participation in social and pro-

ductive activities, their perceived social support, and the ways they understood friendship, family, and aging. Through observation I explored how their day-to-day experiences took shape in relation to their social networks and within their larger residential communities. These primary participants had lived in the community for at least 10 years and as long as 41 years, with an average of 23.5 years. They were on average 75 years old, and about half were college graduates. About six of the participants were poor or working class, based on their employment during their prime working years and based on their financial security in retirement. The remaining 12 were a middle- to upper-middle-class mix of professionals, skilled technicians, and artists/performers.

I assessed the economic status of participants based on self-reported financial stability and on their responses to questions about their retirement savings and reliance on government benefits, namely Social Security and Medicaid. I also analyzed their narratives of aging in place for examples of freedom and constraint. How had they decided to age in place, and to what extent were their choices constrained? If residents indicated they were financially stable, not reliant on Social Security for most of their retirement income, and could afford to live out retirement elsewhere, I categorized them as “economically advantaged” (four participants). If residents reported financial stability, yet this stability relied on either Social Security or the affordable living provided by the community, I categorized them as “economically secure” (eight partic-

ipants). Residents in this category typically indicated that they could afford to retire to places less expensive than New York. Lastly, I categorized as “economically vulnerable” those residents who reported they relied heavily on Social Security and/or Medicaid benefits and could not afford to live elsewhere, either in New York or beyond (six participants). These residents did not perceive viable alternatives to aging in place.

I also interviewed and spent time with “secondary participants,” or individuals who primary participants identified as key sources of companionship and support—integral parts of their social network. These respondents were typically friends of a primary participant, although I also spoke to family members, neighbors, and occasionally community personnel, such as security guards, door persons, and supers. Lastly, I interviewed and observed a range of key community members in both locations, especially those who served as “hubs” of social connection, whether because of formal positions (social workers or directors of service centers) or informal ones (a social doyenne or prominent *bon vivant*).

Both complexes were originally conceived as Midtown Manhattan slum clearance initiatives—urban redevelopment designed to anchor the revitalization of derelict neighborhoods. In the beginning, both complexes existed alongside abandoned industrial spaces, tenement housing, and drug- and sex-related crime. This unsavory and not-so-distant past has been mythologized today, with vestiges of the areas’

industrial grit preserved as fashionable brick facades for multimillion dollar condo buildings, historic architectural details in pricey retail and office space, and the infrastructure undergirding architecturally innovative green spaces. Redevelopment occurred over decades, especially since the 1980s and 1990s, as zoning changes ushered in private market investment capital and while nationwide social trends elevated the status of center-city living. In recent years, demand across the country has grown for walkable neighborhoods with good access to jobs and public transit (Plan, 2021). Violent crime in cities, which peaked nationwide in the late 1980s, has seen a precipitous decline, especially in New York, where the homicide rate fell by 75% in the years from 1990 to 2000 (Thompson, 2021). Safer and more desirable, the neighborhoods studied here saw an influx of new residents and sharply rising rents. New residential construction has targeted higher income professionals, and apartments formerly designated affordable housing have been released, once vacant, from the rent-regulated market, causing out-migration of many low- to middle-income residents.

“Complex A” (see Table 2) is a federally subsidized, rent-regulated (Section 8) complex originally built with city, state, and federal funds. The majority of units are restricted by income, with the remainder allocated to the elderly and to residents of the local neighborhood. “Complex B” is a moderate income, limited equity housing cooperative that, through numerous state and city subsidies and decades of renewed

tax abatements, provides affordable housing for its low to middle income shareholder-residents. Apartments are bought and sold within a regulated system, limiting equity and ensuring long-term affordability for future owners. As strategies of urban renewal, both complexes have achieved their original goals of providing affordable housing while anchoring the regeneration of derelict districts. Many residents have aged in place. Complex B has official NORC (Naturally Occurring Retirement Community) status, though both meet the threshold of having more than 45% of heads of household over 60 years old and both complexes now have on-site social services to address the needs of the high number of older adult residents.

The data presented in Table 2 is based on the Census Bureau’s 2020 Decennial Census and the 2020 American Community Survey (U.S. Census Bureau, 2022). While the two complexes are both in Midtown Manhattan, they are located in distinct census tracts and neighborhoods. I therefore provide data on each complex’s surrounding neighborhood. Because some demographic information on residents of these complexes is not publicly available (household income, for example), I rely on Census data at its most granular level—city blocks—allowing a workable approximation of this information for both complexes. A quick glance reveals significant differences between the complexes and the areas surrounding them. For example, both complexes have two to three times the number of adults aged 65 and over. Median house-

hold incomes in both complexes are less than half that of the surrounding area, likely a reflection of the higher number of retirees and the income-restrictions imposed on residents. The proportion of residents who identify as white is 5-10% higher in the complexes than in the surrounding areas, while the complexes have significantly smaller proportions of residents who identify as Asian. The neighborhoods around each complex have median household incomes \$10,000 and \$22,000 higher than the Manhattan average.

