

**Assessing a Community's Elder-Friendliness: A Case Example of
The AdvantAge Initiative**

David Hanson, Ph.D.
Program Specialist
Pierce County Aging and Long Term Care
(253) 798-3807
dhanson@co.pierce.wa.us

Charles A. Emlet, Ph.D., MSW
Associate Professor
University of Washington, Tacoma
1900 Commerce Street, Campus Box 358425
Tacoma, WA 98402
(253) 692-5827
caemlet@u.washington.edu
(Corresponding Author)

Authors Note: David Hanson is Program Specialist, Pierce County Aging and Long Term Care, Tacoma, Washington (Email: dhanson@co.pierce.wa.us). Charles A. Emlet is Associate Professor, Social Work Program, University of Washington, Tacoma, Tacoma, Washington (Email: caemlet@u.washington.edu).

Abstract

The graying of our population has created a need for elder-friendly communities, but this concept has not been consistently defined nor applied in community assessments. Studies of the topic have examined a range of phenomena—physical environments, religious communities and access to services—in an attempt to develop a comprehensive model for community assessment. This paper describes an elder-friendly community model developed by The AdvantAge Initiative® and discusses how it was used to identify assets and areas for improvement in one Western Washington community and how this assessment is informing strategies to improve older adults' quality of life.

Key Words: Community Change, community initiatives, elder-friendly communities, aged, macro social work.

Communities throughout the United States are increasingly aware of the graying of our population. Adults ages 65 years and over accounted for 12.3 percent of the U.S. population in 2002, and the fastest growing segment of the population is persons 85 years and older.¹ In the coming decades, the 76 million individuals who are part of the baby boom generation will enter young old- age, doubling the current size of individuals in that age range.² Demographic projections suggest that by the year 2030, the older population will more than double, reaching 71.5 million persons.¹

Faced with this demographic change, aging network professionals, policy makers, and government officials are paying more attention to conditions that enable older adults to *age in place*. One area of analysis focuses on identifying factors that influence elders' decisions to migrate from, or remain in, communities in which they have lived. The ability to age in place, which Hooyman and Kiyak³ have defined as the capacity to live in one's private home or apartment even when declining competence reduces environmental congruence, has been tied to the availability of local resources and services.⁴ While aging in place is often viewed from an individual (micro) level, this phenomenon can and should be viewed from a macro perspective that encompasses the larger community. The purpose of this paper is to describe the implementation of an elder - friendly community model that was first reported in *Family and Community Health* by Feldman and Oberlink in 2003,⁵ discuss a process for assessing elder-friendliness, and illustrate how assessment findings in one Washington State community are being utilized to promote community-level change that helps enhance older adults' quality of life.

DEFINING ELDER FRIENDLINESS

Although the term "elder friendly" has been used for a number of years, the professional literature has not provided, to date, a consistent definition of what the term means. Shirreffs, for example, approached the concept from an environmental perspective, suggesting that *comfort zones*

should accommodate older adults beyond the requirement of the Americans with Disabilities Act (ADA).⁶ Concentrating on an entirely different area, Knapp⁷ explored the elder friendliness of various church congregations by evaluating the number of programs designed for older parishioners.

The Elder Friendly Communities Project in Calgary, Alberta formulated a more comprehensive definition of the term in its study, which assessed the assets, capacities, and needs of seniors and their families in four neighborhoods of that city.⁸ Utilizing focus groups, in-home interviews, and key informant interviews, Austin et al. identified several themes as essential elements of elder-friendliness.⁸ Older adults emphasized the importance of being valued and respected, and noted that maintaining their independence and involvement in activities were key to a good quality of life. In addition, they cited financial security for both the material benefits and peace of mind it provided and pointed out that personal safety was crucial to feelings of well-being. Having the means and ability to remain in one's residence or age in place was also stressed, as was ready access to information about senior services. Last, older adults underscored the value of being mobile, whether that meant driving one's car or utilizing public transportation.⁸ Service providers interviewed for this study echoed many of the themes outlined by the seniors, but framed them somewhat differently. Although they too valued the ideal of aging in place, for example, they viewed the issue in realistic terms—noting that the requisite resources are not in place in many instances to ensure that this occurs on a widespread basis. The providers thoroughly understood the need for easily accessible Senior Information and Assistance, but noted the challenges involved in making the current fragmented system seamless.⁸

The key components of an elder friendly community highlighted in the Calgary study help better define a place where older adults thrive. By highlighting personal elements (e.g., feeling valued and respected) and community-based factors (e.g., accessible Senior Information and

Assistance), Austin and colleagues provided important insights into the relationship of individuals to their communities. Their work suggests that an elder-friendly town or city not only has a range of services in place that supports older adults, but is also marked by a climate of acceptance that honors elders' contributions to community life. In this conception of elder friendliness, programs that help people age in place, promote mobility, and ensure safety are key; just as important, though, are the attitudes that people of all ages have toward older adults.

