2019

Resources Available to Aging New Englanders in 2019

Raquel Montero

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A Field Project Submitted in Partial Fulfillment of the Requirements for Honors
in the Department of
Management and Marketing
Healthcare Administration Program

The School of Business
Rhode Island College
2019

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Abstract

This project studies the resources currently available to aging New Englanders in 2019. The four studied resources—case management, transportation, meals, and homemaking services—are critical for older adults aiming to remain in their homes as they age, a practice known as "aging in place." Evaluation of these resources is conducted via a review of existing literature, state agency websites, and interviews of personnel involved with the provision of such services. Qualitative data collected from interviews is compared with existing qualitative data released by the Administration for Community Living (2016). This research also evaluates Rhode Island's strengths and weaknesses in providing these key resources on a municipality-by-municipality basis. One consistent weakness found across both Rhode Island and the entire region is transportation—a lacking, yet crucial resource for older adults aging in place. Communities across the state are encouraged to expand existing transportation offerings and advertise them accordingly. Other prominent successes and gaps are discussed, with recommendations made for each. A study of logic models used by state agencies for the provision of services for older adults was intended; however, no agency reported the use of such a model. Therefore, the researcher devises an original logic model for use in Rhode Island's preparation in providing for the state's growing elderly population.

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Introduction

As the Baby Boomer generation ages into retirement, it is imperative that communities across the United States begin to accommodate and plan for the wellbeing of the aging population now. Although all fifty U.S. states have at least one statewide agency dedicated to aging, whether the aging populations in each state are adequately provided for is still of concern (National Care Planning, n.d.). Per the 2016 Rhode Island Aging in Community report, by 2030, over twenty-three percent of Rhode Islanders will be aged sixty-five or older (Rhode Island Aging in Community Final Report, 2016). To ensure these citizens have the most resources available to them, coordinated action must be taken now. When facing such an issue, it is common to look at demographics and state needs. It is also helpful to evaluate other states' successes, modify them appropriately, and apply them for the benefit of one's own state's citizens. Likewise, this project locates the services currently available to older adults across New England while developing a logic model for use in the structuring of these provisions for the purpose of application in the state of Rhode Island.

In the search for available resources to seniors, it is important to note the sheer number of organizations and agencies that are providing these resources. The Department of Housing and Urban Development (HUD) may handle issues of housing, the Centers for Medicare and Medicaid Services (CMS) handle health care, and various municipality/community groups or non-profits handle transportation, nutrition, and other needs. When multiple agencies and organizations are providing for the same population, communication and collaboration are necessary for effective benefit. An exemplar of this

communication and collaboration can be found in R.V. Wolf's 2012 study of California's law enforcement and public health systems' initiative on working in conjunct to achieve shared goals. Wolf discusses the overlap between the agencies and concludes that mutual concern about the community's wellbeing, analysis of data, problem identification, and problem resolution are crucial in creating a strong partnership of agencies (Wolf, 2012). It is imperative that such partnerships are developed in the provision of more resources for Rhode Island's aging population.

To identify the social services provided to aging New Englanders, this research includes a review of existing literature, state laws, state agency websites, and non-profit organization publications. Interviews (either via email or phone) of personnel involved in the provision and distribution of such resources are also conducted to learn of the successes and limitations agencies across New England have encountered. To increase validity, the researcher reviews existing quantitative data for comparison to the collected qualitative data.

Locating the services available to older adults, however, is only half of the process. It is also necessary to assess which states' programs most effectively and efficiently provide public benefit. The researcher does so by comparing availability and use of the studied resources amongst aging New Englanders in each state. The most reported used services by elders (not including housing or healthcare-related services) are homemaking and heavy lifting of household objects (Cotrell and Carder, 2010). As such, the resources this research focuses heavily on include case management, transportation, meal services, and homemaking/physical functionality.

Logic models are helpful in the conceptualization and implementation of programs or initiatives that seek to provide benefit to a community. When planning for such a demographic shift as the Baby Boomer generation presents, it is prudent to structure such accommodations logically and visually. Although logic models are general in nature, their lack of detail is not indicative of a less effective framework. Joaquín Herranz, Jr.'s 2010 *Public Performance and Management Review* article concludes that it is "the relative simplicity of a logic model that makes it a potent heuristic tool for planning, implementing, and evaluating a network" (Herranz, 2012). As such, in addition to locating available resources, the researcher develops a unique logic model for use in Rhode Island's planning for older adults aging in place.

Literature Review

"Aging in place," or the ability to stay in one's own home as one ages, has gained traction as a desirable, less expensive alternative to long-term care institutionalization for older adults. Due to the considerable costs (financial and emotional alike) of living in an institution, the need for alternatives is prevalent in today's offerings for aging Americans. Given the staggering increase in the aging population as the Baby Boomer generation ages into older adulthood, it is imperative that appropriate changes are made now to accommodate this population. The need for these changes is especially applicable to Rhode Island, whose aging population will increase by 75% by the year 2040 (Health Aging Data Report, 2016).

