One of the most important choices seniors face as they retire is where and how they are going to spend their retirement years. Some will choose to age in the home that they have lived in most of their life. Many who can afford it will choose to join a continuing care retirement community (CCRC) that offers a full range of housing choices, onsite health services and facilities, and a life-care contract. Others will choose one of the varieties of alternatives that are developing nationwide, including congregate living, co-housing, shared housing, senior retirement communities, and multilevel communities. Or they may simply downsize to a smaller home or condominium that they believe is more “senior friendly.”

For many seniors, the desire to maintain the lifestyle and independence that they have enjoyed for years is of crucial importance. Most have worked hard in their early years to attain home ownership, and that has been fundamental to their sense of independence and control over their own lives. Among North Carolina householders aged 65 and over, 81.7% own their own home (with or without mortgages).1 Many, though, realize that living independently will become increasingly difficult as they age, and this realization has motivated the search for support systems.

Three different types of support systems have developed across the country to meet the special needs of seniors who choose to live independently in their own homes: (1) the “Beacon Hill” or village model; (2) naturally occurring retirement communities; and, more recently, (3) university-based retirement communities. The Beacon Hill models (discussed at more length in the sidebar of this article) generally center around a small professional staff assisted by volunteers in order to provide assessment of member needs, careful referral to vetted providers ranging from housekeeping to specialized home health care services, continual monitoring and quality control of services provided, and vitally important social networking and volunteer opportunities to help seniors living independently avoid social isolation. Naturally occurring retirement communities tend to be volunteer-oriented programs that focus on neighbor-to-neighbor support building from informal networking at the start to provision of extensive volunteer services to seniors as they age. University-based retirement communities are of two varieties: (1) those that are essentially CCRCs that include health services and life-care contracts, and (2) those that are structured more like the Beacon Hill model, but with links to a specific university or college. A recent article by AARP specifies four criteria for a comprehensive university-based retirement community: “A location that is accessible to the school (within one mile of the university, preferably), formalized programming incorporating the school and community, a full program of continuing care from independent to assisted living, and a documented financial relationship between the university and the senior housing provider.”2

All three of these approaches include several important challenges that must be addressed in order to make a positive contribution to their members and the community at large:

- to carefully assess the needs of members upon enrollment to assure that they can live safely in their own homes;
- to assure that the program complements, but does not compete with, existing services in the community;
- to be unbiased in selection and continual review of service providers;

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For many seniors, the desire to maintain the lifestyle and independence that they have enjoyed for years is of crucial importance.
to safeguard the privacy of member information, yet ensure its timely availability to providers;
- to integrate and collaborate with existing neighborhood social networks and support systems;
- to incorporate systems and procedures to continually monitor the health and safety of members; and
- to collaborate with available community resources to build a counseling and referral “safety net” for those members who are caught in the downward spiral of failing health and decreasing resources, and for applicants whose health needs or resources are beyond the point that they could be safely and successfully supported by the program.

An Approach in Chapel Hill

During the past four months the authors have worked on designing a program they believe responds to the unique needs and resources in the Chapel Hill, North Carolina area. This community, one of the most resource rich communities in North Carolina, will experience a significant increase in the number of seniors aged 65 and over in the coming decades. This is due to local, natural demographic changes, as well as a disproportionate in-migration of seniors who continue to choose the Chapel Hill area as their “ideal” retirement community. According to a profile prepared by North Carolina Department of Health and Human Services, the number of North Carolinians aged 65 and over will increase from 969,048 in the year 2000 to 2,194,126 in 2029—a 126% increase.1 The population increase in persons age 65 and over in Orange County, where Chapel Hill is located, is projected to be between 150%-200%.2 North Carolina as a whole, according to the US Census Bureau, was ranked fourth nationally in population growth between April 2000 and July 2003, behind only California, Texas, and Florida.3 The impact of this growth and these numbers on existing facilities, such as CCRCs and other retirement-oriented neighborhoods, as well as on existing resources and services will be impressive.

The purpose of the Chapel Hill project will be to provide guidance and support to senior citizens and others who choose to stay at home as they face the complex array of health, personal, social, and home services that will become increasingly necessary as they age. This will be a nonprofit organization financed by annual subscription fees, contributions, and grant support. The organization, its staff, and volunteers will have no interest, financial or otherwise, in a member selecting a service nor will any of the above solicit or accept any payment or other benefits from any provider group as a result of a referral.

The organization will work to achieve the following goals with financing from contributions and grant support, along with minimum staff and extensive volunteer effort:

- Provide a systematic way for subscribers to provide feedback about the effectiveness of services and how the organization can more effectively meet their needs and improve over time in order to improve the continual effectiveness, relevance, and subscriber satisfaction with organizational services.

Exploration of Community Interests

During February of 2010, a series of small focus groups was held involving potential enrollees, health and social work professionals, and community leaders in order to more clearly identify the nature and extent of need and probable interest in such a program. The results, particularly the substantive comments and suggestions, reinforced community interest in the program and helped focus on specific action priorities. Among these priorities are: close coordination with existing services and neighborhood efforts; transportation; translation services; improved hospital discharge planning; building close ties with primary health care providers and coordination; provision of a social support network; and “multi-generational involvement” in volunteer efforts and recruiting.

