UNIVERSITY OF NORTH CAROLINA at ASHEVILLE

ENVISIONING HOME:

HOUSING OPTIONS FOR THE BABY BOOMER GENERATION

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is accepted in partial fulfillment of the requirements
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<u>Abstract</u>

That American society is aging at an unprecedented rate is not in question. What is in question is whether the generation that has so far redefined how we age will continue to do so as the Baby Boomers turn 70, 80 and even 90 and beyond. These Baby Boomers were born into an era of unprecedented prosperity and were the first generation to be given a name by the media.

The Baby Boomers revere youth as no preceding generation has. Yet, time marches on and they are entering their "golden years" at the rate of 10,000 per day. Most want to stay in their homes as they age, yet they do not have the necessary support systems should their mental or physical health decline. Families are smaller and more geographically spread out and the Great Recession of the last decade has turned the financial stability of the Baby Boomer generation upside down. They have seen the value of their homes plummet; they have plundered their retirement savings and 401(k)s to support suddenly bankrupt children and grandchildren. What looked like a secure future a decade ago today seems far less certain.

This Baby Boomer generation believes that it can redefine the final chapter of their lives as it has managed to redefine the other milestones it has met and crossed. They are rejecting institutionalization in favor of a host of housing options. Some have been around for centuries; others are still in the development stage. My thesis will explore these current options and look at what the housing future holds for the Boomers.

Introduction and Background

Americans are aging at an unprecedented rate. By the time the last Baby Boomer turns 65, in 2029, it is predicted that 72 million, or one in every five Americans, will be over the age of 65. More than 9 million, or 2.3%, of all Americans, will be over the age of 85 (www.agingstats.gov). A majority of people approaching retirement age say they want to remain in their homes, aging in place, yet they do not have the necessary support systems to do so should their mental or physical health decline. Nor do they have the financial resources necessary to afford a care community. Families are smaller and more geographically spread out and the recession of the previous decade has made a once secure future seem far less certain. Home values have plummeted, retirement savings and 401(k) plans are now smaller and once independent children and grandchildren are now requiring financial assistance just to stay afloat. These aging Baby Boomers are us, our parents and our grandparents. Where and how these aging Americans will live out their "golden years" requires consideration and planning by the Boomers themselves, by the people who love and care about them, and by all of us, because the financial burden of not adequately preparing is borne by all of society.

For many of the Baby Boomer generation, remaining at home as they age is a perfectly acceptable option. For others, the alternative of living in community or of living in a supportive environment requires that they plan the course of their final years. This Baby Boomer generation has challenged and attempted to revolutionize each stage of life. It is a generation better educated and healthier than the preceding generations. The Boomers will look to self-help and how-to guides in an effort not only to delay the aging process but to do it better than their parents did. They will focus on determining the common characteristics of communities that allow elders to flourish, despite varying degrees of frailty. They are a

generation used to having options. They also are a generation in denial about the realities of aging: about joints no longer working so well, about eyesight beginning to fail at nighttime, about the sound on the television needing to be louder, and about the resources they will need to have saved for their later years. This Baby Boomer generation will look to culture change: to flexibility, to independence, and to less institutionalization in their golden years. The current options of aging in place, aging in community and aging in a supportive environment will encourage them to look at creating housing choices that meet today's needs.

Until a century ago, no one even thought about where they would spend their final days. Those who were lucky enough to live into their sixth, seventh or even eighth decade lived with family. They aged in place, contributing to the household in different ways -- they cleaned and cooked, looked after young children and gave sage advice. Prior to the Industrial Revolution America was a rural society with no railroads, no automobiles, and families remained stationary. There were almshouses for the impoverished elderly, but in 1900 the average life span was 47 (Mandy 92-3) so the demand was not great. By the year 2000 the average life span had increased to 78 (Mandy 93), but it was other circumstances which altered the environment for seniors over that century.

The end of the Civil War and the beginning of the Industrial Revolution saw families disperse as they took advantage of cheap land out west and the completion of the Transcontinental railroad in 1869 made that even easier. This saw the beginning of institutionalization: of orphanages, mental hospitals and rest homes for the elderly. These original rest homes were used only by the poor who had no local family to take them in and were an outgrowth of almshouses. They were supported primarily by local religious groups and many were run

by unemployed nurses. This is why they were called nursing homes. They provided basic food and shelter only and could accommodate up to 18 residents (Carman 10–15).

The Great Depression saw another shift in care for the elderly. Up until the 1930's "most states had laws requiring children to care for their parents" (Baker 12). The Depression forced families apart and made enforcement of these laws impossible. It was during these Depression years that the federal government began assisting the aging population, beginning with the Social Security Act of 1935. This allowed people to age in their community even without family support. The end of the Depression coincided with World War II and saw another change in aging demographics. Women entered the workforce in record numbers, which left them unavailable to act as caregivers for aging parents (Mandy 93). Advances in medical care, like the widespread use of vaccines and antibiotics, made diseases like pneumonia treatable and people suddenly were living longer (Doty 301).

The post-World War II years saw not only a Baby Boom; they also saw the rise of suburban living. Home ownership became part of the post-war American dream. Families became even more spread out as they depended on automobiles and for the first time the concept emerged of aging parents as a burden on their children (Mandy 93). Recognizing that caring for the growing elderly population was becoming an issue of national concern, the First White House Conference on Aging was held in 1961. The outgrowth of this conference was the passage of the Older Americans Act of 1965: the creation of the Federal Adminis-tration on Aging, Medicare, Medicaid, and "community-based services designed to meet the … needs of aging adults" (Kirk 122). Local services such as congregate meal sites, Meals on Wheels programs and case managers for the elderly could now receive federal support.

Additional White House Conferences on Aging were held in 1971 and 1981 to assess the status of the elderly (Pace and Love 249).

None of this, however, has prepared us for the "silver tsunami" (Stafford, *Elderburbia,* xvii) we are now experiencing. While Americans are living longer and fewer women are home to assume the role of caregiver, other demographics are at play as well. The lower birth rate means that there are proportionately more older people than there are younger people. Job mobility increases family disruption. We define the elderly as 65 plus, but the number of frail elderly, defined as 85 and older, is increasing even faster than the number of elderly. Chronically ill persons, who just a few decades ago would barely have survived into adulthood today live long, productive lives, but require caregiving to do so. Women feel less pressure to marry, to bear children and to perform the traditional roles of wives, mothers and caregivers. (Wolf and Jenkins 198, 203-205; Golant "Future of Assisted Living" 20). Re-marriages create blended families of step-parents and step-grandparents in an intertwined composite of caring for multi-generations of in-laws and out-laws who are related by blood, by marriage or in ways no longer remembered. Is it any wonder that caring for aging relatives is being outsourced?

The Baby Boomer generation, those born between 1946 and 1964, are turning 65 at the rate of 10,000 per day. Thanks to the advances in medical care, the Baby Boomers were the first generation to see their parents live to an age that required nursing home care (Putnam 228). They formed a stereotype of aging from that experience which they are determined not to repeat. They learned to advocate for the aging population by watching their parents age (Hyde, Perez, and Reed 57). Baby Boomers hope to combine work with retirement in unique ways, in part because they will need to continue working for financial

reasons. They will want to remain engaged in community and in lifelong learning. Baby

Boomers "value convenience and sociability" (Nelson 201) and are more interested in the

amenities of daily living. Says Mandy, "…if today's seniors are demanding, then the baby

boomers will be much more so. Boomers will want options and they will want choices in

every aspect of their senior-living experience. They will want all that is being offered to

today's seniors and more" (112). Not only do Baby Boomers expect amenities like health

clubs, access to shops and restaurants, they also want access to public transportation,

diversity in housing choices, ages and ethnicity (Nelson 192). But more than anything else,

Baby Boomers want to age at home. But what is "home"?

The word "home' conjures up various images in people. The *Random House*

Dictionary defines home as (1) "a house, apartment, or other shelter that is the usual

residence of a person, family, or household and (2) the place in which one's domestic

affections are centered." As people age, home takes on more meaning. How and where the

elderly live denotes their ability to control their environment. Rubenstein, Kilbride, and Nagy

examine the relationship between older adults and personal space, asserting that, "With age,

it is clear that the relationship between aging persons and their home becomes increasingly

important and intimate … because of the affiliation of place (the home) and personal

experience (biography)" (80).

Home, therefore, is not just a physical place; it is also a storehouse of memories

associated with that space. Convery, Corsane, and Davis, in the introduction to their series of

essays on self-identity, discuss "place attachment," saying that people form an attachment to

a place they have resided in for a long period of time. It serves as an anchor and gives a sense

of identity (3). "Place, as distinct from space, provides a profound centre of human existence

to which people have deep emotional and psychological ties and is part of the complex process through which individuals and groups define themselves …. Place is thus bound up in people's sources of meaning and experience; people and their environments, places and identities are mutually constructed and constituted (Harvey, 2001)" (1).

Phillip B. Stafford, a leading author and advocate for elder-friendly communities, says home represents the creation of memories. In *Elderburbia* he suggests home is more than just the walls surrounding you; it is also the possessions you carry from place to place that triggers those memories (49). He reminds us that giving up the physical space we call home is giving up control (7). Stafford compares moving for an older person to a death, because it can become reminiscent of the distribution of possessions after death (3-6). This is especially true if the move has been initiated by family or is the result of a crisis situation.

Home also involves rituals. There are daily rituals, like housekeeping chores; there are social rituals, like trips to the grocery store; and there are cyclical rituals, like decorating for holidays. These are what Convery, Corsane, and Davis refer to as the "subjective and emotional attachments people have to place" (2). As people age, these rituals become more meaningful to them. Home brings forth memories of days past, of dreams realized or not, of people whose presence, if for a day or a decade, left an impact.