To foster communities that support aging in place in Rhode Island, one must first be aware of the needs (both met and unmet) of this population. As published in the Rhode

Island Healthy Aging 2016 Final Report, focus groups of older adults across Rhode Island revealed that aging Rhode Islanders require better communication with state agencies and resource providers, greater access to transportation services, and more financial security (Rhode Island Aging in Community Final Report, 2016). Further, as reported in the 2017 AARP Public Policy Long-Term Services and Supports State Scorecard, the majority of U.S. states had not made any significant improvement in the accessibility and affordability of services since 2014 (Reinhard, et al., 2017). Clearly, there are gaps in the provisions (and accessibility of such provisions) currently made for the aging population.

To address the lack of comprehensive, coordinated services for older adults, the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services created a series of grants to develop aging and disability resource centers (ADRCs) across the nation. These centers allow older adults and disabled persons to access needed services (meals, transportation, etc.) via a single point of entry/contact (O'Shaughnessy, 2010). Unfortunately, as indicated in the above-mentioned focus groups conducted in Rhode Island, public awareness of Rhode Island's ADRC—The POINT—is meager (Rhode Island Aging in Community Final Report, 2016). This is an obvious limitation to accessing resources. Public awareness of available resources is crucial, as higher awareness of availability of resources has been associated with a later expected need to move from one's current home (Tang & Lee, 2011). When older adults are aware of the services available to them, they are more confident in their ability to age in place.

One benefit of aging in place is potential cost savings, depending on the care needs of older adults. Compared to the costs of living in an institution, for those with the functional and cognitive ability to remain their homes, aging in place significantly reduces the cost of care as one ages. Per the 2015 Genworth Cost of Care Survey, the median annual cost of homemaking services for older adults in Rhode Island was $53,768, whereas median annual cost for an assisted living room was $63,900, and a semi-private skilled nursing facility room was $93,075 (Genworth 2015 Cost of Care Survey).

Even for those who require more intensive assistance than homemaking services, aging in place may still be a possibility. A 2019 study assessed the use of Medicaid 1915(c) waivers for older adults aging in their homes. The investigators found that 1915(c) waiver funds were overwhelmingly distributed to those with developmental disabilities, leaving older adults and those with physical disabilities with fewer resources. Given that the projected expenditure for older-adult waivers in 2016 was $1 billion, and the projected expenditure for developmental disability waivers was $26 billion, it is clear that funding care for older adults aging in place is fiscally feasible through Medicaid 1915(c) waivers if distributed more commonly (Friedman, Caldwell, Rapp Kennedy, & Rizzolo, 2019).

Cost savings were also demonstrated in a 2016 study that investigated the effect of service-enriched elderly housing on resident outcomes. After implementing “Staying at Home” programs, which included coordination of social services in seven elderly high-rise complexes, multiple cost-saving benefits were observed. By providing/coordinating

services on-site in subsidized elderly housing, significant costs from emergency room visits, hospital stays, and nursing home transfers were avoided, saving a total of $212,329 across the program (Castle & Resnick, 2016). However, because these cost savings are not typically seen by those who run such programs, it is difficult to promote the development of other similar programs. Thus, public fiscal incentivization to provide such services may be necessary to remedy this issue.

Not only is aging in place cost-effective, it may have positive implications for health in the aging community. Stoeckel and Litwin concluded that access to resources and services increased social inclusion for older adults, thus increasing overall well-being (2015). However, if an older adult is aging in place outside of a supportive community, risk of depression may in increase (Benefield and Holtzclaw, 2014). Thus, special attention must be given to those aging in their own homes without considerable community support. Another study found that availability of community resources (community centers, robust transportation systems, accessible health care providers) aided in osteoarthritis management in community-dwelling elders (Martin, Schoster, Woodard, & Callahan, 2012).

Aging in place can occur in a handful of settings. Obviously, one may age in place without much support from the community and surrounding area. Another option is a naturally-occurring retiring community (NORC), which develops from an already-existing elderly population living in a certain area. Such communities will often assign building managers and appoint service providers to create a network for residents (Greenfield, Scharlach, Lehning, Davitt, & Graham, 2013). Another model for aging in

place is the village, which, typically, is run by its own members, providing referrals for existing social services while relying more on membership dues than public funding (Greenfield, et al., 2013). Villages were shown to generate higher confidence and greater perceptions of support in older adults living in such communities (Graham, Scharlach, & Kurtovich, 2016). This study also found that villages were more suited to less frail elders who may not immediately require assistance but anticipate needing aid in the future.

To better design a system for aging in place in Rhode Island, all contingencies must be considered. While studying public allocation of social services in New York City, Marwell and Gullickson found a strong, positive relationship between neighborhood need and allocated social service dollars. When distributed by private entities, dollars spent coincided less with actual need on a neighborhood-to-neighborhood basis (Marwell & Gullickson, 2013). Therefore, when considering allocation of funds for such a system, it is beneficial to keep funding sources primarily public in nature. In developing an aging in place system, Rhode Islanders would also likely benefit from a training program aimed at informal caregivers of those seeking to stay in their homes. Training programs were shown to increase awareness of available resources and help residents and caregivers accept external assistance and come to terms with needing such aid (Sanders, Stone, Meador, & Parker, 2010).