Affirming the findings of Austin and colleagues, Golant noted that a variety of factors, in combination, determine whether older adults will age in place even when retirement provides the opportunity to migrate to other areas.⁹ Schiamberg and McKinney suggested that elders' decisions to remain in their communities or to migrate are influenced in part by individual characteristics, which include personal resources, socioeconomic status, care needs, and age-related losses.¹⁰ Equally important, though, are contextual factors, such as economic viability and safety, availability of health care, age-discrimination practices in the community, and the availability of jobs. Housing characteristics, as well as social factors -- including the need for care, the desire to be close to adult children and grandchildren, and the wish to live near friends, also contribute to a lesser or greater extent to these decisions.

THE ADVANTAGE INITIATIVE MODEL

As the foregoing discussion makes clear, conceptions of elder-friendliness have differed according to the discipline of investigators and the purpose of their research. If researchers, policy makers, and community organizers are to advance the concept of aging in place in elder friendly environments, a well-defined model, comprehensive in scope, is needed. As outlined by Feldman and Oberlink,⁵ the Center for Home Care Policy and Research of the Visiting Nurse Service of New York (CHCPR) has sought to provide such a framework with the AdvantAge Initiative®—a project that enables communities to “estimate their current readiness to support the health and well-

being of their older residents.”^{5 (p. 268)} Coupled with that aim, the project advocates that communities develop action plans to address issues that will help improve older adults’ quality of life.

The first phase of The AdvantAge Initiative® was devoted to defining an elder-friendly community by utilizing focus groups to gather input on conditions that enable older adults to thrive. CHCPR staff also reviewed literature on measures of well-being for seniors and this provided additional insights. Themes that emerged from the focus groups and literature review were then translated into domains, dimensions, and indicators that typify a good place for elders—and people of all ages—to live.

A total of 14 focus groups were convened in four localities representing each region of the country--Chicago; Allentown, PA; Asheville, NC; and Long Beach, CA. Participants, which included both citizens and community leaders, were drawn from three age groups: 75 years and older, 60 –74 years, and 35 – 59 years so that the views of older and middle-aged adults would be represented. Citizen participants were diverse with respect to ethnic background, income, and health status. Focus group participants—across sites and age groups—held that “successful aging” depends chiefly on “financial security, health and health care, social connections, housing and supportive services, and transportation and safety.”^{5 (p. 271)} Economic self-sufficiency and good health were identified as important keys that allowed older adults to fully live their lives and remain active. In many ways, focus group participants felt that these two factors formed the foundation for optimal aging in place. The value of social interaction with family members, friends, and neighbors was deemed vital because this fostered emotional well-being and helped older adults feel they were part of the community and not marginalized because of their age. Affordable and appropriate housing, coupled with personal care and chore services, were viewed as integral to helping seniors remain in an independent-living situation for as long as possible. Transportation and safety were

cited as essential conditions for successful aging because they enabled seniors to be mobile and engage in community activities.⁵

The themes generated in the focus groups were subsequently organized into four domains (see figure 1) and several dimensions to form the framework of The AdvantAge Initiative's ideal of a good place for older adults to live.

[Insert Figure 1 about here]

This model stresses that an elder-friendly community addresses basic needs, ensuring that seniors have affordable housing, safe neighborhoods, good nutrition, and access to reliable information about services. Second, an elder-friendly community safeguards the physical and mental health of older adults by providing access to health screening services, medical and palliative care, and physical activity that promotes fitness. Third, an elder-friendly community has accessible transportation available as well as supportive services for caregivers and for those whose health and ability to perform activities of daily living are declining. Fourth, an elder-friendly community emphasizes inclusiveness and civic engagement by encouraging social interaction amongst neighbors, friends, and people of all ages. The four domains shown in Figure 1 are comprised of 33 separate indicators, shown in Table 1, that identify the extent to which a community is elder friendly.