While both neighborhoods have undergone thorough gentrification, more recent years have seen wealth continue to grow. According to the Urban Displacement Project (2021), a research and action group that aims to understand gentrification and displacement, both residential complexes studied are embedded in larger communities characterized by “advanced gentrification,” where a “massive outflux” of the low-income population has coincided with an influx of middle- and high-income residents. Drawing on Census Bureau data from the Decennial Census (1990, 2000, and 2010) and the Census Bureau’s American Community Survey (2012-2016), the UDP’s analyses show significant increases in average household income and rising numbers of residents with college degrees. While these areas had rent increases in the 1990s at or below average for the metropolitan region, more recent years have seen rent increases at double the average. From 2000 to 2016, median rent in these areas doubled, rising from around \$1,000 a month to \$2,000 and above.

All of these residents are, in a sense, gentrifiers themselves, as they live in housing projects that were designed as “slum clearance” in the 1960s and 1970s. The original residents of the complexes, like other *early gentrifiers*, moved into disinvested neighborhoods and formed part of a critical mass of incoming residents that prompted significant social, cultural, economic, and political changes (Schlichtman et al., 2018). In this sense, the perspectives and experiences of contemporary gentrification I highlight below cannot be separated from historical forces and macro-level processes such as deindustrialization, suburbanization, capital mobility, and growing inequality, both nationally and globally (Schlichtman et al., 2018).

I employ Rosenwohl-Mack’s Dynamic-Tension model of aging in place to examine residents’ experiences of gentrification. In the first section below, I outline some of the ways that policies and programs are helping anchor these older adults in their homes and communities, giving them resources on dimensions of place, connectedness, and identity to successfully age in place. I then discuss how the needs of the residents could be better addressed.

Anchored: Perceived Support and Resources for Aging in Place

A majority of the residents in the study had lived in New York City or its suburbs since birth. They had experienced firsthand the restless tides of immigration, cultural

change, and commercial development that continually regenerate the city. Many of their autobiographies of place begin in the 1970s and 1980s, when deindustrialization and out-migration to the suburbs nearly bankrupted the city. The crack cocaine epidemic led to surging crime rates and violent neighborhoods, and the HIV/AIDS epidemic hobbled the vibrant gay community. Affordable housing policies had allowed the respondents to remain in a city that had proved tumultuous and challenging. The respondents overwhelmingly valued their identities as New Yorkers and took pride that they had been long-term residents through some of the city's hardest years, as this 84-year-old male resident of 40 years explains:

When everyone was leaving, we stayed. They thought we were crazy. Everyone moving to New Jersey and my family [to Long Island]. But for a certain kind of person, OK, this is where you wanted to be. In the city, here and in the downtown areas with all the artists and the theater people and even the junkies and street people. That was New York, and it was tough, and we loved it! Living in this building was such a gift for us.

He and others had forged identities in the city, and their memories of bygone places and people added vibrant dimension to their experience of place, illustrating Rowle's (1983) concept of "autobiographical insideness."

Because I was interested in the process of aging in place, I asked residents for the stories of how they came to be in these particular places. Without specifically mentioning gentrification, several residents recounted being young and financially strapped. Their decisions to live in these places were often *monetary*, but also *practical*, as they valued center city living, and *aesthetic*, as they valued the turn-of-the-century, low-rise architecture that gave their neighborhoods character (Schlichtman et al., 2018). Indeed, the somewhat brutalist, modern design of both complexes allowed residents to have it both ways: inside they enjoyed spacious apartments, wide hallways, and working elevators, but outside and mere steps away from busy avenues they could stroll down treelined streets with unbroken rows of well-maintained brick and brownstone buildings. They also enjoyed easy access to cultural amenities, like bars, restaurants, and theaters, and public amenities, like transportation hubs.

The residents drew distinctions, if often implicit, between the gentrification occurring in the past versus now. They did not see their role in past gentrification as problematic, and almost none mentioned those displaced by the construction of their complexes decades ago. (In fact, two respondents stated that the opening of their complexes had enhanced poor residents' housing opportunities.) The longer-term residents described neighborhoods that were once dysfunctional and derelict becoming stable, prosperous, and livable: "Nobody chose to live here back then," an 82-year-

old woman quipped. “This [complex] was the first nice place to live. We were like settlers in the Wild West.”

For many of the residents I spoke with, the stories of “old New York” were part of their identities as aging New Yorkers, and they took pride in the length and endurance of their residency. Without explicitly mentioning gentrification, residents often expressed a distinct pride at having lived through the economic doldrums of 1970s New York, with its drugs, street crime, and litter-strewn subways. They expressed pride at having moved into depressed areas (albeit into nice complexes) when so many had fled to the racially homogenous suburbs. Indeed, at the heart of their identities and sense of being anchored in place was often a distinct cultural authenticity they felt *as New Yorkers*.

Despite enormous neighborhood change, the established social structure of these buildings provided a stability that residents used as a resource, both instrumentally and symbolically. The 82-year-old resident quoted above saw intrinsic value in having a core of residents who remain in place:

Resident: So many of us were here in the neighborhood, before [this complex] was built.

Interviewer: And many of you have lived here since it opened?