It is also necessary to consider how needs vary among older adults aiming to age in place. Three distinct types of seniors currently aging in place were identified in a 2017 study, each with varying needs based on their reasons for aging in place, psychological, environmental, physical, and financial well-being, demographics, and desire to age in

place. The first group "Balanced Achievers," reported aging in place mainly for social reasons (desiring to stay within their communities of often 20+ years) and scored highly on all factors of well-being, This group is most in need of more affordable housing options that will allow them to save on costs, while still remaining in their communities. The second group, "Easygoing Town Keepers," largely lived in rural settings, had balanced levels of well-being, and held strong commitments to safety, security, and family. Thus, community-based approaches would be most successful in supporting their efforts to age in place. Further, as rural areas frequently lack robust transit systems, additional resources allocated to transportation would prove beneficial. The third group, "Finance-Cautious Worriers," scored lowest on each factor of well-being, had the weakest desire to age in place, and tended to live in urban rental housing. Direct financial assistance and efforts to improve energy efficiency (as their older, energy-inefficient residences significantly increase the cost of housing) would likely be most effective in increasing ability/desire to age in place for finance-cautious worriers (Ahn, Kwon, & Kang, 2017).

Applying the aforementioned categories to Rhode Island would be beneficial in the development and provision of further resources for older adults. Based on median income by town, the researcher proposes the following recommendations: Urban, lower-income areas such as Providence, Central Falls, and Woonsocket would likely be most successful by employing solutions for finance-cautious worriers. Towns with higher incomes, including Barrington and East and West Greenwich, could benefit from recommendations made for balanced achievers. Finally, rural areas such as Hopkinton,

Burrillville, and Foster may benefit most from suggestions aimed towards providing for easygoing town keepers (Rhode Island Department of Labor and Training, n.d.).

Methods

This research presents a qualitative review of social services for older adults with comparisons to existing quantitative findings in an attempt to reinforce the validity of qualitative data collected. The qualitative data was collected via an assessment tool designed by the researcher. This tool (Appendix A) measured four types of social services the researcher considered vital in the provision of resources for older adults: case management, transportation, meals (both congregate and delivered), and homemaking services. These services were chosen keeping in mind the most needed services by seniors (Cotrell & Carder, 2010). The tool asked if the organization provided each service or if it was sub-contracted and provided externally, how many clients used each service, where the service was provided if not provided by the agency, and the annual goal for each service provided. For meals and homemaking services, the tool examined different types of services (congregate vs. delivered, laundry vs. cleaning, etc.) provided under the broader categories studied. Finally, the tool asked if the agencies used logic models to plan for provision of services, and if they would be willing to share the models with the researcher.

The participating agencies were primarily either locally based area agencies on aging (AAA's) or state-units on aging (SUA's), as the researcher sought to evaluate provision of services on both local and state levels. The tool was administered to

personnel from these agencies either by email or over the phone, based on the preference of the participating individual. Most respondents chose to complete the questionnaire via email; this option provided less opportunity to probe for more information than the telephone interview. As such, some items were left blank. This limitation will be discussed further in the Discussion section of the report.

The quantitative data used for comparison to the collected qualitative data was retrieved from the Administration for Community Living's Aging Integrated Database (AGID) (2016). The most recent data were from 2016 (Appendix B). The researcher compared the following values with the qualitative data: case management, transportation, delivered meals, congregate meals, and homemaking services. Percentages were calculated for each service; the denominator for each value was the total non-institutionalized aging population in the corresponding state.

The researcher also analyzed quantitative data from the 2016 Rhode Island Healthy Aging Data Report to provide targeted recommendations for specific communities across Rhode Island (Healthy Aging Data Report: Highlights from Rhode Island, 2016). While the report already indicated values significantly better or worse than the state average calculated by municipality, the researcher summarized this data by seeing which indicators were most commonly reported as best or worst in the state to provide a more refined approach in addressing these issues (Appendix C). Finally, key indicators related to the studied social services (case management, transportation, meals, and homemaking) were chosen to include in the logic model for Rhode Island (Appendix D) as outcome measures while improving the state's aging in place system.

Some healthy aging indicators chosen to incorporate into the logic model were not directly related to their corresponding measures due to the lack of more applicable outcomes to monitor. This is indicative of gaps in the state's framework for assessing success of its aging in place system. For instance, transportation was measured by Walkability score (a 0-100 rating of the ability to travel through a community on foot—communities scoring less than fifty were recorded for this report), the percentage of persons 65+ who received a flu shot in the past year, the percentage of persons 65+ who received the pneumonia vaccine in the past year, and the percentage of persons 65+ who received the shingles vaccine in the past year. Although these measures are not directly related to transportation, they are healthy aging indicators that reveal seniors' ability to gain transportation to and from critical medical appointments. Combined with Walkability score, these measures show how well a community allows its seniors to travel, both on-foot and using other forms of transportation.

The researcher also chose to use indirect measures for homemaking services. Percentage of older adults with any physical activity in the past month and average number of physically unhealthy days in the past month were used to capture whether seniors were physically struggling with homemaking/home-maintenance tasks. Older adults who are physically active are less likely to be in pain or struggling physically with everyday tasks; in other words, they are up and active, and are not bedridden or stationary due to pain. Those with fewer physically unhealthy days are less physically burdened with everyday tasks, and likely suffer from fewer homemaking/home-maintenance-related injuries.