Home is a physical place, and just as people can adapt to their environment, so can the environment be adapted to meet the changing needs of people. By going back to the neighborhoods of an earlier time, rather than the social isolation common today in suburban developments, seniors achieve a sense of community and interaction among the various people living within their neighborhood. Homes with front porches that invite friendliness and garages along the rear of the house encourage neighborhoods that are multi-generational,

mixed-use, pedestrian friendly and have green space. Carman and Fox say people need a connection with nature (165) and Beth Baker, author of *Old Age in a New Age* agrees that people of all ages thrive when surrounded by nature, by animals, by other people, even by houseplants. It lowers blood pressure, lessens pain and decreases muscle tension (91).

The built environment encourages homes to have doorways wide enough to accommodate a wheelchair, have door swings, grab bars in bathrooms, lever handles on doors and sinks, and ramps inside and outside (Kirk 126). Communities are encouraged to extend walk/do not walk signals at street crossings, have better street lighting, better street signage, and cut curbs, adds Kirk (126). You increase the human connectedness among the generations says Susanka (39), a leading advocate for modifying our communities to make them more age-appropriate. Golant says that just as people become attached to home, they become attached to their outside environment as well, to the grocery store, the pharmacy, the local park. He sees that as "routine and habitual" behavior indicative of how people interact on a daily basis with the environment around them ("Effects of Residential and Activity Behavior" 241). That psychological attachment, that sense of belonging to a place, a feeling of familiarity to an outside environment can be very important to an aging person. Removing that person from that familiar environment can be disorienting, adds Golant (252). He says that how a person interacts with a new environment often depends on whether the move was voluntary or involuntary: the stresses of packing, moving, saying goodbye to familiar people and surroundings, leaving memories, dealing with movers, if crisis driven or if initiated by adult children can make the adjustment to a new living situation difficult (249-250).

Stafford, in *Elderburbia*, describes what makes an elder-friendly community. It is one that addresses the basic needs of the residents by providing affordable and safe homes in safe

neighborhoods, where residents have access to preventative health services, to medical and palliative care. The community promotes social and civic engagement and maximizes independence for the frail and disabled by providing transportation services and caregiver support. (33) He adds that environments should "promote physical activity, social interaction and easy access to health care" along with affordable housing and transportation options (81). Stafford argues that as the majority of seniors do not migrate to other states, infrastructure improvements are necessary to allow an aging population to continue to live comfortably. They require better street lighting, well maintained sidewalks and walking trails. He also makes a case for permitting Accessory Dwelling Units (see page 37), which current zoning laws prohibit in many communities. ("Living Large While Living Small" 181-2)

Restrictive zoning ordinances, which can prohibit not only accessory dwelling units but family care homes and congregate housing as well, are used by some communities to keep property values high. This can lock older citizens into homes they are unable to afford to maintain but are unable to sell due to recent economic circumstances. As gentrification moves through older neighborhoods, higher home values lead to higher property taxes that are unaffordable and long-term residents can no longer pay the taxes and the maintenance on the family home. Eckert and Murrey call these "enabling factors" (98); people feel forced to remain in their current living situation.

Award-winning architects Dunham-Jones and Williamson look at the various ways the built environment can be retrofitted to benefit not just the aging population but the entire community. They break down retrofitting into three categories: "*reinhabitation* involves the adaptive reuse of existing structures for more community-serving purposes", e.g. community amenities; "*redevelopment* entails replacing existing structures and/or buildings" with

planned mixed-use spaces and; "*regreening* requires demolition of existing structures and restoration of land to green space" (181-2). The French Broad River District in Asheville is a perfect example of all three retrofitting categories. Existing structures like the Wedge Building are being reinhabited as community spaces with restaurants and galleries; other old structures have been demolished to make way for mixed income housing, and there is an increasing amount of green space being developed as parks for people and for dogs. Retrofitting solutions benefits all members of the community including its senior citizens.

The City of Asheville uses tax incentives to encourage mixed-use development, explains Judy Daniel, Director of Planning, at a recent workshop, but often existing neighborhoods are resistant. It is difficult for planners to get financing for mixed-use developments. Developers, says Daniel, are "niche driven;" that is, they are used to building only commercial or residential properties, so they are uncomfortable and unused to planning for mixed-use developments. Finally, she points out, zoning codes tend to lag behind new ideas, not to drive them.

Emily Roberts is a local advocate for public policy that makes our communities more livable for all citizens, especially senior citizens. Local politics dictate how elder-friendly a community becomes, says Roberts in an interview. Whether a city will use its tax dollars to build a ballpark or place benches at bus stops is a policy decision that impacts a senior citizen's quality of life daily. Decisions like these demonstrate where that community places its priorities. Whether or not a community is willing to amend zoning ordinances to accommodate the changing needs of an aging population also speaks to its value system. Do the members of the community value the senior citizens and what they contribute to the community?

As the Baby Boomer generation enters the ranks of senior citizens the built environment will need to accommodate to the changing needs of this increasing number of aging Americans.

The Baby Boomer Generation

In order to comprehend the challenge we are facing we need to look at the size of the Baby Boomer generation, those born between 1946 and 1964. This makes them between the ages of 67 and 48 today.

A combination of increasing longevity, a declining birth rate and a decrease in immigration is leading to that "silver tsunami" as an increasing percentage of the American population reaches the age of 65. In 2010 there were 40.3 million Americans over the age of 65, or 13% of the total population (www.agingstats.gov). The Urban Land Institute estimates that by 2020 this number will have grown to 54.8 million, a 36% increase. By 2030 that number is projected to grow to 72 million, or 20% of the American population. According to current census projections after the year 2030 the rate of growth of the over-65 population will stabilize as the last of the Baby Boomer generation turns 65. This, however, is just when the first Baby Boomers will begin joining the over-85 age group, the oldest old.

While the Baby Boomers are turning 65 at the rate of 10,000 per day, the fastest growing segment of the elderly population in terms of percentage *is* the oldest old, those 85 and older. Those over 85 require the most services. Henry Cisneros, former Secretary of Housing and Urban Development, reported 4.2 million Americans aged 85 and over in the year 2000 (8) while Guo and Castillo report that there were 5.7 million persons aged 85 and older in 2010. They predict that age group to reach 9.6 million in 2030 and over 14 million by 2040 (210 - 211). The U. S. Census Bureau predicts this over-85 population could number

20 million by 2050. In 2010 the 85 and over population accounted for 1.9% of the population, by 2050 they will be 4.3%. And while this is a population that is better educated and healthier than previous generations, the lower birth rate tells us there will be fewer caregivers just as these oldest old need caregiving the most. Between 20% and 25% of Baby Boomers have no children. Furthermore, disabled people are living longer, requiring additional services from that decreasing pool of caregivers.

Older Americans 2010: Key Indicators of Well-Being, published by the U. S. Census Bureau, contains a 2007 community housing survey of Medicare recipients. This provides an excellent snapshot of where Americans over the age of 65 lived at that time. What that tells us is that for the 37.9 million Medicare recipients aged 65 and over, 93% lived independently in their community, 2% lived in a facility that provided some form of assistance in meal preparation, housekeeping services and/or medication assistance, and 4% lived in a long-term care facility. Thus, most Americans remain at home, aging in place. This report does not identify what in-home services, if any, are provided to those who live independently.

The 2010 census showed that 13% of the American population was 65 and over. For North Carolina that number was 13.2% but for Buncombe County it was 16.2% (www.ncdhhs.gov). There are a higher percentage of older citizens in this county and that is a trend predicted to continue as this has long been a retirement mecca. Right now, they may be healthy, active adults but as they continue aging they will need new places to live and will expect additional services to be provided. In addition, they will expect to have multiple options, as there is no one housing choice that is appealing or appropriate for all aging seniors.

There are 72 million Americans who make up this Baby Boomer generation. As a cohort, they expect to redefine how and where they will age. For some, remaining at home will be a safe and affordable option. For others, who value physical safety over independence there will be a continuum of choices available from shared housing to Continuing Care Retirement Communities to Green Houses, with other options in-between. The future will not only require public-private innovation in housing alternatives, it will require that the Baby Boomers take personal responsibility and that they begin to make choices about what is most important as there is no one perfect housing solution.

Aging in Place

"Aging in place," says Ginzler, "is a term that refers to aging independently while living in one's current residence for as long as possible" (53). Rather than moving to a place with support services, the support services come to the resident when needed. The American Association of Retired Persons (AARP) defines aging in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level". AARP reported in 2012 that 80% of those aged 65 and over want to age in place (www.aarp.org). Lehning reports the number at 93% (346). Others quote statistics somewhere in between. In reality, aging in place often becomes the default option rather than a deliberate choice as increasing numbers of elderly age year by year, overtaken by inertia, by economic circumstances or by fear of the unknown.

Most aging in place happens in single-family, detached homes in the suburbs. Currently 70% of Americans aged 65 and over live in such homes (Cisneros 10). Thus, the first level of support becomes family and friends, informal caregivers. As they age, or move away, seniors come to rely on paid, professional caregivers for support. Therefore, the ability

to age in place can be dependent on social structure. "Family structure has significant impacts on where an older person resides. Individuals who are unmarried, whether they have children or not, are more likely to move from a community residence (e.g., private home or apartment) to assisted living than are individuals who are married and have children. Persons who are both unmarried and do not have children are most likely to make that transition" (Wolf and Jenkins 210).