Resident: Oh yeah, from beginning to end! There are a lot of us old timers still around, you can see that. It's like they can't get rid of us. And why would they want to? Without us everything

is new, it doesn't have the same meaning.

Especially in contexts of change, residents took pride in having been around for a long time. As this respondent pointed out, she was already middle aged by the time her complex opened, and she had spent nearly two decades working and living in the neighborhood before she moved in. As her quote demonstrates, some residents positioned their longevity as a bulwark against change. New is not always better, this resident implies.

Talking with residents in their homes allowed me to see how personally anchored they were in these spaces and to see how dynamically interrelated physical objects and place are with one's sense of self. The residents connected physical places with valued roles and identities. A 78-year-old resident led me down the hall to her cluttered art studio, where paintings and canvases topped over each other and containers of all forms organized a seemingly endless array of brushes, papers, and crumpled tubes of paint. Another showed me her piano and reminisced about giving lessons to children for many years and, more recently, practicing for a singing performance she was giving as part of a performing arts event for community members. A 77-year-old gay man came to life as he showed me pictures around his apartment: two best friends posing on a neighborhood stoop forty years ago; a large group of friends gathered at a late-night Broadway restaurant after seeing another friend perform in a show; himself, in one picture, pointing

to the sign of a gay bar, a hot spot he frequented in the early 1980s. While these places are gone or significantly changed today, they nonetheless exist as part of his identity, imbuing his sense of place with emotional depth and nostalgic familiarity—a personal and positive *sense of home*.

Affordable housing polices in combination with on-site aging services benefited these older adults in myriad ways, enhancing their feelings of security and stability as they aged in a changing and challenging city. It is difficult to overstate how fortunate the respondents felt to have stable and affordable housing in their retirement years. They, like most older people, were typically on limited, fixed incomes, and had to think carefully about expenses. Budgeting in later life requires complex calculations—predictions about the length of one's life and future health needs, etc.—a math that befuddles even many financial advisors. Certainty about housing alleviated substantial stress. As a 70-year-old male resident explains, it was like a gift:

It's like winning the lottery! It really is. I know I can stay here, for as long as I want, and I can afford it. It's been such a gift, it truly has. And you can see everybody else is the same—we're *all* getting old here.

Indeed, many residents were aging in place at both complexes—with one having 53% of heads of households over 60-years-old and the other with around 70% over 60. Residents repeatedly stat-

ed how lucky they were to live affordably, especially in New York. Regulated, affordable housing protected these older adults from the sharp increases in rent and property values that had come with gentrification. Most were certain they would be priced out of the private rental market in their neighborhoods. As a 72-year-old male resident said, "I've had friends around here for years, and they've had to move—rents go up and up—and move again, and now they're gone, had to move away." "We would all be priced out," a 68-year-old male said, before adding, "We are the working- and middle-class core of this neighborhood. Have you seen the cost of apartments around here?" These residents felt fortunate not to have to worry about the inexorable rise of rent or capricious landlords. They did not have to worry about searching for new, affordable apartments, possibly in unfamiliar neighborhoods or outside the city. They recognized New York as a special yet deeply unaffordable place where they were lucky to live.

Living in apartment buildings also meant these older adults did not have to worry about large houses to clean and upkeep or yards to be maintained, like their suburban peers. Their modest apartments, which ranged from large studios to two-bedrooms, posed few threats to their ability to age in place. As a 20-year female resident said, "It's perfect—just the right size for me. I used to think, wouldn't it be nice to have a yard? But I don't anymore." Repairs were quickly taken care of by competent maintenance workers, further avoiding stress. More than one res-

ident noted how quickly snow and ice were cleared in the winter, something I had noted in my observations and had also confirmed in a discussion with a community leader. Treating slippery sidewalks was of paramount importance, given the high number of older residents in the complex.

Physical ability was on the minds of many residents as they pondered aging in place, and they were overwhelmingly appreciative of initiatives to ensure their buildings were safe, clean, and, unlike so much of New York's physical infrastructure, accessible. Hallways were wide, public areas uncluttered, and the elevators worked. "This is a good place to grow old," a woman told me in a casual conversation outside. "Just look at all of us!" Her point was well taken. On a cloudy and colorless late winter day, the public areas were populated by older adults, many with telltale signs of declining physical ability: uneven gaits, canes and walkers, or home health aides at their sides. The buildings and grounds presented few obstacles, or the types of "environmental press" (Lawton, 1983) that might discourage those with physical limitations from leaving their apartments. While the complexes were built before the passage of the Americans with Disabilities Act in 1990, they had both been updated in many ways with aging residents in mind.

With an aging body and a disability stemming from early childhood, an 83-year-old female resident of over 30 years used an electric wheelchair, but she had few problems navigating her apartment, or the hallway, eleva-

tor, and sidewalks that connected her to the wider neighborhood. She noted, "I could only live so many places, with this [wheelchair], but I have no problems here." While the subway was prohibitively difficult to access, she liked the buses that ran frequently along the avenues, and she found the bus drivers and passengers accommodating and friendly.