More direct measures were used for the remaining services. The measures chosen for meal services were the percentage of obese older adults and the percentage of older adults with high cholesterol. Such measures reflect the quality of nutrition a municipality's residents may be receiving; those with unbalanced diets are at greater risk of these conditions. Case management was measured through the percentage of older adults seeing a regular doctor and the percentage of older adults that have ever been diagnosed with depression. Regular physician visits suggest a level of care coordination consistent with good case management, and those with access to available resources are less likely to suffer negative mental health outcomes.

Findings

Qualitative Interview Data- Narrative Summary

Rhode Island

The PACE Organization of Rhode Island (Program of All-Inclusive Care for the Elderly) provides comprehensive care for its participants, spanning medical, homemaking, transportation, adult day care, and other services and supports. To qualify for PACE, older Rhode Islanders must be at a level of care equivalent to requiring skilled nursing services while typically remaining in their own homes. Thus, the researcher considered this organization's input integral while studying aging in place. An interview was conducted via email with a staff member to understand PACE's effect in the community. The interviewee representing PACE was Cheryl Dexter, Vice President of Education and Research.

During the interview, Dexter reported services received by the 318 PACE participants in Rhode Island. For case management, she indicated that the service was provided not by one individual, but by a comprehensive interdisciplinary team of eleven professionals involved in participant care. All 318 of PACE participants receive this care planning. In lieu of specific numbered goals for providing services, PACE aims to provide seamless, comprehensive care for each of its participants.

Transportation is also provided for all 318 PACE participants; this may include: transportation to and from PACE's day centers, to and from medical appointments, and other purposes if necessary. This service is mainly provided through PACE-owned vans; the organization also sub-contracts to ambulance companies when necessary.

Dexter also reported that PACE is responsible for its participants receiving three meals every day. At the day centers, participants receive a morning snack, a three-course lunch, and an afternoon snack. If the participant or an informal caregiver is unable to procure meals outside of the day program (breakfast, dinner, lunch if participant does not attend the day program), he or she may receive delivered meals, homemaking services to prepare meals, or meals sent home from the day center.

About 160 PACE participants receive homemaking or CNA services. Dexter explained that ~30 participants reside in nursing facilities and 15-20 reside in assisted living facilities, and do not require such assistance. The remaining ~100 living at home do not require this type of aid. PACE orders, authorizes, and pays for the care, but it is primarily delivered by sub-contracted home care agencies.

To plan provision of services, instead of using a logic model, PACE uses individualized care plans developed by interdisciplinary teams. After assessing participants and their personal goals and wishes, the team develops the plan, starting with creating problem statements, followed by setting SMART goals (Specific, Measurable, Attainable, Relevant, Time-bound), then listing interventions to implement for the achievement of such goals.

Massachusetts

WestMass ElderCare, a private, non-profit organization in western Massachusetts, is an area agency on aging (AAA) that provides case management and connects older adults (and other populations, such as the developmentally disabled) with social services across seven communities in the Greater Springfield area (Belchertown, Chicopee, Granby, Holyoke, Ludlow, South Hadley, and Ware). Funded in part by the Massachusetts Executive Office of Elderly Affairs, WestMass ElderCare helps older adults to continue living independently in their homes. Clearly, this organization was a viable candidate to interview for this research. Representing WestMass ElderCare in the assessment conducted over the phone was Brenda Bronner, director of the organization's home care program.

Bronner reported that all of WestMass ElderCare's home care clients received case management by organization employees, totaling to 3,035 receiving this service. For the remaining services, the organization sub-contracts out to local agencies to provide services for WestMass Elder Care. To choose such agencies, they must first apply for a

contract; WestMass Elder Care then ranks each company with a report card, choosing only those with the most favorable results. No annual goal was reported for each service provided.

Transportation, Bronner reported, is a significant unmet need in western Massachusetts. Out of the 3,035 receiving case management, only 391 received transportation aid (senior center shuttles, public transit waivers). Transportation is typically paid for with state funds.

One of the organization's most popular services was meal provision, with congregate meals provided for 2,086 clients, and home-delivered meals provided for 2,135 clients. WestMass ElderCare's congregate meal program was impressive; serving meals not only in elderly housing complexes, this aid was available in various key points in the community, such as schools. Further, the organization waives meals at a local Hispanic restaurant, accommodating for the significant Latino population of the area.

Homemaking services were provided to 1,426 WestMass ElderCare clients. Bronner listed some of the most common tasks required by clients: meal preparation, housekeeping/light cleaning, personal shopping, and medication pickup. Pick-up laundry service and heavy cleaning were considered separate services from homemaking. Bronner noted the biggest needs in homemaking services: vacuuming, laundry, and personal shopping. To provide any homemaking services, nurses must create care plans for clients, with personal care aides fulfilling all duties deemed necessary and providable.

Bronner reported that WestMass ElderCare does not use a logic model but explained some of the process of providing care to clients. To qualify for the organization's home care program, a potential client must have at least six impairments in completing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). They are evaluated by an assessment tool to determine such impairments. The assessment also evaluates met vs. unmet needs, existing informal and formal supports, and economic frailty. Because some clients require more assistance than others, organization dollars are allocated according to specific service plans developed for clients.