Program Focus

The program will be built upon a base of the following four essential functions: social networking, assessment of needs and interests, referral to qualified providers, and monitoring and follow-up of referrals.

Social Networking

The demographic nature of the Chapel Hill area, with neighborhood clusters spread out geographically within and
Beacon Hill Village

Beacon Hill Village (BHV), created in Boston in 2002, was established to enable senior residents to continue living independently in the community. This nonprofit, member-directed program offers a wide range of services through a “one phone call” concierge service. The program aims to address any member need through referral to a vast resource base of screened service providers, a core professional staff, and specially trained volunteers.

Members are encouraged to call for any reason, and BHV offers a wide range of services and social activities such as household repair, personalized transportation, in-home health care, and organized trips to the theater or to educational lectures. In its eight years of operation, BHV has grown to almost 500 members, ages 50 to 98, with current annual dues of $600 per individual and $890 per family. It also offers a Member Plus Option to subsidize lower income members, and its budget is supplemented by private donations and grants.

The success of BHV has tapped a surge of interest nationally, establishing a model which to date has spawned the creation of villages in 50 other communities across the United States. In January 2010, these villages, with the sponsorship of BHV and NCB Capital Impact, formed the Village to Village (VTV) Network (http://vtvnetwork.clubexpress.com). This developing network aims to provide shared resources on village business operations, strategic planning, coordinated web services for the Network, websites for individual villages, and technical assistance in the formation of new villages.

outside the center of town (much like many North Carolina towns), will require a “village network” consisting of a collaboration between neighborhoods, each with its own volunteer base and door to door communication links with local residents. This network will be core to assuring social connectedness among members, locally-oriented volunteer assistance with transportation, daily check-in with the frail elderly, improved participation in community social and educational activities, and, of key importance, maintaining program-wide integration of services within the community as a whole. As in other such networks across the country, these efforts will be augmented by a website that provides secure access by members to information on program services, activities, community resources, and discussion groups.

Assessment of Needs and Interests

Subscriber service needs will be identified by an initial subscription questionnaire and interview. Individual and household needs will be carefully tracked and revised as subscribers use the organization’s service and through follow-up phone calls, periodic surveys, and other information gained in routine contact by organizational staff and volunteers.

Referral to Qualified Providers

Organizational staff and volunteers will provide subscribers with specific recommendations and supporting information on approved providers that meet specific needs, as indicated during assessment and upon direct request. This service will be comprehensive in scope with particular emphasis on health care, social contacts and events, home maintenance, tasks of daily living, and transportation. All providers recommended by the organization will be initially screened and vetted for quality, security, and pricing practices.

Monitoring and Follow-up of Referrals

The organization will negotiate advantageous terms where possible and continually monitor the performance of provider organizations in meeting subscriber needs and in regard to any changes in staffing patterns, costs, and security measures. It will also follow-up with subscribers to solicit their opinion of the services provided and to identify any future needs for service or support.

Special Relevance to Provision of Health Services

The complexity of health services, combined with the increasing needs of the elderly and their decreasing cognitive abilities and confidence, make access and efficient utilization of medical care particularly difficult and the value of a program such as this promising. Among the services routinely provided by similar programs across the country are continual monitoring of member health status and needs, providing transportation and companions to medical visits, assuring compliance in following instructions and medications, communication with younger family members in needs assessment and care planning, coordination of discharge procedures and instructions, and a variety of health education and support groups.

Conclusions

Aside from the incentive of seeing other similar programs develop and succeed across the country, this effort is in line with a recommendation in the 2007-2011 Aging Services Plan developed by the North Carolina Division of Aging and Adult Services that reinforces an earlier recommendation to encourage “North Carolina’s communities toward becoming more senior-friendly as well as livable for all people through collaboration among citizens, agencies, organizations, and programs, in both the public and private arenas.”

As in other communities in North Carolina, there are three general levels of need within the Chapel Hill community: those who have the financial resources and income to choose to enroll in one of the local CCRCs or live independently; those in a large middle-income group—some who could afford the CCRC option, some not; and a significant number who live at or near the poverty level. Although the initial focus of the Chapel Hill program will be on the middle- and upper-income
groups who choose to live independently, explorations have already begun and will receive continuing priority to improve the safety net for members and a referral resource for those who fall in the lower-income categories. The national Program of All-Inclusive Care for the Elderly (PACE) offers one alternative in this regard and its effectiveness is already being demonstrated in a nearby county.6

Given the dramatic growth in those over age 65 expected in North Carolina over the next decades and the precedent of village programs, naturally occurring retirement communities, and university-based retirement communities across the country, it is very likely that physicians and other health workers will see similar developments in their own communities. We would urge health care professionals and others with interests in the needs of the elderly to get involved as these programs develop and work to ensure that they focus on improving awareness, coordination among existing programs, and efficient use of existing health resources. One senior physician in our first focus group provided an insight that has guided much of our planning by pointing out that two strong motivators among the elderly are the striving to be independent and in control of their own lives and the desire not to be a burden on their children or society. Another participant added a third common motivation, that of the need to “continue to be of some use, to continue to making a contribution of some kind.” We believe that these basic drives fuel the interests among seniors in living as independently as possible and that will make community efforts such as the one we are attempting to build in the Chapel Hill area successful over time. NCMJ

REFERENCES