Even younger respondents without physical limitations recognized these positive benefits of the physical environment around them. "I'll be able to grow old here, God willing," a 66-year-old man said. "I don't have any problems now, but you don't know, down the road. I'll be thankful I'm here," a woman told me while chatting in a lobby. I heard about these feelings of security many times over, often in conjunction with appreciation for the affordability of living in these two complexes. As one resident explained, "Living in a walkup only works for so long." Indeed, many apartments in the area did not have elevators, and those that did tended to be significantly more expensive to live in.

A government grant in the NORC-designated complex was funding modifications to apartments to help residents age in place. Experts with training in environmental gerontology and occupational therapy conducted audits of older residents' apartments, then worked with maintenance crews and contractors to make modifications. Doorways were widened and easy-open doors installed to accommodate residents and their walkers and wheel-

chairs. Updated hardware was installed on kitchen and bathroom cabinets so that weakened or arthritic hands could operate them more easily. Grab bars and slip-resistant flooring were installed in bathrooms—a common site of falls—and new lighting was comprehensive, consistent, and not glaring. One woman said, “I feel very safe in my home, and that’s something—I’m 86.” Another reported, “My son doesn’t worry about me as much, especially about falling. I thought my home was safe, but it’s now even better. Thank goodness for the men who came and did the work.” Just as minds were put at ease by affordable, predictable housing costs, minds were also put at ease knowing that these complexes could accommodate the future uncertainties of aging bodies.

With so many residents aging in place, social connections had been cultivated over years and even decades. Ethnographic observations allowed me to see these connections firsthand: residents being greeted personally by the host at a local diner, the convivial nature of a regular bridge game, greetings, and brief chats with passersby in hallways or while sitting outside. Residents all knew one another and engaged in the kind of “neighboring” and reciprocal connections that prove to be valuable resources to support health and well-being while aging in place. Residents also knew the staff in their buildings, such as cleaning and maintenance workers, security guards, and doormen. The importance of such connections became especially clear one day when an older resident suffering from dementia went missing. Her alarmed fam-

ily contacted the building staff—not the police—and she was located by a maintenance worker who escorted her back to her apartment. Both complexes had a strong sense of community, of being places where people knew, respected, and helped each other.

The NORC-designated complex had a vast array of programs, activities, and classes aimed at bringing people together and enabling health and well-being on multiple dimensions. With little contact with his family of origin, no children, and few close friends, an 82-year-old man had nearly all of his multidimensional needs—nutritional, medical, psychological, and social—met by the senior services center located on the ground floor of a nearby building. As a kind of “one-stop-shop,” with nearly a dozen social workers who coordinate care for hundreds of seniors, the center connected individuals to each other and to important resources that help promote successful aging and independent living. Indeed, without the center, it is unclear how this resident would survive. Almost all of his network ties went directly through the center in one way or another. Clearly heeding calls for older adults to maintain social connections and engagement, both complexes had services and programs that aimed to foster community and social engagement.

I also heard striking stories of volunteer work and organizing in the larger neighborhood and city. One resident had volunteered for over 20 years at a nearby senior center, serving meals and teaching classes to a diverse group of

seniors whose health and housing were often less stable than his. Another resident, an 87-year-old woman, recollected volunteering at the height of the HIV/AIDS crisis. Thirty years on, her details are vivid, revealing aspects of how her identity have been shaped by connections to the neighborhood and city:

It was a beautiful community, just full of love and creativity. And then ... We all knew someone who was dying. It was once a month, sometimes more, for a while. You'd see men on the street, people from around the neighborhood that you recognize, and you'd see... that they were sick. And then one day, you don't see them anymore. And so, I volunteered and answered calls, just horrible calls, from men, estranged from their families, or not able to reach out to them, who needed help. They needed to see a doctor, they couldn't get in to a doctor, or their doctor wouldn't see them. They needed housing or medicine, or food—just food! It really was a community of people who came together, to help these men, when no others would.

She continued to volunteer until she was physically unable, delivering meals to aged-in residents and helping to plan social events to bring older adults together. Her storytelling reveals the importance of volunteering to her life and the way connectedness grounds person to place.

Displaced: Perceived Threats and Restrictions to Aging in Place

While affordable housing and aging-related services had shielded them from many of the negative aspects of gentrification, in other ways long-term residents were not protected and experienced a diminished sense of control over their circumstances, especially in terms of their identification and engagement with the wider communities around their complexes. They were frustrated by rising costs of goods and services, lack of opportunities for volunteering and work, and the dearth of meaningful intergenerational mixing.

The upscaling of both neighborhoods had left many long-term residents feeling economically and culturally sidelined. After spending considerable time in both areas, it was clear that shops and restaurants increasingly catered to a new set of residents and visitors: “Everything is for young people, with money, and tourists!” one resident said. Both neighborhoods featured lively restaurant and bar scenes, with many of these places new and ostensibly upmarket. Affluent consumers had copious choices among specialty shops, bakeries, and a full range of fitness studios and gyms. Apartments and condominiums were aggressively marketed on the sides of bus stops and buildings as “luxe,” “luxury,” “modern,” and “premier.” A typical advertisement boasted of a “boutique collection of residences” with “hotel-inspired ame-

nities” like concierge service, fitness center, outdoor terraces, and lounges for work and study. An accompanying picture showed a stylishly designed and spacious apartment, lit by a wall of windows, while another showed a large outdoor terrace decorated with chunky cushioned outdoor furniture and potted trees.