Those who do choose to age in place in a single family suburban home face the prospect of isolation. Houses in America, with driveways and garages facing the street and decks along the rear of the house replacing the front porch, have increasingly disconnected neighbors from one another. Dan Buettner, author of *The Blue Zone,* maintains that the average American today has two close friends that he or she can count on (91). Likewise, Ted Fishman in *Shock of Gray*, Beth Baker in *Old Age in a New Age,* and Philip Stafford in *Elderburbia* discuss the disconnect between older people today and their family and friends. Family members have moved away in search of new opportunities, friends have relocated to be closer to their family, have died, or have moved into more age-appropriate housing. For an older person who is no longer capable of driving a car, the chance to spend time with a friend is rare. Baker, in particular, paints a portrait of an older woman, stuck at home alone in front of the television eating a frozen meal that makes aging in place appear as an unappetizing option.

But a new, different image of living alone is also beginning to emerge. Klinenberg reports that elders who live alone are more satisfied with their lives than those who live with others, that they have no additional physical or cognitive decline than those who cohabitate, and that they have as many social contacts (158). Perhaps living alone forces these elders to

be more engaged in community, to maintain social contacts and to be more aware of remaining physically active.

There are seniors who have no choice but to age in place. Many find that they do not have the financial resources to move. Middle-income seniors find themselves unable to afford the fees of retirement communities, yet they do not qualify for low-income benefits. For some, the illness and/or death of a spouse has left little in the way of savings. For others, the recent economic downturn decimated pensions and IRAs. Some are helping to raise grandchildren or are supporting suddenly bankrupt children. Homes currently occupied by senior citizens are harder to sell. "Outdated wallpaper, old appliances, and poor maintenance often deter buyers. According to a 2008 survey from the American Senior Housing Association, nearly a quarter of seniors haven't made a home improvement in ten years, and 41 percent say they won't spend money to attract a buyer" (Ginzler 54-5).

Current tax policy favors owning a home, and owning more home than you need. "While our culture seems to revere the notion of aging in place, our public policy continues to favor institutionalization …. The conflict between what people say they want (to receive services in their own homes) and the way their tax dollars are spent …" is inconsistent (Thomas and Blanchard 14). Thus, some seniors are aging in place because they have no alternative. A short-term interest-free home improvement loan, repaid upon sale of the home, might encourage seniors to update their homes, sell them and move into more age-appropriate housing. Interest would begin accruing if the home was not sold within 24 months or some reasonable time frame. Likewise, communities could look at alternate ways of taxing citizens rather than allowing for deductions and rebates for home ownership.

Sometimes, the key to aging in place is providing supportive services to residents. One way to achieve this is through a Naturally Occurring Retirement Community, a NORC. Naturally Occurring Retirement Communities began developing as "existing residents within a concentrated area or building complex" began aging without the necessary support systems (Kirk 118). "A NORC is an innovative service delivery method that takes advantage of economies of scale so that providing services where concentrations of seniors are aging in place makes it possible to serve even more older adults at lower costs, enhances their ability to stay in their homes, and avoids costly institutionalization" (Guo and Castillo 219). Communities began to recognize that bringing support services to older citizens before a crisis erupts is good policy. NORCs enable seniors to age in place while they remain engaged in community. Members are "partners in service delivery rather than just recipients" (Enguidanos et al. 42), an empowering way of keeping neighborhoods diverse. Not only do NORC residents volunteer in community, they are solid taxpayers, if only indirectly through payment of rent, they don't use schools and they provide institutional history. That is, these senior citizens recall the history of their community: their children went to school there and played in the playground. They remember the candy store on the corner, the clothing store down the street, the small shop that sold books and sundries.

The first NORC was founded in 1985 in a multi-unit housing development in New York City. Funding was provided by the Federation of Jewish Philanthropies of New York (Ginzler 57; www.aging.ny.gov). This was in response to the increasing number of older people in the neighborhood who were either remaining in place or were moving into the development as younger tenants moved away. The term "Naturally Occurring Retirement Community" is attributed to Michael Hunt and Gail Gunter-Hunt that same year (Kirk 117).

In 1995 New York State allocated resources to non-profits to establish ten NORCs. Legislation passed by New York State in that year defined a NORC as a community with more than fifty percent of the residents aged 50 or older (Ginzler 57). By 1997 funding had been increased to 14 buildings. In 1999 New York City followed suit and provided separate NORC monies for 34 buildings. Between 2005 and 2006 New York State allotted funding for 22 buildings to create NORCs. New York State has remained a leader in NORC funding, providing one million dollars annually in matching grants to facilitate establishing services at NORCs (Guo and Castillo 221). Between the years 2002 to 2008 45 pilot NORCs in 26 states received funding via the Older Americans Act (www.aging.ny.gov).

One such community was the Park La Brea apartment complex in Los Angeles. An underserved community with many Asian immigrants, Park La Brea was studied by Enguidanos et al. as an example of early NORC formation. The existing management of the property was initially contacted to ensure their cooperation, as it was considered to be key to success. Next, a collaboration of agencies created a needs assessment of the tenants to identify gaps in service, duplications in service and build awareness. They determined that the greatest needs were transportation, social activities, and lack of awareness of available services. They came to realize later on in the process that when doing the needs assessment the frail elderly were inadvertently omitted due to their social isolation. They tend not to answer the door or the telephone, nor do they engage with neighbors.

As a result of the needs assessment Park La Brea tenants were provided with coordinated services, often through currently existing providers. For example, transportation to grocery stores and medical appointments was arranged via Jewish Family Services transportation vans. Apartment units were modified with safety features such as grab bars in

showers. A directory of available resources was created. There were monthly day trips to increase social engagement. A local hospital came on-site to administer flu shots as well as provide educational lectures on health and wellness. Local college students performed home chores for the residents. The tenants participated as well. Some who were World War II veterans went to the local high schools to tell of their war experiences.

Park La Brea received funding for the years 2004 through 2007 via the Older Americans Act. During those years there was no membership fee to participate in the NORC program, and they had a membership of 467. Upon completion of the grant period the NORC Advisory Board instituted an annual membership fee of $25. Membership declined to 150, but it did continue, in part due to a $100,000 gift from an anonymous donor. In 2008 they received another grant through the Administration on Aging to continue operations and to keep membership dues at an affordable level. One of the earliest NORCs, Park La Brea was an experiment. It was judged a success, as "connecting seniors to their community and developing a social network" (Enguidanos et al. 42) had accomplished a major goal for the funders.

Beacon Hill Village (www.beaconhillvillage.org), perhaps the most widely known NORC, was begun without government assistance. Founded in 2002 Beacon Hill Village is a membership organization open to persons aged 50 and over living in specific Boston neighborhoods. Currently, annual membership dues are $675 for an individual or $975 for a household. Discounted memberships are available for qualified persons. Members receive transportation services including weekly grocery trips, discounted taxi and limousine services, and free transportation for medical procedures. There are referral services for discounts to home health agencies, wellness programs, plumbers, dog walkers and various

additional services. There are trips to local restaurants, to museums and to movies. There are fitness groups and more.

This concept has become so popular that in 2010 Beacon Hill Village assisted in the formation of the Village to Village Network (www.vtvnetwork.org). Today there are almost 100 villages worldwide with over 100 in development with the goal of not just promoting and replicating but also improving the model where "residents incorporate as a not-for profit organization, managed by a board of directors and operated by a combination of volunteers and paid staff or solely by volunteers" (Ginzler 63) for the delivery of services to members at a negotiated rate. Despite annual membership fees many times higher than those of Park La Brea, Beacon Hill Village still needs to raise an additional forty percent of its annual budget from other sources say Enguidanos et al. The fact that even Beacon Hill Village with its higher membership fees is unable to be self-sustaining demonstrates that the existing NORC model will need adjustment if it is to survive as a service model for aging in place.

The Naturally Occurring Retirement Communities in New York, especially in New York City, are vertical, or housing-based, NORCs. That is, they are defined by a particular housing complex regardless of whether the occupants rent or own. Suburban NORCs, like Beacon Hill Village, are horizontal or open, meaning they are circumscribed by a neighborhood, usually of single-family detached homes (Ginzler 57). All NORCs tend to have certain attributes in common: they require the active involvement of all the participants and are self-governing; there is a coordination of service providers; a menu of available services which avoids duplication but fills in gaps of needed services; a stable (rather than transient) participant base; and, a focus on preventative rather than crisis based services (www.aging.ny.gov). Services are drawn from a pool of known, established service

providers. Unlike an age-restricted community (see page 26) or a retirement community (see page 39), NORC members continue to interact with those of other generations, enabling them to feel an integral part of their community. Often they possess institutional knowledge of the neighborhood as they are long-time owners or tenants who have aged in place (Kirk 118, 123-4; Guo and Castillo 219; Enguidanos et al. 30).

Buncombe County residents, with the assistance of Culture Change in Aging Network – Buncombe County (www.ccan-bc.org), have begun exploring the possibility of creating a NORC in this locality. Long a retirement haven, Buncombe County currently has more citizens aged 50 and over than it has aged 17 and younger (*Asheville Citizen-Times*, 5 May 2013). Buncombe County and the city of Asheville have several apartment complexes that house primarily elderly citizens, many low-income, such as Vanderbilt Apartments, Battery Park, and Aston Park Towers for example. These are potential local NORCs.

Using the power of bringing service delivery to residents rather than residents to the service and using volume discount may be an excellent option for many older persons as our population ages. Isolation is decreased, institutionalization is delayed and longevity increased. Members of the NORC feel empowered by retaining their independence and autonomy. While there is some consensus required, the level of participation is voluntary.

A NORC is just one way of bringing needed support services to those who are aging in place. Another is PACE, an acronym for Program of All-Inclusive Care for the Elderly, an innovative delivery system designed to assist the frail, low and middle income elderly delay the cost and despondency associated with institutionalization. PACE participants remain at home while receiving services.