Vermont

The Vermont Department of Disabilities, Aging, and Independent Living is the state unit on aging (SUA) in Vermont. SUA's, in contrast with area agencies on aging (AAA's), oversee statewide operations in providing services for older adults, whereas AAA's are involved with the actual provision and allocation of services for aging populations. In obtaining qualitative data from agencies across New England, the researcher sought to interview both SUA's and AAA's to gain a better understanding of how each type of organization contributes to the community. The interviewee from the Vermont Department of Disabilities, Aging, and Independent Living was Monica Caserta Hutt, Commissioner of the department.

Case management, Hutt reported, is contracted to AAA's and home health agencies across Vermont. Approximately 3,200 Vermonters receive case management

through either an AAA or a private agency. Throughout the state, the primary aim for case management is person-centered planning for all individuals.

While the SUA does not provide or track transportation services, they are still present in the state of Vermont. Hutt explained that per the Older Americans Act, AAA's across the state are expected to fund and provide transportation services for older Vermonters.

Meals, like transportation and case management, are provided by the state's AAA's. Statewide, approximately 20,000 older Vermonters receive meal assistance. No differentiation between congregate and delivered meals was made. The state's main goal for meal assistance is to provide nutrition for the neediest older Vermonters.

Homemaking services are also contracted and provided through the AAA's and home care agencies. Approximately 1,300 Vermonters receive these services. No logic model or other alternative was provided to demonstrate how the state plans the provision of services for older adults.

Connecticut

The Connecticut Department of Rehabilitation Services is one of multiple governmental bodies overseeing provision of services for older adults in the state of Connecticut. Considering the fragmented provision of service in the state and difficulty in finding contact points for other departments, the researcher chose to interview the Department of Rehabilitation Services, as Kathleen Sullivan's—the interviewee—contact information was most available. The information she provided as Director of Planning,

Communications, and Operational Readiness is from the 2018 federal fiscal year (FFY), running from October 2017 to September 2018.

Connecticut measures case management based on both hours of service and individuals served. In FFY 2018, 875 unduplicated older adults in Connecticut received 8,218 hours of case management. These services were provided through the five AAA's located in Connecticut.

Transportation is also provided by local agencies sub-contracted by the state's AAA's. In FFY 2018, 103,460 one-way rides were provided, while the number of individuals served is unmeasured. Connecticut also differentiates unassisted one-way rides from assisted one-way rides. 70 unduplicated older adults received 1,172 one-way rides with assistance (i.e. escort services) for those with physical or cognitive limitations in FFY 2018.

Meals provided by sub-contractors of the five AAA's in Connecticut are measured by individuals served and number of meals. In FFY 2018, 14,524 unduplicated older adults received 603,333 congregate meals at various community locations. 6,985 unduplicated seniors received 1,265,484 home-delivered meals in the same year.

Sullivan explained that homemaking services are aggregated into one measurable category in Connecticut; they largely consist of cooking, cleaning, laundry, and other light household chores. In FFY 2018, the state's AAA's sub-contracted 51,356 hours of homemaker services for 812 unduplicated individuals living at home. No logic model or

alternative was provided to demonstrate how the state plans provision of services for aging residents.

Several attempts were made to contact Maine and New Hampshire, but these were unsuccessful.

A quantified comparison of this data to existing data from the Administration for Community Living to assess validity was attempted. However, because states measured services differently (persons served, hours of service, etc.), this type of comparison was not logical. Still, similar conclusions can be drawn from both the collected qualitative and existing quantitative data. These are reviewed in the Discussion section of this report.

Healthy Aging Indicator Data

Transportation

Rural and suburban communities across Rhode Island scored the worst on the Walkability measure. Coventry, Foster, Glocester, and Scituate, all mainly rural communities, also scored worst on flu shot and shingles vaccine measures for older adults. Urban communities, such as Central Falls, Pawtucket, Providence, and Woonsocket, also scored poorly on the same measures.

Case Management

The communities with the most successful case management outcomes (percentage of older adults seeing a regular physician and percentage of older adults ever diagnosed with depression) were Jamestown, Little Compton, Middletown, Newport, and

Portsmouth. Providence scored the worst on both measures, with other, mostly urban communities also scoring poorly on percentage ever diagnosed with depression.

Meals

Measures of meal provision (percentage of obese older adults and percentage of older adults with high cholesterol) were worst in primarily urban settings. Woonsocket scored the worst in both categories, and North Kingstown scored the best.

Homemaking

The selected homemaking measures were the percentage of older adults who had any physical activity in the last month and average number of physically unhealthy days for older adults. East Greenwich, North Kingstown, and northeast Providence (measured separately to account for the socioeconomic disparity between this region and the rest of the city) each scored highest on these measures. Other municipalities in the southeastern Rhode Island area also scored favorably on the physical activity measure.

Discussion

This research contributes to the body of existing knowledge of aging in place by studying the services available to aging New Englanders and identifying the gaps in these provisions. By interviewing various state agencies and reviewing existing literature and data, a greater understanding of the services available to older adults across the region was fostered. While originally intending to look at existing logic models designed for provision of services for elders, the researcher learned that few agencies use such models.