Changes in the availability and cost of food undermined feelings of control and well-being among residents. Daily groceries, especially, came up repeatedly in interviews, which is unsurprising given that acquiring food is one of the most important and regular tasks of life. The comments by a 77-year-old resident were typical:

The grocery store just gets more expensive. And they’ve changed the store. It’s more expensive now and they changed the layout, and you can see that different people shop there now. They redesigned that whole section with the fruits and vegetables and the cheeses, with more expensive items, and only so they could charge more for everything. And they stopped selling a lot of the brands I used to buy, like my bread and my frozen food, so I have to go somewhere else.

The more technologically savvy residents had begun shopping online, alleviating some of the stress of acquiring basic goods and familiar brands. Most of the older, long-term residents I encountered, however, relied on more traditional methods: rolling carts or

wheeled bags, phone orders for grocery delivery (provided by one store in each neighborhood, for a fee), or the help of friends and neighbors. They wondered why the food was so expensive, and they wondered why the city could not do more to ensure a wider range of options.

Food is a window into the residents’ anxieties about economic and cultural dislocation. Beyond a necessity, food is imbued with social and cultural significance. Our food beliefs and practices connect us to others and can be a touchstone for cultural identity. Any disruption in one’s food routines—stores or restaurants closing, changes in stock and layout, rising prices—can undermine one’s sense control and threaten valued parts of identity, as seen in this quote from a 76-year-old woman who had lived in her complex for nearly 40 years:

Everything in the neighborhood has changed, and a lot of it’s good. But you look around at the shops, and they’re not for daily life, are they? They’re for eating out, or buying expensive gifts, or going to bars—all the new bars! Every other store is a bar or a restaurant. It feels like it’s not my neighborhood anymore. It’s like normal people, people like us don’t live here anymore.

Her sentiments relate to both economic strain and a sense of cultural dislocation. The place she had called home for so many years had changed considerably, diminishing her sense of familiarity and continuity but also, in more

complicated ways, undermining her sense of belonging and connectedness.

The revived economy of the broader area of midtown Manhattan had also increased the number of pedestrians and vehicles, not to mention bikes and pedicabs—all hazards that could potentially undermine older residents' feelings and security and efficacy outside of their buildings. While one complex is located in a more congested area, both are located amidst busy avenue thoroughfares, and residents spoke regularly of traffic safety concerns. These dangers were immediately clear whenever I walked with residents outside. Foot traffic on sidewalks moved fast, especially on the avenues during busy morning and evening hours when a frenetic, purposeful pace seemed standard. Walking uptown a few blocks with an 82-year-old man during the evening rush, I grew steadily more aware of our slow pace and the wide space we occupied walking side to side. Foot traffic streamed in both directions, with impatient pedestrians leaping around us. In just a few blocks we dodged sidewalk café tables, open cellar doors accepting food deliveries, and tourists stopping to read menus. While cross walks provided enough time even for slow walkers like us, backed up traffic and pushy drivers edging into their turns made crossing feel decidedly perilous. Impatient pedestrians surged forward against crosswalks, whenever there was a gap in traffic. In many places sidewalks were crumbling, had chunks missing, or were uneven. Adding to the chaos was the noise—a cacophony of car horns, sirens, and engines. "You

venture out at your own risk!" one resident warned. Another asked, "How do more people not die?" A 92-year-old woman who walked sturdily yet slowly with a cane complained that "People are very impatient. And I don't mean to age stereotype, because that goes both ways, but young people are very impatient on the sidewalks. It's unnecessary, and it's dangerous!"

A common topic of conversation among of long-term residents was a lack of community engagement *outside* of their housing complexes. Somewhat paradoxically, the NORC-designated complex had been so successful in creating community *within*, that some older residents worried about becoming further disconnected from the wider community, especially after its significant demographic and cultural changes. One resident noted that the complex was a vibrant and wonderful place to live, yet: "We are like an island here at [the complex]. So many of our needs are taken care of, quite nicely I might add. But there is an element of ... isolation, of a kind. I don't think that's inevitable as we age." Another quipped, "We're at risk of becoming an old folks' home! We get older and they get younger." Residents I spoke with wanted more engagement with the community around them, even if it was getting younger.

Remarkably, an entirely new neighborhood called Hudson Yards was being constructed at the time of the study on the far west side of Manhattan, adjacent to the ones profiled here. Built partially on top of working railyards, this new neighborhood of

gleaming glass towers and “luxé” residences also included vast amounts of space for corporate offices and a 7-story, 750,000 square foot retail mall (described in promotional material as “luxury shopping”). The new towers, some among the highest in the city, loomed over the view from a 75-year-old resident’s apartment. “It’s like something out of Dubai,” she said gloomily. It was startling to peer out her window and imagine that just three years earlier, none of these towers had existed and that an entirely neighborhood could be constructed from nothing. “Who lives there?” she asked. “I wonder, what do they do? Where do they come from? It’s a lot of [pause] not knowing.” I probed her to further articulate her discomfort, and she explained that she worried her complex, with so many older, long-term New Yorkers on fixed incomes, was becoming a “community island” disconnected to the area outside, economically and otherwise. Her sense that city planners had failed to take into account the needs and experiences of older residents was echoed by others: “What’s it got to do with us? Nothing!” one man said. Another resident, a 70-year-old community government representative, lamented the lack of power older city residents had in planning:

Development is not undertaken with our needs in mind. What will we do with a new mall, or more luxury condominiums? We are fortunate to get help from the city, to fund services and programs, but we want to be a part of things outside. We want to thrive and work and volunteer, and so

on—contribute to our communities and be productive.