A PACE building is currently under construction in south Buncombe County and is scheduled to open in the spring of 2014. Funded by CarePartners Foundation with no government assistance, they applied for and received an agreement from the state to serve 150 low income residents in Buncombe and Henderson counties. In a telephone interview with David Beijer, the Executive Director of the new program, care provided by PACE will be highly coordinated. He explained that PACE services are capitated, which means that the provider receives a set payment per participant (they will be referred to as participants rather than as patients) regardless of the volume of services received. That includes the cost of any hospitalization. Participants pay no co-pay and no deductible. All costs are covered by Medicare and/or Medicaid. There will be an Interdisciplinary Team, an IDT, which will establish the level of care required for each participant. The IDT will be made up of multiple staff members including the medical director, a physical therapist, an occupational therapist, a social worker, sometimes even a van driver, to provide his or her perspective on each participant's status.

The PACE facility will have an adult day-care on campus, so the IDT will determine for each participant if he or she comes to the day-care or if he or she remains at home and receives services in the home. Home modifications, e.g. a wheelchair ramp, can be arranged through the PACE program and paid for by Medicare and/or Medicaid, something which is not currently available to most seniors. Transportation to and from the adult day program will be provided, as will transportation to medical appointments.

PACE will be divided into four divisions: adult day, therapy clinic, medical clinic and administration. The level of care will be comparable to that of a nursing home while the participant remains at home, surrounded by memories of a lifetime. As PACE will be under

the CarePartners umbrella, coordination with services provided by Mission Hospital and by Hospice and Palliative Care will be easily accessible. They hope to expand their services to adjoining counties over time once they have proven the effectiveness of care via the PACE delivery system.

Public policy has traditionally dictated that a senior citizen must reside in an institution in order to receive reimbursement for care, while common sense suggests that targeting lower-and middle-income residents and providing them with in-home services would be a lower-cost alternative to institutionalization (Stone, Harahan, and Sanders 331). This new PACE program does exactly that; provides public monies for in-home care that previously required institutionalization. PACE is an example of an innovative public-private collaboration which appears as though it will benefit those who want to age in their homes.

In order to successfully age in place, people need to feel safe in their homes; they need access to transportation; to cultural events and to lifelong learning; to good medical care; to adequate nutritious food and; the ability to maintain civic engagement. The AARP Foundation website reminds us that it is easier to prevent isolation among seniors than to fix it. When local non-profits, government agencies and private industry partner with seniors to provide these services, seniors are more successful in remaining in their own homes. Supportive services such as home delivered meals, congregate meal sites, transportation, and mental health counseling help keep the elderly at home as well as keep them socially engaged with others in the community. For many, home modifications can make the difference between remaining at home and needing to move. Indianapolis modified seventeen homes in one year using outside funding and volunteers from Lilly Pharmaceuticals (they are headquartered in Indianapolis) to make those homes more age-friendly

(Stafford, *Elderburbia* 40). Philadelphia has been a leader in modifying its older row houses to accommodate an aging population (Lehning 352; *Philadelphia Inquirer* 13 April 2012 and 4 May 2012). Stone, Harahan, and Sanders write that by taking existing housing stock, modifying it to accommodate the elderly and the disabled and then providing services to enable them to remain in place society would solve multiple problems. It is a means of housing the elderly and disabled in a form they most desire while finding a use for what is now blighted housing in poor areas (340-350).

For those who remain in their homes, the need for support services can fluctuate. Some elderly require assistance with dressing and bathing after a hospital stay, or after an illness such as flu or pneumonia, but once they have regained their strength the help is no longer necessary. I am reminded of a Meals on Wheels recipient who lives alone in a large house in downtown Asheville who returned home from a hospital stay after a fall. Although she is in her early 90's and physically frail, she is mentally alert and absolutely refused to go anywhere other than back to her home. For the first several months after she returned home she received visits from aides and nurses, but those benefits quickly were exhausted as public reimbursement exists primarily for institutional care rather than for home care (Lehning 346). More than two years later she remains in her home with the assistance of family, church and local non-profit agencies. She is alone a great deal of the time and her loneliness is evident. Would she be happier in a "facility" where, in all likelihood, she would have little or no privacy and would have to adapt to the schedule of others? Of the limited options currently available, I don't think she regrets her choice.

Aging in place is easier if services come to the home. The availability of in-home care has exploded in recent years to meet the expanding need. Mountain Home Care, which serves

primarily Buncombe and Henderson Counties, began ten years ago with one employee and today has a staff of between eighty and eighty-five persons. Mountain Home Care is licensed by the state to provide in-home care services, which are different from home health services. In-home care is unskilled care, such as bathing, dressing and toileting; home health is skilled care such as wound therapy and nursing services. During an interview, Lana Wilde, owner-operator of Mountain Home Care, describes her seventy to eighty clients as averaging mid-80s in age with all but about ten living in a private home. The other ten reside in a care facility that does not provide adequate support services. She remarks that many of the clients remain with the agency for an extended period of time, although some are short time referrals who are in need of assistance when they return home after a hospital stay for surgery or after an accident. Wilde says that in most of the cases she is familiar with, the decision to leave home and enter a care facility is crisis driven. Much of what her in-home care provides is companionship and peace of mind for the homebound elderly.

Golant, Parsons and Boling point out that urban communities are better equipped to provide their elderly residents with access to large academic medical centers and a wider variety of non-profit agencies (15). Those in isolated rural areas lack support services that others may take for granted. And not all experts are in agreement on the benefits of aging in place. Thomas and Blanchard write: "Because it is fixated on a location (the private home) and pays little heed to the factors that make up actual quality of life, commitment to aging in place can turn out to yield benefits that are … mythical … and may actually do harm" (9). Guo and Castillo feel that there is a "social interaction" that is enjoyed by those living in a senior retirement community that those who elect to remain at home lose (216). For some

elderly, aging in place is no longer safe or comfortable. All people need to feel they have a quality of life that is sustaining for them.

Aging in place will continue to become easier as advances in technology make it safer to remain at home for the frail elderly and the handicapped. The concept of using technology to make space accommodate people of differing abilities, also called universal design, began with Ronald L. Mace of North Carolina State University. Dr. Mace was instrumental in passage of the Americans with Disabilities Act, which led to such universal features as 32" entryways, levers on door handles, and bathrooms on ground floors. Today, assistive technologies are a booming industry.

For-profit companies like Philips offer an array of services, both high- and low- tech to consumers. Under their Lifeline label, Philips has the Medical Alert Service, which allows the subscriber to push a button in the case of a fall or other emergency situation. Also now available is a Medication Dispensing Service, automatically disbursing medications and then providing an audio reminder to the subscriber of when medications are to be taken. Philips also has developed a free Independent Living Skills Assessment in conjunction with Boston University as part of their Lifeline service. Philips has introduced their Telehealth Service, allowing medical professionals to monitor the status of patients from home. There is a consortium of Silicon Valley companies working together to create new devices to assist the elderly to safely age in place. Wolf and Jenkins predict that these new technologies will enable the frail elderly to remain at home longer and will thus "suppress the demand for assisted living residences" (207).

The expanding use of e-mail and the internet increase socialization for isolated seniors living alone (Kutzik et al. 225). Those over 65 are increasingly embracing technology

as a means of staying connected to family and friends. Debbie and Steve Wilkins, co-managers at BellaVista Retirement (see page 44), lament that the building was constructed without wi-fi access throughout the entire structure. Today, only two years after completion of the building, tenants complain about that lack, say the Wilkins'. Today's senior citizens do not want to be left behind in the age of technology. Technology is not meant to replace human caregivers, it is meant as a "tool to enrich the lives of older people and those with disabilities as well as provide better and more cost-effective care" (Kutzik et al. 223). Much of today's technology is not affordable for the impoverished elderly. Over time, as the technology becomes more commonplace, that will probably change. For those who live alone isolation remains an issue. No device will ever replace the human touch.

Aging in place is the preferred option for the majority of today's senior citizens. They feel connected to home and to community. Remaining at home represents autonomy and independence, hallmarks of American character going back several hundred years. Some who continue to live alone have learned to structure their environment to meet their changing needs. They close off part of the house that they can no longer reach because of a flight of stairs, because they can no longer afford to heat the entire house or because the roof is leaking and there is no money to fix it right now (Rubenstein, Kilbride, and Nagy 20). These writers remind us that "Civil rights laws have increasingly extended the domain of choice to groups of disenfranchised and disempowered people, even when … the choices made may be clearly deleterious or self harming…" (3-4). A case was brought by Disability Rights NC against the State of North Carolina which is resulting in the current relocation of develop-mentally delayed and elderly persons back into the community and out of institutional care.

The courts determined that people, even old people, have the right to make their own choices about where they will live out their days.

While aging in place remains the preferred option for older Americans, it is not feasible for everyone. The costs and responsibilities of home ownership can become onerous and the isolation can seem overwhelming. For them, there are the various options of aging in community, whether it is an age restricted community designed for "active retirees", a shared housing or co-housing community, a planned urban village or a granny pod.

Aging in Community

Aging in community allows seniors to retain the autonomy of having a private residence, whether it is an entire house or just one room, while being secure in the knowledge that someone is nearby, that someone "has your back" in the event of an unexpected illness or sudden bad weather and can be called upon to be of emergency assistance. There is a structure to this living arrangement that is absent when aging in place. Those who elect to age in community need to bear in mind that circumstances may require an additional move should their physical or mental health deteriorate dramatically.

Age-Restricted Communities

On January 1, 1960 the first "planned active adult community" was opened in Sun City, Arizona by Del Webb. This was an unknown commodity. The developer feared the worst and hoped for the best. Ginzler reports that in the first three days, over 100,000 people came to visit the model homes (55-6). And so was begun the age-restricted communities that have sprung up all over the nation. At least one person in the household must be of a certain minimum age, usually 55. While the community management provides no supportive

services, the residents tend to help one another through crises by bringing food, helping with transportation to medical appointments and checking on one another's well being.