Thus, the researcher created an original logic model customized to Rhode Island's current aging in place system (Appendix D) that will allow the state to plan provision of services and evaluate its successes and shortcomings in this endeavor. By considering the inputs, activities, outputs, and outcomes of the aging in place system, Rhode Island may better target services to areas most in need of specific services.

Transportation was the least-provided service out of the four studied. Some states measured transportation by number of rides given, while others measured the service through number of persons served. One state, Vermont, did not even track transportation at a state level. Thus, to improve seniors' ability to age in place across the region, improvement in transportation accessibility and measurement of provided services must be primary considerations. Healthy aging indicators relating to transportation include: Walkability score (0-100 rating of the ability to travel on-foot in each town), percentage of persons age 65 and older who received a flu shot in the last year, percentage of persons age 65 and older who received a pneumonia vaccine in the last year, and percentage of persons age 65 and older who received the shingles vaccine in the last year. The Walkability score of each community along with the percentages of older adults able to access critical immunizations each year measures seniors' ability to access transportation in the community. As Rhode Island improves its provisions for transportation in the state, monitoring these key indicators and checking for increase or decreases will help to gauge the state's progress in this area.

New England states reported lower-than-expected figures on older adults receiving case management. Because case managers coordinate the services received by

older adults, greater success in providing *all* services can be achieved with the improvement of case management accessibility and quality. Outliers existed in the data obtained from Massachusetts and Rhode Island respondents. Both organizations, WestMass ElderCare and PACE, provide case management for all their clients. While these data are not comparable to state averages, they are exemplars of case management provision. Thus, Rhode Island seniors would benefit from increased promotion/advertisement of PACE and other existing community-based elder care services: Child and Family Services of Newport County, East Bay Community Action Program, TriCounty Community Action Program, Inc., and Westbay Community Action (State of Rhode Island: Division of Elderly Affairs, n.d.).

Homemaking services consisted largely of cooking, light cleaning, and laundry. These services are some of the most needed by older adults (Cotrell & Carder, 2010). However, homemaking, too, lacked in its provision to aging New Englanders, with the exception of Massachusetts. Clean, livable homes are necessary for proper aging in place—fresh laundry and linens, a clean living environment, and prepared meals allow older adults to live happily and healthily. Continuing to link seniors to case management, and, as a result, homemaking services will aid in seniors' ability to remain in their homes and enjoy a higher quality of life.

Meals were the best-provided service across New England. Title III of the Older Americans Act requires that states receive federally funded grants for delivered and congregate meal programs for older adults (Colello & Napili, 2018). With legislation delineating financial provision for these services, meals are the most accessible social

service studied currently available to older adults. Not only do seniors benefit from nutrition received from delivered and congregate meals, they also receive social engagement and, in the case of delivered meals, regular wellness checks to ensure their safety and wellbeing in their homes. Thus, Meals-on-Wheels and other delivered and congregate meal services are key in any aging in place system. To improve provision of other types of services, greater allotment of funds via legislation like Title III of the Older Americans Act is recommended.

It is possible to see similar trends across New England in the Aging Integrated Database (AGID) data published by the Administration for Community Living (Appendix B). The most commonly provided services across New England were delivered and congregate meals—values as high as approximately eighteen percent of older adults receiving such services in a state are observable. Transportation is the most lacking, with only two out of six New England states displaying any data on the service. Case management and homemaking, too, have meager values, mostly hovering around a fraction of a percent. These observations are consistent with the qualitative findings collected by the researcher.

Appendix C summarizes by town the best and worst outcomes of healthy aging indicators related to the studied social services in Rhode Island (case management, transportation, meals, homemaking services). The southeastern part of the state had the most positive outcomes overall: Little Compton, Middletown, Narragansett, Newport, and North Kingstown each scored better than the state average for percentage of older adults ever diagnosed with depression (an outcome indicator of case management),

percentage of older adults with high cholesterol (an outcome indicator of meal services), and percentage of older adults who had any physical activity in the past month (an outcome indicator of homemaking services). Because these municipalities are more affluent than others in the state, greater funding for services has likely made a positive impact on seniors' ability to age in place. Thus, targeted state funds directed to more needy areas will address disparities in elder resources statewide.

Rural areas scored worst on transportation measures (Walkability score, % flu shot in past year, % shingles vaccine in past year, % pneumonia vaccine in past year) While most rural and suburban areas scored poorly in Walkability, Coventry, Foster, Glocester, and Scituate's poor performance in Walkability in addition to multiple other measures (flu shot, shingles vaccine) may suggest difficulty in accessing such provisions in these areas. This is likely due to less robust public transportation options and greater physical distances between community destinations. The farther apart a community's resources are, the more difficult it will be for seniors without cars to reach them. Thus, these municipalities would benefit most from increased awareness of Rhode Island's contract with healthcare transit company MTM, which provides non-emergency medical transportation for older adults in the state. An expansion of public transit routes into these areas would also help seniors age in place in rural settings.