These types of sentiments reflect the varied and complicated ways that gentrification was constantly affecting the balance of agency to threats in the process of aging in place.

It seemed unlikely that long-term residents of both complexes would have many social ties to those working and living in the new neighborhood. While most had experienced negative disruptions to their social networks as friends were forced to move by rising rents, such disruptions had been gradual, over a span of decades as gentrification incrementally brought in more wealth and drove population shifts. The new neighborhood marked alarming and rapid changes unlike those before, epitomizing an outside world that increasingly seemed literally and symbolically disconnected from residents’ lives.

Discussion and Conclusion

With the population of older adults rising nearly the world over, aging in place has garnered a large amount of attention as a strategy for promoting successful aging and saving costs, especially compared to institutional settings. For individuals, aging in place may enable them to maintain independence, perhaps in a cherished home, while also staying connected to friends, family, and community. Yet the research presented here and elsewhere shows the need for a critical and informed perspective on aging in place. First, some

older adults may not experience aging in place as a choice, but rather as an outcome of constraint and lack of viable alternatives. Second, places, as well as individuals, change over time. The “Dynamic Tension” model utilized here captures aging in place as an active, dynamic process that depends on the right balance of agency to threats on dimensions of place, connectedness, and identity (Rosenwohl-Mack et al., 2020).

Gentrifying neighborhoods highlight the need to account for change when designing policies to support those aging in place. Undoubtedly, gentrification brought benefits to these neighborhoods, especially in terms of safety, cleanliness, and overall status and appeal. And yet there were downsides for long-term, fixed-income residents. In addition to housing, costs had increased significantly. Affordable groceries and household goods were harder to get, and construction, traffic, and other hazards presented obstacles to navigating neighborhood streets and sidewalks. Moreover, demographic shifts and new development left these residents feeling economically and culturally isolated.

Affordable housing was hugely beneficial to these older adults as they aged in place. Having solved the problem of housing gave them a sense of control and accomplishment that is difficult to overstate. They enjoyed the privacy and familiarity of their homes and desired to continue living in them. Remaining in place also made practical sense, as their housing was safe and affordable and proved amenable to

age-related declines in health. An array of aging services affirmed residents’ identities as older adults and provided them with resources to stave off threats to their ability to connect with others, to maintain valued roles and activities, and to simply stay put in the homes they knew and loved.

As proud, long-term New Yorkers, they took pleasure in their housing. While the city changed around them and presented ongoing challenges to residents of all ages, they were firmly anchored in their homes and able to “make it” in a challenging city. The nature of the two complexes seemed to buffet the residents against the rapid changes in the surrounding neighborhoods, giving them a sense of stability and security, especially in the face of gentrification and steeply rising costs of living for most city-dwellers. They were so deeply anchored in their buildings, communities, and the larger myth of New York, it was hard for them to imagine living elsewhere, even as they imagined changes ahead as they aged. Being so firmly anchored, especially by affordable housing policies and on-site aging services, enhanced their feelings of security, stability, and independence, arguably making them more resilient in the face of change.

At the same time, their feelings of dislocation and estrangement related to gentrification reveal the costs of aging-in-place programs and services that fail to recognize neighborhoods and communities as crucial to healthy aging and independent living. As one resident quoted above complained, she

did not know where she lived anymore. The neighborhood was becoming unrecognizable because of the economic, social, and cultural changes spurred by gentrification. While thankful for her “community island” that sustained her, she increasingly felt like a tourist—curiously observant yet detached—when she ventured out. Her sense of “not knowing” who the people were around her left her feeling sad and displaced.

New development, especially the proliferation of multimillion dollar residences, had come to symbolize for the residents troubling aspects of New York City in the 21st century: extreme economic inequality, the outsize power of private investment in city planning, and the threat to local community posed by generic chains and seemingly unbridled luxury residential development. While the new neighborhood bills itself as “the cultural center of Manhattan’s new West Side” and as a “template for the future of cities” (*Live, Shop, Work & Dine in New York | Hudson Yards*, 2021), it was hard to imagine a commercial and residential development less relevant to the needs of the older adults I spent time with. This irony was all the greater given the development’s proximity and massive scale.

Residents’ concerns about economic and cultural dislocation raised important questions about gentrification and the needs of the aging in place population: besides affordable housing, what other policies could promote older residents’ well-being in the face of these changes? How would the city’s approach to redevelopment look differ-

ently if the needs of older residents were truly prioritized? And how could policy promote integration across age lines and better connect older adults to their communities?