These early communities were designed around golf courses, and had club houses with tennis courts, bridge tables and other amenities to appeal to the "active retiree". This active adult community represented a clear division between work life and retirement. Today's senior does not stop working one day and live on the golf course the next. Today's senior citizen may have an "encore career," do volunteer work in the community, and take courses at a local college. Retirement has become a series of transitions. These communities lack diversity. Everyone in an age-restricted community is usually of similar income bracket and of similar background; obviously they are of similar age. These are communities that are neither affordable to lower income nor appropriate for the frail elderly.

My former neighbors, Gladys and Al, moved into an age-restricted community in south Florida 25 years ago from northern New Jersey, leaving behind a lifetime of friends and family. At the time, she was 55 years old and he 57, the minimum age to enter such a community. Both continued to work for the next several years. Because they were considerably younger than most of their neighbors when they first moved to the community, and they were working, they made few friends and felt isolated there. Ten years ago, when Gladys retired, they made the decision to move to a different, but still age-restricted, community in another town several miles away. This time, as they were more commensurate with the median age of residents and were no longer working and thus available to join in activities, they quickly made friends and began enjoying the lifestyle. Today, Al is still able to drive, so they go to doctor's appointments, can get their own groceries and continue to be independent. Over the years, Gladys and Al have helped many of their neighbors. For them,

living in a community where they have neighbors of a similar age and of a similar economic

and cultural background is making their aging process easier.

Age-restricted communities continue to find their niche. Crowfields, on Henderson-

ville Road in south Asheville, is a popular community. The Del Webb communities in the

southern and the western states are favorite retirement destinations for many. While the

residents of age-restricted communities are often older than the minimum, many are active,

engaged members of their towns. "Snowbirds," part-year residents who spend the winter

months in warm-climate states and return to their northern homes for the summer months,

often make up a significant portion of the population of age-restricted communities.

Residents feel comfortable leaving for months at a time, assured that their property will be

safe as there are always neighbors nearby who are aware of who is in town and who is not.

Neighbors look after one another and support one another.

Shared Housing and Co-housing

Sometimes confused with one another, shared housing and co-housing are two

different intergenerational, intentional forms of housing available to the aging population.

Shared housing comprises two or more people sharing a common space within one home or

structure; co-housing is made up of separate dwellings with shared amenities. Neither is very

common right now, but both are growing in popularity.

Shared housing can be intergenerational and as such can provide benefits to aging

seniors. Having a younger person in the home can help maintain independence by providing

financial assistance and companionship (Granberry 157). However, shared housing can also

lead to a loss of privacy. If the persons sharing the home are not related, some communities

have zoning regulations limiting the number of unrelated adults who may share a home

(Ginzler 62). Both the City of Asheville and Buncombe County permit up to five unrelated adults to share a residence. Gillian Phillips, Planning Director for Buncombe County, explained at a recent workshop that it is parking and noise issues that are most likely to create problems with neighbors.

Intergenerational shared housing among adult family members can lead to controversy, especially as it is likely to highlight the financial discrepancies among the various household members (Glick and Van Hook 1152-3). Glick and Van Hook likewise see these multi-generational shared housing arrangements as not very stable and subject to frequent moves (1159). There has been more intergenerational shared housing as a result of the recent economic downturn, as hard pressed family members move in together and support one another. The economic recovery now underway will likely reverse that trend as unemployed and underemployed family members find jobs, college graduates move away, and mortgage financing once again becomes more available. Thus, an older person dependent upon a shared housing arrangement for income maintenance, for assistance with activities of daily living or just for companionship, may now find himself or herself alone.

Shared housing among Baby Boomers is becoming more mainstream as the "Golden Girls" concept is embraced by an increasing number of women who understand the benefits of mutual support. AARP reports that 80% of clients of online matching services are women and that "four million women age 50-plus live in U.S. households with at least two women 50-plus – a statistic that is expected to rise" (Abrahms 18). Abrahms attributes this to a variety of reasons:

- one of three Baby Boomer women will be without a spouse after the age of 50
- women continue to outlive men by an average of five years

- adult children will not live nearby

- several financial reasons:

    the recent recession

    the increasing costs of health care

    the additional costs associated with living longer

- women appreciate the social connections that are an integral part of shared

    housing

- women feel physically safe in shared housing

- women prefer being able to divide chores

Abrahms also points out that shared housing often enables the participants to live in a nicer

house in a better neighborhood as they can enjoy the benefits of shared utility bills, shared

maintenance costs and shared property taxes. She suggests that the financial benefits of

shared housing will be the deciding factor in making this an increasingly popular option for

Baby Boomers (18).

Abrahms does not hold back when outlining the pitfalls of shared housing. In addition

to the loss of privacy she discusses the need to deal with the habits of others, to carefully

assign chores among the household, be specific about a pet policy, list the dos and don'ts of

all common areas, to agree on the temperature of the house in winter and summer, be specific

about quiet times, and to clearly define any guest policy. Lastly, Abrahms advises that

everyone have an exit strategy (19).

Marianne Kilkenny has lived in a shared home in north Asheville for more than two

years. At a local workshop in 2012 Kilkenny said she feels that any loss of privacy is more

than made up for by a sense of security and camaraderie. As one of the 20 to 25 percent of

childless Baby Boomers, Kilkenny says she considers her housemates as a form of extended

family and has appeared on television and has written articles extolling the virtues of shared

housing.

Whether family or friend based, shared housing as a group dynamic can be complex.

Eckert and Murrey wonder if the success of a shared housing arrangement is dependent upon

a strong, charismatic leader (103). Should one person leave, the entire structure can lose its

cohesion. If the shared housing is just two people, the interdependency can become skewed.

Much of the potential conflict can be avoided by careful planning and by frequent group

meetings as there seems no way to plan for every possible contingency.

Shared housing and cohousing both make use of shared space, but otherwise they are

very different forms of housing. Kilkenny defines shared housing as having one roof and

cohousing as having separate roofs. "Cohousing is a residential development that is designed

to emphasize interaction among residents, while respecting individual privacy. Multiple

housing units are built around a common area, creating an intentional neighborhood. For

older adults, this design can provide an environment where community plays a critical role in

one's ability to continue to live independently" (Ginzler 62). The intentional design of a

cohousing community is what makes it so appealing to its residents. Some are designed just

for seniors, making it an age-restricted cohousing community; others are designed to be

multi-generational. Each resident has his or her own separate dwelling, arranged around

common spaces to be shared by all.

The first American cohousing community was developed in 1991 in Davis, California

by a husband and wife architect team (Durrett and McCamant) who brought the concept back

to the United States from Denmark (Granberry 146). Residents in a cohousing community

retain a sense of independence while fostering codependence on neighbors. Granberry

repeats the six common qualities necessary for successful cohousing taken from Durrett.

They are:

1. participatory process

2. deliberate neighborhood design

3. extensive common facilities

4. complete resident management

5. nonhierarchical structure

6. separate income sources (147).

A cohousing community is committed to community building, continual learning and

environmental stewardship. It is human scaled, resident controlled and intentional. The

communities are built to be interactive. That is, they are designed with front porches, parking

areas in the back, and with common facilities.

All cohousing communities are designed with a large central common space.

Community members share several meals a week in this space. It is where they pick up their

mail. There is a common laundry room, although some members may have laundry facilities

in their homes. Members share tools, garden and exercise equipment, books, etc. Each

community has an elected board of directors, plus several committees; for example, a

landscaping committee, a maintenance committee, a care committee. The community is

structured like a condominium association with an annual budget and monthly maintenance

fees, some of which are deposited into a reserve fund for major expenses like roof repairs.

Today there are 120 cohousing communities in the United States, 11 in North Carolina. Some are intergenerational, some age restricted. Currently there are only four age-restricted cohousing communities in the United States. One of these is ElderSpirit in Abingdon, VA.

Conceived and created by retired nun Dene Peterson, ElderSpirit is a cohousing community made up of 29 middle and low income homes for renters and owners age 55 and over. Every one of the current 43 residents has a job within the community, and if one is incapacitated the other community members immediately step up to support the ill member. Each member must serve on at least one committee.

At a housing forum in Asheville in September, 2012 Peterson acknowledged that the members had been extraordinarily lucky in not having faced any serious health or financial issues to date. While each member of the community had expressed his or her personal desire for end of life care when that becomes necessary (nursing home, go to a child's home, home health care, etc.), this had not yet been tested. One year later, this community has now begun to see changes in some residents. Surgeries, accidents and illnesses have taken a toll, and one member has now moved into an assisted living community.

All decisions at ElderSpirit are made by committee, and conflict resolution is a process that takes great patience but eventually encompasses all opinions. The key to Elder-Spirit lies in mutual support and making all feel needed. Because they feel so committed to this process of community and spirituality, ElderSpirit has a Goodness of Fit questionnaire on their website so potential members can determine ahead of time if they think living at ElderSpirit will be beneficial for them and for the community. For those members who own their homes, 50% of any profit upon the sale of the home goes back to ElderSpirit.

An intergenerational cohousing community is nestled on a side street in west Asheville. Westwood began design in 1994 and the first owners moved into their homes in 1997. Today, there are 24 homes on 4 acres. As with other cohousing communities, the homes are compact and environmentally conscious. Members share tools, garden equipment and even some appliances. Westwood has three community dinners a week in the common dining room. Participation is voluntary, but a resident who declines to attend all three should probably rethink the decision to live in a cohousing community. Residents are required to serve on at least two committees and to give a minimum of four hours of work each month to the community. Should a member fail to contribute the required four hours of labor they are expected to pay $10 per hour. Westwood, like ElderSpirit, has a Board of Directors and multiple committees.