[Insert Table 1 about here]

THE ASSESSMENT PROCESS IN ONE COMMUNITY

The goals of the The AdvantAge® Initiative are to assist communities in assessing their elder-friendliness, identifying areas where supports need to be strengthened, and documenting where older adults are served well. One of the project sites is a Western Washington community, which is home to slightly more than 100,000 people within its city limits and surrounding

unincorporated areas, over 10,000 of whom are 65 years and older. It was selected along with nine other cities and counties nationwide to participate in the project after submitting a letter of interest; agreeing to designate a coordinator to manage activities at the local level and to serve as a liaison to the CHCPR; and outlining a plan to convene a group of stakeholders from the aging network, government, and business sectors to function as an advisory body. In January 2001, a community task force was convened to oversee the project, and one of its first duties was to develop a communication plan to inform the public, and older adults in particular, about the telephone survey of citizens 65 years and older to gather data on elders' quality of life in the four domains.

A telephone survey of 514^{*} randomly selected respondents served as the main tool for gathering data from older adults. Task force members worked with local media, senior centers, senior housing sites, and other organizations serving elders to inform community members about the project and the survey's legitimacy. The research firm retained by the CHCPR to conduct the study obtained the names and addresses of Medicare beneficiaries in the target area from the Centers for Medicare and Medicaid Services (CMS)—a practice that is no longer viable because of Health Insurance Portability and Accountability Act (HIPAA) regulations. Names and addresses were then randomly selected and matched with telephone numbers obtained from an area telephone directory. CMS mailed letters to potential respondents explaining that they might be contacted by the research firm to participate in the survey and assuring them that their participation was entirely voluntary.¹¹ The research organization also sent potential respondents reminder post cards about the survey shortly before it commenced in January of 2002. The telephone survey, which contained approximately 100 questions related to the four domains discussed previously as well as

* n = 514 is unweighted. The weighted n of 10,166 represents the non-institutionalized population of adults age 65 and over in that community based on Census 2000 data.

key demographic information, required 30 to 45 minutes to complete. The 514 interviews were concluded in April 2002.

The profile of older adults who completed the community survey is shown in Table 1. Fifty-eight percent of respondents were female, half were between the ages of 65 and 74 years with the other half being 75 years and over—14 percent of which were at least 85 years of age. The vast majority were white (97 percent), most (65 percent) were married, and almost half (48 percent) had completed some college or higher. Fifty-four percent had incomes at or above 200 percent of the federal poverty level (\$17,720 at the time of the study), 24 percent had annual earnings below 200 percent of the federal poverty level, and 22 percent declined to report their income. Seventy-eight percent had lived in the community for ten years or more. The majority (84 percent) owned their own homes, 71 percent lived with others, and 93 percent stated they had one or more living children. Of those with living children, 76 percent reported living within 60 minutes of their children.

[Insert Table 2 about here]

Overall, these older adults claimed to be in good health with 85 percent stating they felt their health was excellent or good. Approximately the same proportion indicated no limitations in activities of daily living (ADL), and only eight percent indicated limitations in instrumental activities of daily living (IADL). The majority (87 percent) reported they were not currently working. The importance of aging in place is evident with these elders as 92 percent agreed with the statement that they would like to stay in their current residences for as long as possible.

CHCPR researchers conducted an initial analysis of the indicators and reported results of the survey to the local task force. Findings were sorted by the following demographic characteristics: age, gender, income, education, ethnic background, health status, degree of isolation in the community, and activity limitations. This allowed for comparison of selected groups of individuals.

which revealed notable disparities. Those with yearly incomes under 200 percent of Federal Poverty Level, for example, fared less well than their peers with higher incomes in several areas (e.g., paying for prescription drugs, needing home modifications to enhance mobility/safety, staying physically active, and in self assessments of their physical health). Similarly, older adults living alone or without friends in their neighborhood were at greater risk of not thriving than those who were part of a social network. Indeed, isolated elders were less likely to be aware of assistance services, and were less likely to be physically active, to socialize with friends or neighbors, and to volunteer. The data also showed that elders who described themselves as in fair or poor health typically faced greater challenges in maintaining a good quality of life. Presented in this manner, the findings provided a snapshot of the status of all older adults coupled with illustrations of the challenges faced by particular groups of elders.

As the community task force received the telephone survey results, a data analysis committee comprised of its members reviewed them to determine their meaning and importance. For some indicators, the findings revealed positive news about the community, and the data analysis committee recommended informing the public about these elder-friendly elements. Results for other indicators, however, pointed to a problem or unmet needs in the community that had to be addressed, and the data analysis committee referred these issues to the task force for further deliberation. In most cases, findings of this sort required additional inquiry, which necessitated convening focus groups or interviewing key informants to investigate questions that had been raised or not fully answered by the telephone survey.