The UN’s Plan of Action on Aging (*Madrid International Plan of Action on Aging*, 2002) provides guidance on how these questions might be answered. Perhaps most importantly, the plan of action calls on governments to support age-integration in communities. Truly supporting multigenerational, multicultural communities requires intentional and sustained investment in local infrastructure. While the goal of multigenerational communities is laudable in and of itself, there are clear benefits in terms of more equitable access to important resources such as food, healthcare, housing, and employment and the myriad benefits to self and society that come from keeping older adults active, engaged, and healthy.

Naturally Occurring Retirement Communities present an intrinsic conundrum apparent in the perspectives of the residents profiled here: the same high concentration of older adults that allows for the efficient provision of age-related services also promotes the age segregation many lamented. NORCs have earned their central role in efforts to promote successful aging in place, but we would be wise to include efforts to promote age-integration—both within and beyond these communities. Programs to keep residents active, engaged, and healthy do not need to be age restricted—at least not all of them. A fruitful area of research

could investigate which programs are most effective when age-restricted and how, more generally, to balance specific objectives for serving the aging population with the goal of age-integration.

There are useful models already in existence for the types of housing policies that could promote age-integrated communities. Large residential developments in cities like New York are often required to provide affordable housing for low-to middle income residents. Tax abatements and other incentives could similarly be tied to the provision of a certain number of units for older residents. Conversely, NORC's could intentionally recruit younger residents to balance out the population. Analyses of age structures at the community level could guide policy makers as they implement age-integration policies.

Local government could also be more aggressive in ensuring access to affordable food and other basic necessities. Strategic partnerships and zoning policies could ensure that the retail landscape in a neighborhood addresses the needs of all residents, especially those aging in place. Input from aging community members could be formally mandated to ensure their voices are heard in important decisions related to such zoning and redevelopment. New York City's FRESH Program (Food Retail Expansion to Support Health) has shown success in addressing the "food deserts" often found in economically distressed communities and could serve as a model for how tax incentives,

re-zoning, and streamlined government access for key businesses could make communities more retail-friendly for older residents (*Healthy Food Access*, 2022).

Government agencies and non-governmental organizations could sponsor intergenerational activities in neighborhoods, and could also create programs aimed at fostering opportunities for older residents to work or volunteer. In conjunction with campaigns to raise awareness of older adults' value and productivity, such programs could meaningfully address the feelings of disconnection and lack of purpose many residents in this study felt, especially in the areas outside their complexes.

For the older adults in this study, housing policies have made aging in place appealingly affordable, even amidst a rising economic tide of gentrification engulfing their larger community. From their perspectives, affordable housing policies have gifted them with security as they advance in age, have helped to cultivate an immediate environment enriched by social ties and opportunities for engagement, and have also enabled the efficient provision of many services typical of ("naturally occurring") retirement communities. At the same time, zoning changes and an infusion of private market investment capital have combined with "back to the city" social trends to elevate the status of center city living and to dramatically gentrify their larger community. Residents are left feeling anchored yet simultaneously displaced.

References

- Andrews, G. J., Cutchin, M., McCracken, K., Phillips, D. R., & Wiles, J. (2007). Geographical Gerontology: The constitution of a discipline. *Social Science & Medicine*, 65(1), 151–168. <https://doi.org/10.1016/j.socscimed.2007.02.047>
- Atkinson, R. (2015). Losing One's Place: Narratives of Neighbourhood Change, Market Injustice and Symbolic Displacement. *Housing, Theory and Society*, 32(4), 373–388. <https://doi.org/10.1080/14036096.2015.1053980>
- Buffel, T., & Phillipson, C. (2019). Ageing in a Gentrifying Neighbourhood: Experiences of Community Change in Later Life. *Sociology*, 53(6), 987–1004. <https://doi.org/10.1177/0038038519836848>
- CDC. (2017, June 8). CDC - Healthy Places—Healthy Aging and the Built Environment. <https://www.cdc.gov/healthyplaces/healthtopics/healthyaging.htm>
- Freeman, L., & Braconi, F. (2004). Gentrification and Displacement in New York City in the 1990s. *Journal of the American Planning Association*, 70(1), 39–52.
- Healthy Food Access. (2022, March 6). Healthy Food Access. <https://www.healthyfoodaccess.org/new-york>
- Henig, J. (1981). Gentrification and Displacement of the Elderly: An Empirical Analysis. *The Gerontologist*, 21(1), 68–75.
- Lawler, K. (2001). *Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population*. Harvard University.
- Lawton, M. P. (1983). Environmental and Other Determinants of Well-Being in Older People. *The Gerontologist*, 23, 349–357.
- Le Gates, R. (1986). The Anatomy of Displacement in the United States. In N. Smith & P. Williams (Eds.), *Gentrification of the City* (pp. 178–200). Unwin Hyman.
- Lees, L., Slater, T., & Wyly, E. (2008). *Gentrification*. Routledge.
- Lewis, C., & Buffel, T. (2020). Aging in place and the places of aging: A longitudinal study. *Journal of Aging Studies*, 54, 100870. <https://doi.org/10.1016/j.jaging.2020.100870>
- Live, Shop, Work & Dine in New York | Hudson Yards. (2021, November 21). <https://www.hudsonyardsnewyork.com/>
- Madrid International Plan of Action on Aging. (2002). UN: Second World Assembly on Ageing.