Like most condominium associations, Westwood cannot control who moves into the community, but they do try to meet prospective owners ahead of time by inviting them to a common meal or to a work day. Westwood, unlike ElderSpirit, is not a handicapped accessible community. While it is multi-generational, it has become more appealing to older citizens as younger families have chosen to live elsewhere. This could create some potential problems. Parking is not convenient to most of the homes and the common building has three levels with no elevator access. As the population of Westwood ages, they are finding that they need a larger Care Committee to be more dedicated to looking after the members.

Cohousing on a smaller scale is called a pocket neighborhood, or a cottage development. Like a cohousing community, a pocket neighborhood is developer driven. It is smaller and less structured than a cohousing community. The advantage to a pocket neighborhood is that it allows older adults to live in smaller, compact spaces in close proximity to

family or friends, their existing support system. Chapin, who writes and advocates extensively on behalf of pocket neighborhoods, describes the ideal pocket neighborhood as between 6 to 12 households, each with a separate, nested home but with shared common and outdoor space. This, he says, means that each neighbor knows all the others by name, creating a sense of community while still maintaining privacy and autonomy. (53-4) At a workshop in August, 2013, Judy Daniel, Planning Director for the City of Asheville, said that pocket neighborhoods are permitted within existing neighborhoods in Asheville. They may not exceed 12 dwelling units and must look like the existing homes.

Cohousing, shared housing, and pocket neighborhoods sometimes require zoning modifications as the design is neither the typical suburban development nor is it the urban village concept. As there is much shared space, the individual living units are sometimes smaller. Some communities have ordinances that have minimum square footage requirements for homes. Many seniors are interested in "downsizing"; in having fewer possessions, doing less entertaining and just living in a smaller, and more compact space.

Like any form of communal living, being part of a cohousing or pocket community requires consensus building. Regardless of whether the community is for seniors only or is multi-generational, being part of a community involves abiding by majority rule. For some, coming to such a community after a lifetime of suburban living with its individual homes on individual pieces of property, learning to be part of community living can require a great deal of adjustment. But, as Granberry says, being part of a cohousing community encompasses the concept of looking after one another while retaining some independence (146).

Urban Village

For those who are not interested in participating in committees, in shared responsibility, in building consensus among neighbors, but who also do not want the social isolation associated with suburban living designed for young families and healthy adults there is the urban village. A planned community, an urban village is the opposite of suburbia. The urban village is a neighborhood with a town center, a variety of shops and restaurants, and green space. Homes are usually energy efficient, there are often walking and jogging trails, coffee shops and internet cafes which can provide intergenerational socialization. Because urban villages are often of more recent design, they also tend to have sidewalks with handicapped ramps, better street lighting, and homes designed to accommodate handicapped residents. A resident in an urban village can choose to interact with neighbors as though living in a cohousing community or can remain aloof, as though living in suburbia.

Two urban villages in Buncombe County, Biltmore Park and Biltmore Lake, both have college campuses on or near their communities. Today's seniors have made it very clear that they are not finished with learning, or with volunteering. In an interview with John Cowan, the Chief Operating Officer of Givens Estates in Asheville, he declared that Givens considers Biltmore Park, with its multi-generational amenities to be a bigger competitor than Deerfield Retirement Community. Cowan says that the residents can age in place in an urban village, have access to its multiple amenities and then arrange for in-home care should their health begin to fail. Today's Baby Boomer generation is more concerned with the conveniences provided than previous generations. They are willing to live in smaller spaces, but want more carefully planned space with "better utilization" says Cowan. The Baby Boomer generation has demonstrated that it is more interested in continuing educational

opportunities, in exercise and wellness and in protecting the environment than it is in golf courses and club houses. They want smaller homes that make better use of space. They want to walk to movies and restaurants. They want internet cafes. Many are tired of being tied down to a mortgage, preferring to be renters (Dunham-Jones and Williamson 180).

Urban villages have been criticized for appealing primarily to white, upper-income and better educated people (Stafford, "Living Large while Living Small", 179; Frey 199). More singles are attracted to urban living than are married couples. Urban villages are seen as elder-friendly spaces which integrate social and physical amenities (Stafford, *Elderburbia*, 141). Urban villages are also seen as spaces which will enable seniors to age in place with services easily available to them as needed. Over time, urban villages might filter down into more middle and lower income communities. Perhaps some urban villages could be convinced to set aside some units as subsidized housing for the elderly. Local governments could provide tax incentives to developers to encourage this.

Accessory Dwelling Unit

For those who truly are looking for smaller and more compact space, an Accessory Dwelling Unit (ADU) may be a perfect solution. Lennar Corp. is the nation's premier builder of accessory dwelling units, or granny pods. Lennar is advertising "NextGen – The Home within a Home" – a granny pod attached to the original structure so there is no problem with zoning. NextGen is a complete suite featuring a bedroom, living room, an eat-in kitchen, a separate garage, with its own porch and entrance.

Some communities currently restrict the construction of accessory dwelling units, citing overcrowding, a decline in property values, a decline in available parking and an increase in crime as the reason (Ginzler 62). Lehning argues that these restrictions limit the

options available to seniors, that for "older adults who need to downsize because of financial

or physical functioning reasons … ADUs serve as an alternative form of housing, whereas

for older adults who can remain in their own home but require some financial or personal

care support, adding their own ADU creates a rental unit or a living space for a caregiver"

(347).

Diana, my former boss, is a 74 year old widow who lives in Henderson County in a

home she designed and built with her husband ten years ago on almost two hundred acres.

Now that she lives alone, Diana has come to realize how truly isolated she is. Her solution:

an accessory dwelling unit. Last year Diana added a small totally self-contained cabin

alongside her home. Diana says if and when she needs assistance instead of going to a

facility she will have someone come and live in her ADU, or she will move into the ADU

and have her helper(s) move into her home.

An ADU attached to an existing home in the suburbs does not necessarily help an

aging person with transportation needs, with socialization, lifelong learning or community

engagement opportunities. Similar to moving in with a son or daughter, it can actually be

more isolating. It is, however, another weapon in the arsenal of options that exist.

Aging in a Supportive Environment

For some, the comfort of knowing there is always assistance available in the event of

an emergency, there is always someone to pass the time with, or play cards with, trumps the

self-determination found by living independently. Choosing to age in a supportive

environment can mean anything from living on the campus of a Continuing Care Retirement

Community to moving to an assisted living facility to being a patient in a skilled nursing

home. The definition is that some level of support services is an integral part of the

community in which you are living, regardless of whether or not you are currently utilizing those services. These services can range from assistance with bathing, dressing and toileting, commonly referred to as activities of daily living (ADLs), to 24-hour nursing care.

Continuing Care Retirement Community

A Continuing Care Retirement Community (CCRC) is a legal entity. The resident agrees to give the CCRC a pre-determined amount of money and in return the CCRC agrees to take care of the resident for his or her life span. Frank Mandy, an author who has spent much of his career working for for-profit life care communities, writes that the first CCRCs were created to provide life-long residential care for retired clergy. A donated or outdated building was used for housing and in return all resources were pooled, providing a "modest but secure living" for life (92). These, say Mandy, were usually secured by verbal agreement. The CCRC as we know it today was created by the Religious Society of Friends, the Quakers.

When the first CCRCs opened, the transaction was simple. The resident turned over all his or her assets to the CCRC, or paid a one-time non-refundable entrance fee, and in return received lifetime care. Today, there are three basic types of CCRC contracts. The Type A contract, also known as a life-care agreement, calls for an entrance fee plus a monthly maintenance fee and guarantees unlimited care for life. A Type B contract, called a modified agreement, involves a smaller entrance fee and smaller monthly payments and gives limited care services. There is also a Type C contract which is a fee for service or pay as you go arrangement. This agreement assures the resident access to needed services, but usually at current market rates. (Barbour 156; Mandy 94-5)

CCRCs saw a rapid expansion from the 1970s to the mid 1990s. As of 2007, 96% were not-for-profits and many of them were church sponsored. Since the residents are turning over a good portion, if not all, of their assets to the CCRC, there is an advantage to the connection to a religious organization. People trust churches with their money. And the CCRCs have an excellent financial track record as well as being regulated by the states. (Mandy 95-100)

Designed as a not-for-profit, the CCRC provides a "fully integrated continuum of care on campuses designed to allow older adults to live as independently as possible while guaranteeing the availability of long-term care services should they be needed" (Mandy 94) or, as Mandy continues, CCRCs "function like a long-term care insurance policy" (94). The stigma attached to being in an environment that has skilled nursing attached is offset by the assurance that the resident will never become a burden to his or her own children.

CCRCs offer three levels of care to their residents; independent living, assisted living and skilled nursing. Those who are in independent living are usually in an apartment or a "cottage". These residents have a lock on their doors. They usually receive some basic services such as one communal meal daily, weekly housekeeping, transportation if needed and community amenities such as hiking trails, outings to movies or concerts, etc. Assisted living residents receive assistance with some activities of daily living referenced above. Skilled nursing has nursing care on the premises twenty-four hours a day, seven days a week. It is for the sickest, frailest residents, and can be utilized as a rehabilitation facility by residents who have had recent surgery or have suffered an illness or injury.

CCRCs became less popular in the mid-1990s. Some of that is attributable to the rise of assisted living facilities with their comparable amenities at less cost and some to the anti-

development fervor that began to spread across the nation. The attraction of a CCRC, to "live with one's peer group" while engaging in "intergenerational" activities and "lifelong learning" (Mandy 106-7) can now be found in other housing forms.

The Urban Land Institute reports that the recent recession has caused the population of CCRCs to decline even further. This is due also to the inability of people to sell their existing homes to buy into a CCRC; the lack of sufficient retirement savings by younger retirees; and the aversion to any form of institutionalization, regardless of how appealing the packaging (2). Because the cost of "buy-in" at a CCRC is so high, assisted living communities are becoming more appealing than CCRCs.