KEY ASSESSMENT FINDINGS

In their response to the telephone survey, older adults pointed to three areas in which they felt their community accommodated the needs of older adults.

[Insert Table 2 about here]

First, the vast majority of elders (81 percent) praised their neighborhoods as good places to live, noting that their neighbors were helpful and trustworthy. Second, when questioned about their access to health care services during the past year, significant percentages of seniors reported receiving blood pressure checks (95 percent), physical examinations (67 percent), mammograms (64 percent), and Prostate Specific Antigen (PSA) tests (64 percent). Virtually everyone (96 percent) had a physician they saw on a regular basis. Third, a substantial portion of older adults (90 percent) indicated that they participate in a variety of cultural, religious, and leisure time activities, suggesting that they are an active group with opportunities for community involvement.

The task force identified seven areas, shown in Table 2, where efforts to enhance the community's elder-friendliness seemed warranted: 1) access to information and assistance, 2) participation in physical activity, 3) volunteer involvement, 4) access to affordable housing, 5) gaps in meeting care needs, 6) transportation and pedestrian safety, and 7) employment opportunities for older adults. These issues were selected because of what was learned through the telephone survey and follow-up data gathering, and because the task force felt that each lent itself to interventions that would yield positive results.

Access to Information and Assistance

The telephone survey revealed that 20 percent of older adults did not know whom to contact if they needed help. The fact that one of five elders did not know where to turn for assistance raised concerns about the presence, visibility, and effectiveness of Senior Information and Assistance in the community. Coupled with this, the county's Area Agency on Aging (AAA), which houses Senior Information and Assistance, was named by only a small percentage as the resource they would contact. In contrast, over 30 percent said they would consult a medical center or provider and 20 percent indicated they would turn to a senior center. Although the latter sites make information available for older adults, their resources are not as comprehensive as those maintained

by Senior Information and Assistance. Moreover, Senior Information and Assistance is staffed by specialists who, through intake interviews, may discover additional needs a caller has, and if indicated, refer them to case managers for ongoing assistance.

Participation in Physical Activity

The telephone survey showed that just under 50 percent of older adults engaged in physical activity three or more times per week, while 25 percent seldom or never exercised. Importantly, some subgroups of seniors had even higher percentages that seldom or never exercised: those with low-incomes (32 percent), those with one or more activity limitations (39 percent), those who are isolated (33 percent), and those who are in fair or poor health (38 percent). Because physical activity plays an important role in helping older adults maintain good health, the rates for those who are not active generated special interest. The telephone survey provided a partial answer as to why people did not exercise—over half, for example, said they were physically unable. Additional explanations emerged from a focus group that was convened to study this issue. Along with personal reasons, a number of environmental factors—lack of sidewalks, safety concerns related to bicycle path and trail use, and incomplete information about available opportunities for physical activity—were identified. Hence, as the task force considered this issue, it recommended developing approaches that addressed both personal and community barriers that prevent seniors from being physically active.

Involvement in Volunteer Activities

Recent studies have noted that while the number of older adults who volunteer in their communities has been increasing, opportunities for meaningful volunteer work may not be sufficient to attract the attention and commitment of the baby boom generation as it ages.^{12, 13} The results of the telephone survey indicated that elders volunteered at a rate (27 percent) similar to that of older adults in the other communities studied, but the fact that three out of four seniors do not

volunteer is noteworthy. Recognizing that this population represents a vast untapped resource, the task force convened a focus group to better understand keys to increasing volunteerism and the obstacles that stand in the way. Participants in the focus group, which was made up of volunteer coordinators and volunteers, underscored the value of personal contact in recruitment, the need for incentives to ensure retention, and transportation assistance as vital to sustaining a viable volunteer corps. The telephone survey data, which documented the level of volunteerism among older adults, along with information gleaned from the focus group, which highlighted factors that are important in sustaining robust volunteer efforts, provided the task force with a perspective from which to frame opportunities for action.

Access to Affordable Housing

According to the telephone survey, one of five elders spent more than 30 percent of his/her income on housing. In addition, almost 30 percent said they were “somewhat confident,” that they can afford to remain in their residences for as long as they would like, while eight percent indicated they were “not too confident,” or “not confident at all” that they can afford to remain in their residences. Given the projected growth of the senior population, these findings pointed to a need for action related to the availability of affordable housing. Thus, a focus group was convened made up of housing stakeholders in order to further explore this issue and to recommend measures to address it. Participants in the focus group noted that seniors’ needs for housing are not thoroughly understood, suggesting that more research might be done in this area. In addition, older adults may lack sufficient information about the range of housing options and assistance programs (e.g., Home Equity Conversion Mortgages and low-income homeowner tax exemptions) that exist. Last, ensuring the preservation of the community’s affordable housing stock was deemed a high priority at a time when rental property owners are opting out of subsidized housing projects for low-income elders in favor of managing residences that charge market rate rents.