- Oswald, F., Jopp, D., Rott, C., & Wahl, H.-W. (2011). Is Aging in Place a Resource for or Risk to Life Satisfaction? *The Gerontologist*, 51(2), 238–250.
- Plan, T. F. R. (2021, September 26). *Pushed Out: Housing Displacement in an...* (<http://fourthplan.org/>) [Text/html]. The Fourth Regional Plan; The Fourth Regional Plan. <http://fourthplan.org/reports/pushed-out-housing-displacement-in-an-unaffordable-region>
- Rosenwohl-Mack, A., Schumacher, K., Fang, M.-L., & Fukuoka, Y. (2020). A new conceptual model of experiences of aging in place in the United States: Results of a systematic review and meta-ethnography of qualitative studies. *International Journal of Nursing Studies*, 103, 1–21.
- Rowles, G. D. (1983). Place and Personal identity in Old Age: Observations from Appalachia. *Journal of Environmental Psychology*, 3(4), 299–313.
- Rowles, G. D. (1990). Place Attachment among the Small Town Elderly. *Journal of Rural Community Psychology*, 11, 103–120.
- Rowles, G. D., & Ravdal, H. (2002). Aging, Place, and Meaning in the Face of Changing Circumstances. In R. S. Weiss & S. A. Bass (Eds.), *Challenges in the Third Age* (pp. 81–114). Oxford.
- Schlichtman, J. J., Patch, J., Lamont Hill, M., & Marcuse. (2018). *Gentrifier*. University of Toronto Press, Scholarly Publishing Division.
- Singelakis, A. T. (1990). Real Estate Market Trends and the Displacement of the Aged: Examination of the Linkages in Manhattan. *The Gerontologist*, 30(5), 658–666.
- Smith, R. J., Lehning, A. J., & Kim, K. (2018). Aging in Place in Gentrifying Neighborhoods: Implications for Physical and Mental Health. *The Gerontologist*, 58(1), 26–35.
- Thompson, D. (2021, May 24). Why America's Great Crime Decline is Over. *The Atlantic*.
- Thorslund, M., & Silverstein, M. (2009). Care for Older Adults in the Welfare State: Theories, Policies, and Realities. In V. L. Bengtson, D. Gans, N. M. Putney, & M. Silverstein (Eds.), *Handbook of Theories of Aging* (2nd ed., pp. 629–640). Springer Publishing Company.
- Urban Displacement Project*. (2021, November 21). Urban Displacement. <https://www.urbandisplacement.org/>
- U.S. Census Bureau. (2022, March 4). *Decennial Census and American Community Survey (ACS)*. Census.Gov. <https://www.census.gov/programs-surveys/decennial-census/about/census-acs.html>

Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. S. (2012). The meaning of “aging in place” to older people. *The Gerontologist*, 52(3), 357–366. <https://doi.org/10.1093/geront/gnr098>

APPENDIX A: Table 1

Table 1: Characteristics of Primary Participants	
Median Age	74.5
Sex	
Male	5
Female	13
Race/Ethnicity	
Hispanic	3
White	11
Black	2
Asian	1
Mixed	0
Other	1
Education Level	
>HS ¹	1
HS ²	5
HS+ ³	3
College ⁴	9
Primary Occupation ⁵	
Professional/Technical	12
Manual/Service	6
Economic Security	
Advantaged	4
Secure	8
Vulnerable	6
Mean Length of Residence	23.5 Years

¹Did not finish high school; ²High school graduate; ³Some study or degree post high school;

⁴College graduate (BA or higher); ⁵Primary employment before retirement

APPENDIX B: Table 2

Table 2: Characteristics of Complexes and Neighborhoods					
	Complex A	Neigh. A	Complex B	Neigh. B	Manhattan
Age					
Senior ¹	27.60%	8.85%	39.35%	14%	14.4%
Older Adult ²	53.70%	36.20%	31.70%	34.8%	30.8%
Young Adult ³	5.20%	45.60%	16.80%	38.3%	35.4%
College ⁴	2.67%	3.35%	3.84%	3.1%	4.72%
Child ⁵	10.80%	6.02%	6.735%	9.81%	14.6%
Median Income⁶	\$31,600	\$85,500	\$45,750	\$98,100	\$75,500
Race/Ethnicity					
<i>Hispanic</i>	16.80%	18.40%	18.60%	17.20%	23.80%
<i>White</i>	63.50%	49.50%	60.40%	55.70%	46.80%
<i>Black</i>	5.90%	7.00%	7.20%	6.90%	11.80%
<i>Asian</i>	8.40%	20.20%	8.20%	15.00%	13.00%
<i>Mixed</i>	4.40%	4.00%	4.00%	4.10%	3.70%
<i>Other</i>	1.00%	.90%	1.60%	1.10%	1.00%

¹65+; ²40-64; ³22-39; ⁴18-21; ⁵0-17; ⁶2020, Household