Assisted Living

Assisted living facilities include some supportive services in the living arrangement for persons who are not yet totally dependent. The level of service varies by facility and by need. Assisted living facilities can range from small family care homes with as few as two beds to large corporate-owned institutions catering to hundreds of residents with varying stages of physical and mental infirmities.

Polivka and Salmon trace the history of assisted living to the 1970s, when society began looking for ways to assist young disabled adults to live independently with some autonomy and privacy but still receive the daily help required (399). These young people with disabilities were outliving their life expectancy due to continuing medical advances, but could no longer be cared for at home and could not live alone. Because the assisted living setting was more homelike than a nursing home, the idea spread quickly to elder care. Assisted living facilities place more emphasis on social or quality-of-life criteria and less emphasis on the delivery of health care services such as pharmaceutical needs. Golant reports

that as of 2007 there were 38,373 assisted living properties in the United States with more

than one million residents ("Future of Assisted Living" 6–9). According to Carman, the

average age of the residents is 85; they are 79% female and 99% Caucasian (19-20).

That 1% non-Caucasian are clustered in small family care homes, also referred to as

board and care homes, as adult foster care homes or as group homes. Golant calls them "poor

person's assisted living because it is dominated by occupants receiving federal and state

government assistance" ("Future of Assisted Living" 6), meaning Medicare and Medicaid.

While there is a more homelike atmosphere, that can be at the expense of some privacy for

the residents. Carder, Morgan and Eckert credit these small board and care homes with

having a more "quasi-family" type atmosphere and compare living there to a shared housing

arrangement (see page 28) with communal living areas (148, 151). Ginzler likewise sees

these homes as more like a "private residence in which several older adults (usually no more

than six people) receive assistance with activities of daily living, meal preparation, and

transportation. The homelike environment of adult foster care promotes a sense of

independence and control. There is no official definition of adult foster care, and there are no

standard regulations for such homes" (64). Actually, since 1995 North Carolina has defined

an assisted living residence as "any group housing and services program for two or more

unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal

a day and housekeeping services and provides personal care services …" (G.S.131D-2).

Thus, states do regulate these smaller care homes.

Carder, Morgan and Eckert discuss the many challenges faced by family care homes

in competing with the larger assisted living residences. Often dependent upon Medicaid and

Supplemental Security Income (SSI) for payment, the population is frequently made up of

minorities and the less well-educated. The profit margin is slim and it is difficult to take advantage of the economies of scale available to larger homes. With a small staff, often the owner of a family care home is doing multiple tasks. When there is paid staff, they rarely are offered benefits, training or opportunities for advancement. Time is spent fulfilling state regulations leaving no time or money to lobby for change. Local zoning requirements often prohibit signage that would allow local persons to know of the availability of space in a family care home, and tight budgets frequently prevent advertising. Family care homes rarely can offer the amenities of a large assisted living facility; a fitness center, a pool, hiking trails, etc. (Carder, Morgan and Eckert 152-6).

Assisted living facilities are sometimes referred to as "intermediate care nursing homes with a chandelier" (Doty 305). Today's Baby Boomers fear institutionalization, but they fear becoming a burden to their children or grandchildren even more. For that reason, "private consumers often enter assisted living with low levels of need for medical, nursing, or aide services. … Many private consumers who choose assisted living want to escape from burdens of home ownership and home maintenance…. More important, many private pay consumers are seeking an alternative to… dependency on informal family care" (Doty 323). The irony of this is that if you go into a care facility too early, you run the risk of depleting your resources just when you need them the most.

Becky is in her early 60s and her widowed mother just turned 88. In an interview in June, 2013 Becky recounted that her mother has lived at Givens Estates, in the independent living section, for over ten years. Her mother's short term memory is now beginning to fail, so her eight daily prescription medications need to be managed, and she can no longer adequately perform the activities of daily living. Givens wants Becky's mother to move from

independent living into assisted living, but this would deplete her limited remaining resources even faster, so Becky goes to her mother's apartment twice daily to help, plus hires an aide when she cannot be there. Nonetheless, the funds are about to run out, and Becky will then move her mother into her own home. As Becky works full time, she will need to hire an aide to come in and assist her mother during the daytime when this happens. This is exactly the situation Becky's mother was hoping to avoid by moving onto a campus that had various levels of care available. Again, as government reimbursement currently exists only for those who are either completely destitute (Medicaid) or are in a nursing home on Medicare which has strict time and qualification guidelines, the options are limited.

As retirees, some of the Baby Boomer generation will feel comfortable with the idea of an assisted living community when they require help with the activities of daily living. For others, who consider the idea of "institutionalization" of any form an anathema, this is a generation that will advocate for new and better housing options as it ages. Says Golant in discussing assisted living, the Baby Boomers want "a setting that is secure, safe, supportive, and comfortable but does not assault their individuality and autonomy" ("Future of Assisted Living" 24).

This sentiment is echoed by Debbie and Steve Wilkins, co-managers of Bella Vista Retirement in Asheville. A hybrid, Bella Vista is not fully an assisted living community but neither is it merely an age-restricted community, representing a unique place in the continuum of options increasingly available to today's older citizens. Bella Vista is age restricted housing with limited services. Bella Vista opened in August, 2011 with 120 studio, 1 bedroom, and 2 bedroom rental units. On the day I visited, they had only 2 vacant apartments. Bella Vista provides 3 full meals daily to residents, housekeeping services,

transportation to shopping and medical appointments and many activities. What they do *not* provide is any assistance with activities of daily living, which would require them to get a license as an assisted living residence. One in-home care agency maintains an office on site, and other in-home care and home health agencies are quite present on the premises. The average age of the residents is between 83 to 85, they are approximately 65% women and the residents, but the women in particular, are looking for security when choosing to move into Bella Vista, say the Wilkins'.

Wolf and Jenkins credit women returning to the work force in record numbers with the rise in the number of assisted living care facilities. They say that the informal, unpaid care that women used to provide to elderly parents and parents-in-law could no longer be sustained in a two-income household. It became necessary to find a formal, paid means of providing the services needed. An assisted living facility or family care home was the solution of choice for many (200).

These various forms of service-driven housing are not cheap. Until recently, there was no government reimbursement for assisted living residences. Now, recognizing that the line between assisted living and skilled nursing is blurring, some states are beginning to reimburse for care provided in assisted living residences. Currently, Medicare continues to reimburse only for rehabilitative services under strict federal guidelines. Different states have different Medicaid reimbursement policies. Wolf and Jenkins conclude that the ability to access government assistance for lower income seniors effects their decision on whether or not to move into an assisted living residence or remain at home; "(C)hanges in Medicaid with respect to reimbursement levels, coverage of medically needy individuals, adoption of the

personal care option, and participation in waivered home health programs have all carried

implications for individuals' and families' decisions about long-term care" (208).

Often, it is adult children who initiate the move into an assisted living residence.

Manus wonders who are more assisted when an older person moves into an assisted living

environment, the caregivers, usually adult children, or the older persons themselves (10). If

the move is initiated by the senior, says Manus, there tends to be a greater sense of autonomy

and control than if the children have orchestrated the move. The person moving needs to be

involved not only in the decision to move but also in all the additional resulting decisions;

choosing the place, deciding what to take and what to leave, hiring a mover, etc. (9-10). Caro

et al. reveal that "older people often excuse themselves from what they recommend for other

older people" (23) as can be seen in their own reluctance to give up "home." Adult children,

concerned primarily with the physical safety of an older parent, must also take into account

the challenges involved in moving an older person "because they require giving up a familiar

physical setting, disposing of some valued possessions … paying for the move, and learning

to live in a new setting" (Caro et al. 5). Certain circumstances can precipitate a move: the

death of a spouse; children, friends or neighbors moving away; having to give up a driver's

license; the rising cost of home maintenance. Older people often live in older houses which

are less well equipped to facilitate their needs as they age and which require more

maintenance (Caro et al. 5) as discussed on page 8.

There are multiple resources to find an appropriate assisted living residence. In North

Carolina, each county has a Council on Aging which publishes a listing of all licensed

facilities (www.ncdhhs.gov). Recently, the University of North Carolina at Chapel Hill

launched a new website (www.alce.unc.edu) ranking licensed facilities. Likewise, moving

itself has become easier thanks to the National Association of Senior Move Managers (www.nasmm.org). Founded in 2002 with 16 companies, today over 800 member firms assist seniors in moving from their homes into smaller spaces, whether they are going to assisted living or to a granny pod. The movers help with donating usable items to charity, removing unusable items to local dump sites and arranging for items to be safely stored for transport to loved ones if necessary.

Like so much else connected with housing for aging citizens, assisted living is changing. Assisted living began as a way of providing a more homelike, autonomous atmosphere in a more residential setting. Mullen and Singer report that between 1991 to 1999 assisted living properties in the United States increased by almost 50% and the number of beds by 115%. Occupancy rates reached a high of 95% in 1997 and by 2005 had slid down to 88.5% (268-9). As their article was written in 2006, prior to the economic downturn, when people were able to quickly sell an existing residence, occupancy rates have probably fallen since then. Many of the residents who are today in assisted living would have been in a nursing home several years ago. Some of this has to do with the social versus the medical model of care, and some with the way we in this nation choose to pay for assistive care for the elderly.

The social model of care allows the resident to participate in choices about how they live, about the services they will receive and about the level of care involved (Hyde, Perez and Reed 48; Doty 323; Polivka and Salmon 400). The medical model of care is what we associate with the traditional nursing home as described by Baker and others: long corridors of sterile two-bed rooms where residents are referred to by their ailment rather than by their name; there is no privacy; no choice in what is eaten, or in when bathing occurs. Say Hyde,

Perez and Reed, the social model of care is not disease management but quality of life

management. Everyone probably knows someone who has elicited the promise from a child

or grandchild never to place them in a nursing home no matter what happens. Anything is

better than ending your days in such an institution.