Unmet Care Needs

Only 10 percent of seniors needed help with either an activity of daily living (ADL) or instrumental activity of daily living (IADL), according to the telephone survey results. Of that percentage, however, 56 percent indicated they had one or more unmet need—a troubling but not unexpected finding. As the population of those 65 years and older has grown, the number of people who need assistance with ADLs and IADLs has increased, and unfortunately, not all qualify for state-funded in-home care, which is targeted to serve those with primarily ADL or personal care needs (e.g., bathing, dressing, toileting, etc.). Hence, seniors who lack transportation to go shopping or who could use help with light housekeeping have few resources available to them. Interestingly, these needs were deemed critical by the volunteer coordinators and volunteers who participated in the focus group on volunteerism, an indication of the ways in which the two issue areas are interrelated.

Transportation and Pedestrian Safety

Findings from the telephone survey related to transportation and pedestrian safety raised several issues that required further exploration. It is clear, for example, that the overwhelming majority of the community's older adults (96 percent) travel by car, either as drivers or passengers. At the same time, though, when asked to name problems in their neighborhoods, significant percentages of seniors cited such things as heavy traffic (49 percent), limited access to public transit (28 percent), poor street lighting (26 percent), and walk and wait signs that change too quickly (21 percent). Hence, dependence on personal vehicles as one's primary means of transportation appears to create its own set of problems. Given these data, a focus group was convened to discuss the barriers that older adults face in using public transportation, gaps that exist in transporting

seniors with special needs, planning that is underway or needed to encourage greater use of alternative transportation, and potential street and sidewalk improvements.

Employment Opportunities for Older Adults

Most of the community's citizens who were 65 years and older were retired (87 percent), but one of seven of this group (14 percent) would like to be working, according to the telephone survey. What was not apparent from this finding is why some elders want to work, and additional investigation is needed to determine if the explanation is primarily financial, mainly due to a need to keep busy, largely attributable to the psychic benefits that people derive from work, or perhaps, a combination of these reasons. Knowing more about why older adults want paid employment will inform approaches the project can take to address this issue.

TRANSLATING FINDINGS INTO ACTION: THREE EXAMPLES

The telephone survey provided a snapshot of older adults' views regarding a range of issues and subsequent investigation of selected areas utilizing focus groups helped answer questions that arose when the survey data were examined. This information, in turn, served as the foundation for creating action plans to promote elder-friendly change, as the examples below demonstrate.

Enhancing Access to Information and Assistance

The survey results documenting where seniors turn for help and the percentage who had no idea whom to contact came at a propitious time. The Area Agency on Aging (AAA) had recently assumed responsibility for operating Senior Information and Assistance after it had been the province of the human services department of the county's largest city—by contract with the AAA—for a number of years. While Senior Information and Assistance was located in this city department, anecdotal evidence suggested that seniors living outside the city limits (which includes residents of The AdvantAge Initiative® site) often regarded this as a service for city residents only. The survey data confirmed that suspicion. Upon taking over this function, the AAA was eager to

counter this notion and to promote the program as the resource of choice for all of the county's elders. As a result, the AdvantAge Task Force, in consultation with aging network partners, recommended several strategies, which included more effective distribution of Senior Information and Assistance print materials, an intergenerational Senior Information and Assistance poster project, enhanced coordination with those from a variety of fields who are in contact with older adults, and outreach to isolated, low-income individuals. These concerted outreach efforts, highlighted by the distribution of Senior Information and Assistance posters created by high school art students in consultation with a group of seniors, yielded promising results. In 2003--the year the AAA assumed responsibility for Senior Information and Assistance—370 calls were received from the five zip codes that make up the community. In 2004, Senior Information and Assistance fielded 934 calls—a 250 percent increase in the number of people from this community seeking help.