It is important to note, however, that urban areas like Central Falls, Providence, and Pawtucket also performed poorly in vaccine-related measures. This may be explained by socioeconomic factors rather than physical ease of access.

Recommendations for Future Study

Those studying aging in place in the future would benefit from studying the nation as a whole; an extended period of research time or direct contact points with state agency personnel would aid in studying provided services across the country. During the limited period this study was conducted in, contacting even the six New England states posed a challenge. Given the proper time frame and contacts, a nationwide study would provide recommendations to the entire country, broadening the scope of this research. Because the aging of the Baby Boomer generation into retirement poses a significant challenge for current aging in place systems, a nationwide evaluation of services provided will be necessary to assess readiness and needed improvements for this change in demography. The last of the Baby Boomers will age into retirement in 2029. The efforts made in the coming decade will impact this generation for years to come; it is crucial now to study the success and limitations of aging in place systems to prepare for the increased demand of services for older adults.

Further, future studies of aging in place would also benefit from evaluating housing available to older adults. While *where* seniors are living is just as important as the services they receive, the time frame and scope of this project did not allow a proper study of senior housing. A comprehensive study of where current community-dwelling seniors live, along with available types of living communities (government-subsidized housing, naturally-occurring retirement communities, villages), and which demographics of seniors are best suited to each type of living arrangement would help states prepare for the incoming generation of older adults to ensure proper housing is available.

Limitations

Various limitations were encountered throughout the course of this research. The most considerable of these was the broadness of the research topic (a nationwide study of services and housing), and the subsequent decision to limit the scope of the project to the six New England states. Because research took place over a twenty-one-week period (one fifteen-week semester and one six-week summer session), a thorough assessment of each state in the nation would not have been feasible. Further, the researcher also decided not to include housing as an analyzed component in the study, as the topic would have been too broad to examine in the limited time span of the project. While housing is and will continue to be a key factor in aging in place, the researcher decided to focus instead on the services that allow older adults to remain in their homes, regardless of the type of housing they reside in. The role of housing in aging in place would be better suited to its own study separate from social services, given its scope.

Further, out of the six New England states, only four were reachable for interview during the research period of the project. Due to the limited time frame of this research, contacting state agencies and completing assessments with consenting personnel was especially challenging. For most states, contact information was not readily available on government-sponsored websites. The researcher attempted to contact agencies both via email and phone when contact points were available. Some agencies were not responsive to phone calls and provided no email address to contact relevant

personnel. For this reason, local agencies/AAA's were more readily accessible for interview. Even after appropriate contact points were secured, after multiple attempts, no contact was achieved for some agencies. When the only contact point available was a phone number, the researcher was limited to contacting the agencies during business hours. This timeframe for contacting agencies was further limited by the researcher's academic and work commitments.

Another limitation of the study occurred with the form of assessment used. For convenience and increased rate of response, respondents were given the choice of either email or phone interviews. While phone interviews allowed for more probing for information and clarity on respondents' answers, most of the participating agencies elected to respond via email. Due to this, many agencies did not report using any logic model, nor did they reference an alternative planning tool or mechanism in the provision of services. They also largely did not indicate any annual goals for each service provided. Naturally, these agencies—SUA's in particular—do not have as much time to respond to each inquiry received.

The above-mentioned lack of logic models used by SUA's and AAA's in the planning of provision of services for older adults also posed a significant threat to the original objectives of this study. While the researcher had assumed that states would have developed and used logic models or alternative planning tools to distribute services and resources, this was not the case among the interviewed agencies. One of the initial aims of this research was to analyze existing logic models and devise a similar one for use in

Rhode Island. Instead, the researcher evaluated Rhode Island's current inputs, activities, outputs, and outcomes for elder social services to create a logic model for use in the state.

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Appendix A

Services Available to Older Adults Questionnaire

1. Does your organization provide case management?

a. If so, do your clients use this service? How many?

b. If not, do you contract with another organization? How many clients receive this service?

i. If not, where do your clients receive case management from?

c. If offered, what is your annual goal for case management service?

2. Does your organization provide transportation services?

a. If so, do your clients use these services? How many?

b. If not, do you contract with another organization? How many clients receive these services?

i. If not, how do clients access transportation?

c. If offered, what is your annual goal for transportation services?

3. Does your organization provide meal services?

a. If so, what kinds? Meals on wheels? Congregate meals?

b. If so, do your clients use these services? How many?

c. If not, do you contract with another organization? How many clients receive these meals?

i. If not, where do your clients get meals if they cannot prepare them themselves?

d. If offered, what is your annual goal for meal services?

4. Does your organization provide homemaking services?

a. If so, what type of services are most used by clients? Meal preparing, laundry service,
housekeeping/cleaning, any others

i. How many of your clients use this service?

b. If not, do you contract with another organization or provide referrals for homemaking? What type of services are most used? How many clients use the service?

c. If offered, what is your annual goal for homemaking services?

i. If not, where do your clients receive homemaking services?

5. Does your organization use a logic model to plan provision of services?

a. If so, would you be willing to share it for me for this project?