Skilled Nursing Homes

        "Promise me you'll never put me in a nursing home." No two words strike fear

among the elderly like "nursing home." Those words bring forth visions of sitting slumped in

a wheelchair, neglected by staff, with no privacy, no autonomy, and "cruising down life's

off-ramp" (Thomas xii). Baker says that our society warehouses older people by placing

them in an institution, "viewing old age as a disease to be conquered, rather than a life stage"

(20).

        The nursing home that comes to mind is created along the "medical model"

referenced above. There is no privacy and no sense of personal identity. As in assisted living

facilities, nursing home occupants do not have locks on their doors. Most residents are on

multiple medications, as though trying to fix something that is broken. You can't fix old age,

says Thomas. "Nursing home residents receive too much treatment and too little care"

(Thomas 9) because reimbursement is based on treatment. Life inside is controlled by staff

and is for their convenience, not the residents.

        Thomas discusses the trifecta that afflicts many nursing home residents -- loneliness,

helplessness and boredom (23-5). He reminds us that these are social issues, not medical

issues, so the solution lies in changing the social environment not the medical environment.

In 1995 in upstate New York Thomas introduced the Eden Alternative, which began a slow

transformation in nursing home care which continues today. This transformation is slow

because of the way our system reimburses for nursing home care, because it is hard to embrace change, and because the elderly have little political clout.

The Eden Alternative has pets of all kinds living among the residents. There are dogs, cats, birds and fish that live on the premises, don't just visit on someone else's schedule. There are live plants everywhere. Instead of a lawn of grass, there is a garden of homegrown fruits and vegetables which are grown to be eaten. Children are a constant presence in the facility. There is a day care center on site, an after school program and a summer day camp. Staff turnover is decreased, the number of daily medications is decreased, and the death rate slows down (35-53).

In 2005 Dr. Thomas received a grant from the Robert Wood Johnson Foundation to create his first Green House (www.thegreenhouseproject.org). The Green House principle is based on nurturing and person-centered care. Green Houses deliver skilled nursing care in a holistic, homelike atmosphere where there are between 6 to10 residents in a cluster arrangement. Each resident has a private room with bath, which opens onto a common kitchen and dining area. Residents and their family and friends are welcome to use the common facilities at any time. Residents choose what to eat and when to eat it. Pets are welcome; the facility is quieter than at an institution. There is a dedicated staff, and because the care is more person-centered, staff turnover is much lower than in a traditional nursing home. Green Houses are licensed as long-term care facilities and so are Medicare and Medicaid eligible. Currently there are 144 Green Houses in 32 states with plans to open more.

Long-term care is evolving from the medical to the social model of care for several reasons. One is the public perception of nursing home care as the warehousing of older people waiting for death to take them. Another is that assisted living facilities are

encroaching on nursing homes by keeping residents long after they actually qualify for nursing home care. These assisted living facilities "siphon off" the private pay elderly who at one time constituted the framework of the nursing home industry by bringing in home health care and other forms of assistance (Calkins 94, 106-7; pbs.org/frontline). The emergence of NORCs, of urban villages and of the ability to age in place with assistance is offering options to those who at one time had no choice but to enter a nursing home. Some assisted living facilities are now accepting dementia patients. This leaves nursing homes as repositories for low-income impaired elderly because they are the only places willing to accept Medicaid patients. Traditional nursing homes are fighting back by moving away from the long-term custodial care model to a model of providing chronic, post-hospital rehabilitative care, which is reimbursed by Medicare. (Calkins 97-8).

Like the other forms of housing for senior citizens, nursing homes are evolving to meet the changing demands of their constituency. As the needs change, and the reimbursement policies change, the way nursing homes look will change as well.

Conclusion

The Baby Boomer generation has begun moving into the ranks of the senior citizens. As a cohort, they are a group that believes in collaboration, yet each individual will need to take personal responsibility for his or her own aging process. The Baby Boomers have embraced physical exercise as though they invented it, yet now they are having their joints replaced in record numbers. Illnesses once considered fatal are now chronic with the associated costs skyrocketing. Like the generations preceding them, the Baby Boomers are in denial about aging. They are refusing to acknowledge that they should no longer drive at night or that negotiating stairs is becoming more difficult. Diet books dedicated to preserving

youth, like the South Beach Diet and the Wheat Belly Diet, become instant best sellers. When they fail to deliver the promised fountain of youth, they join the ranks of how-to guides consigned to the recycle heap.

American society has a long history of housing creativity, from the Utopian movement of the 1850's to the Naturally Occurring Retirement Communities of today. Many of the Baby Boomer generation will refuse to be warehoused in age-segregated communities. This Baby Boomer generation has refused to move in lockstep with previous generations, or with one another. So, where and how will they live?

Cisneros says that we need to do a better job of listening to older people and of addressing their concerns and frustrations (14). He argues that designing communities to better address the issues of aging would enable seniors to age at home safely. Baldwin et al. remind us that when seniors remain at home or in a village setting this delays spending down their assets and the need to apply for government assistance, especially Medicaid (109). They also maintain that those seniors suffer from less isolation and less depression. Baker writes that all people, regardless of age and circumstance, need to remain engaged in life. They are entitled to self-determination: what to wear, when to bathe, when and what to eat (45). This is also the premise of Dr. Thomas' Eden Alternative and Green House Project.

Older citizens can anchor a community. Regardless of whether it is a neighborhood of single family residences or a cohousing community, it is often the senior citizens who not only provide the institutional background but who are the least transient among the residents. They pay their taxes year after year. They volunteer time in their community. They look after their neighbors. If the goal is to make these communities more livable for everyone, including older adults, then society must be willing to adapt to changing the infrastructure

accordingly: zoning restrictions need to be amended to allow for smaller, denser structures; public transportation needs to be more accessible; communities need to have better street lighting and longer crosswalks to allow for aging and handicapped citizens. We need to encourage innovative public-private partnerships to create service models, like NORCs and PACE programs. Some of these ideas will become permanent, others will fade away.

We Baby Boomers need to take personal responsibility for how and where we will age. Many today are buying and building homes with aging in mind. We are looking for a bedroom and bathroom on the main floor, for wider doorways, for assist bars and ramps. Where we Boomers spend our final years can no longer be by default. It needs to be deliberate and planned. Some of our generation is determined to leave a financial legacy for our children, aware that this next generation might not have the opportunities to accumulate wealth or to receive government benefits that we have enjoyed. But we are also anxious about a different form of legacy – of late night phone calls, of rushing to find an appropriate housing situation, of going through decades of boxes filled with clothes and memorabilia. This is a burden we do not want to visit upon our children or grandchildren, but can only be avoided by planning for future needs, by talking to families and friends about our wishes, and by exploring all available options.

Attitudes about aging will change as the Baby Boomer generation ages. We need to stop defining old age as anyone over the age of 65 because it does not mean the end of "innovation, entrepreneurship and creativity," writes Freedman (163-4). This serves to remind us that, as we age, we can continue to control our destiny and to feel empowered because there are an ever-increasing range of options. All the euphemisms about aging will take on new meaning as one in five Americans will be over the age of 65 by the year 2030.

Some housing options will evolve, like NORCs. Others will be deliberate, like cohousing communities. Some seniors will prefer the security of housing with services like CCRCs; others will prefer living independently as long as possible with options like PACE services hopefully becoming more widely accessible.

New options will continue to become available as new ideas take hold. In Pennsylvania and Delaware right now there is a Continuing Care Retirement Community at Home (www.friendslifecare.org), which operates just like a CCRC but without walls. All the services available to a participant in a CCRC are made available to a participant in their home environment. As with other innovative concepts, while it begins on a small scale, which is expensive, over time it expands and becomes more attainable to more income groups. It will take public demand and collaboration among "public health experts, land use planners, and designers of the built environment" (Kirk 115) to change the landscape so that citizens of all income levels have multiple housing options as they enter their senior years.

Housing options will expand to differing groups to meet expanding needs. Dr. Thomas' Green House project, a skilled nursing facility, is really a family care home with nursing care, which allows it to qualify for Medicare payments. Local governments will need to cooperate with seniors in innovative ways to assist in aging in place. Just as human nature is to rise to an occasion, so it is if you take an able-bodied, alert 90-year old and place him or her in a supportive environment, his or her ability to be self-sustaining will deteriorate. Enabling seniors to age in place as long as possible remains the preferred option, as long as there is a plan should their mental or physical health decline.

For many older people, there is a need to balance physical safety with social interaction. Physical safety can be a major concern, particularly for the frail elderly. In the

fall of 2012 news of Hurricane Sandy in the Northeast brought stories of the elderly and the handicapped stuck in high-rise apartment buildings for days on end, their caregivers unable to reach them, with no water, no food, out of needed medications. Some were so frail they were unable to leave their wheelchairs. It is why children encourage parents to move into supportive communities. But these facilities are not without similar issues. During the first week of March, 2013, the media reported the story of an elderly woman in an independent living facility in California who died while the staff waited for help to arrive -- no one there was allowed to administer CPR.

Regardless of whether a Baby Boomer decides that aging in place is too isolating and that he or she will be better served by relocating to a community setting or that living in community requires too much consensus building and interaction with others, it is time for those of us who are part of the Baby Boomer generation to take individual ownership for where we will live the final part of our lives. Allowing others to determine that, allowing it to be crisis driven, is no longer acceptable. We need to stop believing that growing older is what happens to other people rather than to us and to the people we love. We also need to be respectful of the choices made by others. If none of these options currently available seem like good ones, let's work to invent some new and better ones.

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