Promoting No- and Low-Cost Physical Activity Options

In its efforts to encourage higher levels of physical activity, the task force joined with a non-profit healthcare research and education organization, a county health department, a city parks and recreation department, and a local hospital to develop a guide listing no- and low-cost exercise programs for seniors. Funding was secured to cover the costs of researching and documenting essential information about a range of exercise options (e.g., aerobics, dance, tai chi, balance and strength training, and more) and compiling these listings in booklet form for distribution to older adults. In addition, the project brought together several community partners (the parks and recreation department, a senior housing provider, the senior center, a local hospital, and the health department) to develop a walking group for seniors since research shows that regular physical activity, such as walking, is key to preventing falls and reducing the risk of cardiovascular disease, osteoporosis, and obesity. The local senior center and a senior housing complex served as meeting sites for the bi-weekly walks and over 30 walkers of all abilities initially joined the group.

Donations from the parks and recreation department, local merchants, and citizens funded the purchase of t-shirts featuring the group logo, neck wallets, and an array of prizes, all of which were given to the walkers at a kick-off event for the program.

Transportation and Pedestrian Safety

Elders' responses to the telephone survey, coupled with what was learned through the focus group on transportation and pedestrian safety, provided useful data to support a grant application for creating senior-friendly crosswalks near a downtown senior center and post office branch used by a significant number of older adults. Project representatives alerted the community's public works department to the grant funding opportunity and supplied selected findings about seniors' opinions on walk and wait times at intersections, traffic volume, and the condition of sidewalks and roads for the proposal. Funding for elder-friendly street improvements was awarded, and the project will participate in the planning process for developing and implementing features, such as signage and pavement lighting, that improve pedestrian safety.

Future Actions

The project will undertake additional actions in the future related to volunteerism, unmet care needs, housing, and employment for older adults. Volunteer participation and unmet care needs, for example, will be linked so that both issues can be addressed simultaneously. Discussion in the focus group on volunteerism revealed that the need for light housekeeping and transportation for shopping and appointments far exceeds the capacity of existing volunteer programs to provide these services. It is reasonable to assume, however, that increasing the number of volunteers who provide chore services will help fill this gap and the project will work directly with several volunteer programs that provide such services to enhance their recruitment and retention. In addition, the project will explore ways to increase funding for an existing chore service program and advocate, in collaboration with aging network partners, to increase state support for home- and

community-based services, reversing the trend of recent years during which funding has not kept pace with needs.

Further research into elders' needs related to housing and employment seem warranted, and the project's role will focus on providing leadership in these areas in two ways. First, it can bring stakeholders together for discussions about actions that could be fruitful. A public awareness campaign about Home Equity Conversion Mortgages, for example, might be one outcome of such deliberations and evolve into an initiative to strengthen counseling services about this form of assistance for older homeowners. Similarly, if employers are educated about the contributions elders can make in the workplace and seniors are made more aware of existing opportunities for employment, both will benefit. Second, the project can advocate for the interests of older adults by providing support for measures favorable to the development of affordable senior housing (e.g., the establishment of a local housing trust fund).

CRITIQUE OF THE ADVANTAGE INITIATIVE MODEL

The AdvantAge Initiative® model provides a useful conception of an elder-friendly community's ideal characteristics, a process for assessing older adults' quality of life, and a foundation for promoting change that emphasizes both short and long term planning. The model's four domains (basic needs, physical and mental health and well-being, social and civic engagement, and support for the frail and disabled), each with multiple indicators, capture key areas of concern and offer a means to measure community responsiveness to seniors' needs. As discussion about this definition of elder-friendliness has evolved, however, questions have been raised about other elements that might be included.

Spirituality

Religion and spirituality are important in the lives of most older people.¹⁴ While these concepts are increasingly acknowledged in the literature, The AdvantAge Initiative® model, in our

opinion, did not adequately address these needs and activities. Only two questions were clearly identified as relevant to religion and both were associated with church as a potential activity or volunteer site. To neglect this issue is not uncommon however. Similar to the domains of the model discussed here, Rowe and Kahn¹⁵ presented a model of successful aging which included the avoidance of disease and disability, maintenance of cognitive function, and engagement in social and productive activities. Crowther and colleagues, in examining the successful aging model have suggested that the “spiritual dimension...has not been integrated into promising intervention models that promote successful aging”¹⁶ (p. 613) We recognize that the spiritual dimension is significantly broader and deeper than church attendance, and as Atchley pointed out, it should include the introspective elements of faith and practice. Thus, further refinement and development of the model could better address the areas of religion and spirituality. It could be argued, for instance, that spirituality is a key factor in one’s physical and mental health and well-being, to isolate one domain in which it might fit. Viewed thusly, a community’s encouragement to cultivate spirituality—expressed through its tolerance of diverse beliefs and support for engaging spiritual issues related to caregiver support, palliative care, and death—would be vital to meeting elders’ needs in this area.