Appendix B

2016 Aging Integrated Database (AGID) Data						
	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Case Management	856	87	6,225	1,139	810	6,987
%	0.26%	0.05%	0.94%	0.78%	0.77%	9.28%
Transportation	77	0	371	0	0	0
%	0.02%		0.06%			
Delivered Meals	6,227	4,685	48,728	13,140	2,100	5,616
%	1.90%	2.94%	7.35%	8.99%	2.00%	7.46%
Congregate Meals	16,674	11,019	27,868	17,956	5,867	13,451
%	5.09%	6.91%	4.20%	12.29%	5.58%	17.87%
Homemaking	903	60	45,815	3,599	0	73
%	0.28%	0.03%	6.91%	2.46%		0.10%
Total Non-Institutionalized Pop.	327,578	159,400	662,942	146,128	105,139	75,290

Note: Retrieved from Administration for Community Living: Aging Integrated Database (AGID). (2016). Retrieved April 25, 2019, from https://agid.acl.gov/

Appendix C

Healthy Aging Indicator Successes and Weakness by Service Category

Case Management		Transportation			Meals			Homemaking	
% w/ regular doctor	% ever DX'ed w/ depression	Walkability <50	% flu shot	% pneumonia vaccine	% shingles vaccine	% obese	% high cholesterol	% phys. activity	# phys. unhealthy days
Jamestown	Barrington	Burrillville	East Providence	East Providence	East Greenwich	East Greenwich	Exeter	Charlestown	East Greenwich
Little Compton	Charlestown	Charlestown	North Kingstown	Providence	North Kingstown	North Kingstown	Foster	East Greenwich	North Kingstown
Middletown	Cumberland	Coventry	Providence NE		Providence NE	Providence NE	Jamestown	Jamestown	Providence NE
Newport	Exeter	Exeter	Burrillville		Woonsocket	Central Falls	Lincoln	Little Compton	Providence
Portsmouth	Jamestown	Foster	Coventry		Burrillville	Pawtucket	Little Compton	Middletown	
Tiverton	Little Compton	Glocester	Foster		Central Falls	Providence	Middletown	Narragansett	
Warren	Middletown	Hopkinton	Glocester		Coventry	Woonsocket	Narragansett	Newport	
Providence	Narragansett	Lincoln	Pawtucket		Foster		Newport	North Kingstown	
	Newport	Little Compton	Providence		Glocester		North Kingstown	Pawtucket	
	North Kingstown	Middletown	Scituate		Pawtucket		Portsmouth	Providence NE	
	Portsmouth	Narragansett	Woonsocket		Providence		Providence	Portsmouth	
	Richmond	North Kingstown			Scituate		Richmond	South Kingstown	
	Scituate	North Smithfield					Cumberland	Tiverton	
	South Kingstown	Portsmouth					Johnston	Central Falls	
	Westerly	Richmond					North Providence	East Providence	
	Central Falls	Scituate					Tiverton	Johnston	
	East Providence	Smithfield					Warwick	North Providence	
	Johnston	Tiverton					West Warwick	Providence NE	
	North Providence	West Greenwich					Westerly	Woonsocket	
	Pawtucket						Woonsocket		
	Providence								
	Warwick								

Appendix D

Inputs	Activities	Outputs	Outcomes
CASE MANAGEMENT -Regional programs across RI*	-Assessment of older adults' conditions, needs (met/unmet), and desires -Coordination of and connection to needed services for older adults	-Better/prompter referral to needed services -Earlier identification of unmet needs	-Increase coordination of care for older adults -Reduce negative health outcomes (incl. mental health) by 20% -Increase life satisfaction **Corresponding healthy aging indicators**: % with regular doctor, % ever diagnosed with depression
TRANSPORTATION -Public transit (RIPTA) -MTM contract—non-emergency medical transportation	-Informing older adults of low/no fare options for seniors/low income seniors -Transportation of seniors to/from medical appointments	-Better communication of affordable transportation options -Better coordination of transportation services for older adults	-Increase attendance of medical appointments by 20% -Increase participation in social, religious, community activities by 15% -Increase seniors' sense of belonging in community -Increase quality of life/life satisfaction **Corresponding healthy aging indicators**: Walkability score, % flu shot, shingles vaccine, pneumonia vaccine
MEALS -Meals on Wheels program -Ocean State Senior Dining Program	-"Hot, nutritious noontime meal to frail, homebound seniors five days per week" -Regular wellness checks during meal delivery -"Nutritionally balanced, hot lunches served five days a week"	-Better management of nutrition-dependent conditions (diabetes, high cholesterol, etc.) -More social engagement for older adults	-Improve nutrition for older adults -Decrease complications from nutrition-dependent conditions by 10% -Receive confirmation of elders' wellbeing during wellness checks (Meals on Wheels) **Corresponding healthy aging indicators**: % obese, % high cholesterol
HOMEMAKING -Senior companion program -Home health aides -Home modifications	-Laundry, light cleaning, grocery shopping, meal preparation for older adults	-Increased ability to remain in home longer -Healthier older adults living at home	-Decrease falls/fractures/etc. caused by strenuous tasks by 10% -Increase physical activity in elders (in lieu of inactivity due to home maintenance- related injuries) by 20% -Increase life satisfaction **Corresponding healthy aging indicators**: % with any physical activity in past month, # physically unhealthy days