Livable income

As noted earlier, elders with incomes below 200 percent of Federal Poverty Level (FPL) — \$17,720 in 2002 when the survey was conducted—fared more poorly than those with higher incomes on a number of indicators. Seniors with lower incomes, for example, were more likely to have difficulty affording home modifications to enhance their mobility and safety. In addition, those who earned less than 200 percent of FPL were less likely to avail themselves of preventive health services, such as blood pressure screenings and physical examinations, and more likely to have trouble paying for prescription medications. Given the primacy of one’s earnings in determining their quality of life, it is worth asking if “livable income” should be added to the

domain of basic needs? Although the definition of a livable income varies from state to state and from urban areas to rural communities, making this a feature of the basic needs domain would identify a standard that accurately describes how much income an elder requires to live comfortably. Utilizing 200 percent of FPL as a benchmark to investigate differences among those earning above and below this amount is useful, but does not fully illuminate the central role that income plays in older adults' daily lives.

DISCUSSION AND CONCLUSION

The AdvantAge Initiative® model of assessing a community's elder-friendliness stresses both quantitative and qualitative approaches to gathering data, and as noted earlier, can be helpful in broadening understanding of a particular indicator and/or providing a more complete picture of the meaning of survey findings. The project's belief in employing both quantitative and qualitative methods rests on the assumption that, to quote historian Kenneth Burke, "a way of seeing is always a way of not seeing."¹⁷ Hence, when findings from the telephone survey generated questions that could not be answered by the available quantitative evidence, the task force convened focus groups and contacted key informants to probe further into the issue. By encouraging input from community stakeholders in this process, the project reinforced the importance of enlarging the circle of public involvement in its efforts, which is fundamental to increasing awareness of elders' concerns and enlisting partners to address them.

As issues were framed to define their impact on older adults and the community, approaches for addressing them highlighted the need for both short and long term planning. In the case of elders' lack of knowledge about where to turn for information about senior resources, for example, a number of strategies were identified to increase public awareness of available programs. In all, these recommendations represented solutions that were readily implemented and yielded easily quantifiable results within two year's time. In contrast, efforts to ensure that older adults have an

adequate supply of affordable housing call for a long-range, multi-faceted planning process. This involves enhancing both the quality and dissemination of information about housing options. It will also require advocating for the preservation of, and addition to, the community's affordable housing stock. Implicit in the AdvantAge Initiative's elder-friendly indicators is a recognition that change in some areas can be accomplished through practical, discrete interventions, while other improvements will take longer and involve extensive coordination, judicious mediation, and sustained advocacy with multiple stakeholders.

Although The AdvantAge® Initiative focuses on characteristics that make communities "elder-friendly" and promotes change aimed at benefiting seniors, its vision is ultimately broad in scope. Indeed, the model embraces the view that what is good for older adults is also good for people of all ages. Streets and sidewalks that are made safer with elders in mind, for example, also benefit those who are young and middle-aged, particularly if their primary means of getting around is walking. A stable supply of affordable housing for seniors coupled with a range of supportive services that enable them to live independently is a boon to adult children who serve as their parents' caregivers. And ensuring that opportunities are available for older adults to fully participate in community life not only enhances elders' feelings of belongingness, but also enriches interaction between generations and informs decision-making on myriad issues. In sum, The AdvantAge Initiative, while aimed at assessing older adults' quality of life and fostering change that is in their best interest, is dedicated to serving the common good, as well.

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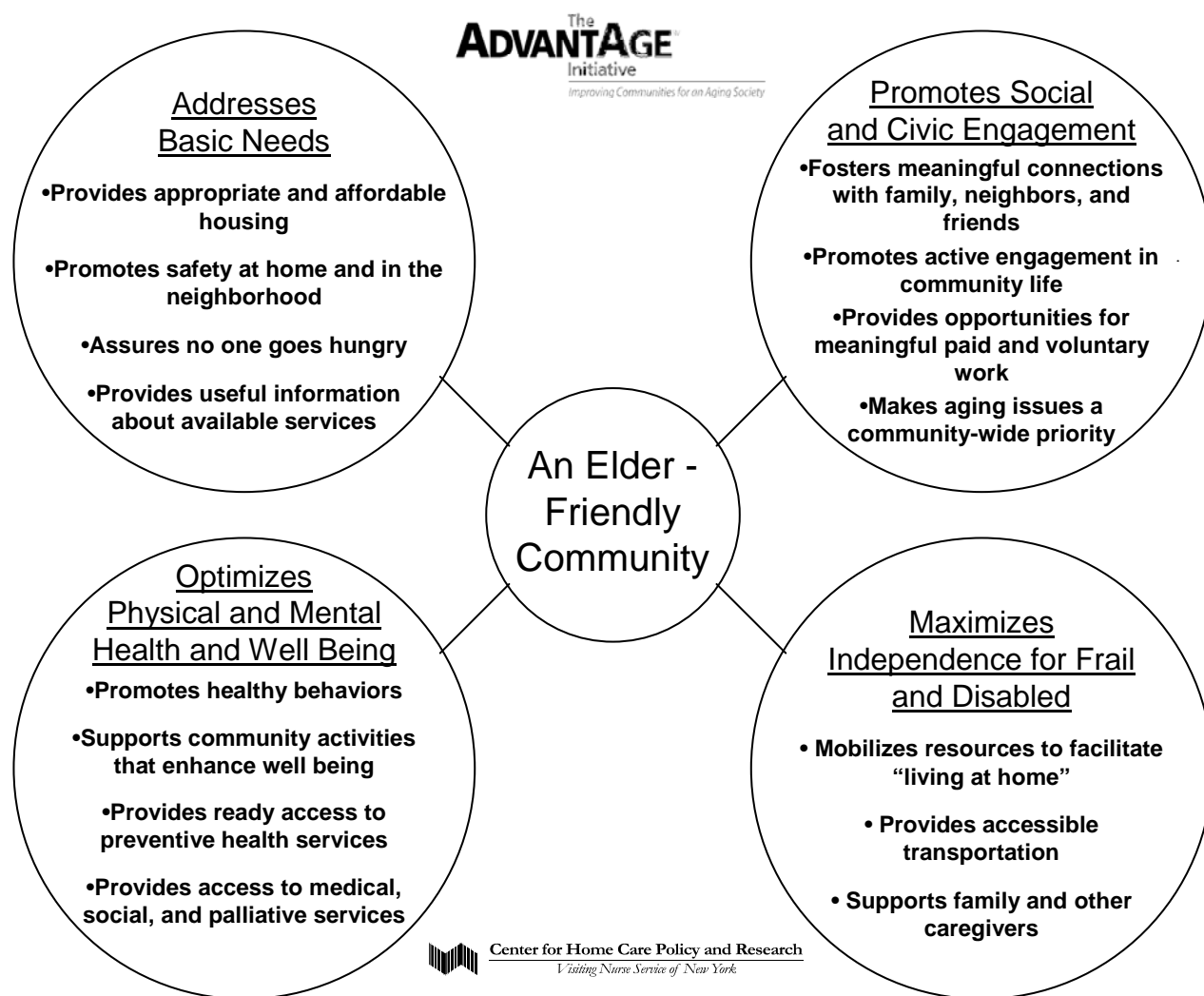


Figure 1. The AdvantAge Model for evaluating elder friendly communities.

Table 1. The AdvantAge Initiative Indicators List Essential Elements of an Elder-Friendly Community

Addresses Basic Needs	Optimizes Physical and Mental Health and Well-being	Maximizes Independence for the Frail and Disabled	Promotes Social and Civic Engagement
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<ul style="list-style-type: none"> ● Affordable housing is available to community residents 1. Percentage of people age 65+ who spend \geq 30%/$<$ 30% of their income on housing 2. Percentage of people age 65+ who want to remain in their current residence and are confident they will be able to afford to do so ● Housing is modified to accommodate mobility and safety 3. Percentage of householders age 65+ in housing units with home modification needs ● The neighborhood is livable and safe 4. Percentage of people age 65+ who feel safe/unsafe in their neighborhood 5. Percentage of people age 65+ who report few/multiple problems in the neighborhood 6. Percentage of people age 65+ who are satisfied with the neighborhood as a place to live ● People have enough to eat 7. Percentage of people age 65+ who report cutting the size of or skipping meals due to lack of money ● Assistance services are available and residents know how to access them 8. Percentage of people age 65+ who do no 9. know whom to call if they need information about services in their community 9. Percentage of people age 65+ who are aware/unaware of selected services in their community 10. Percentage of people age 65+ with adequate assistance in ADL and/or IADL activities 	<ul style="list-style-type: none"> ● Community promotes and provides access to necessary and preventive health services 11. Rates of screening and vaccination for various conditions among people 65+ 12. Percentage of people age 65+ who thought they needed the help of a health care professional because they felt depressed or anxious and have not seen one (for those symptoms) 13. Percentage of people age 65+ whose physical or mental health interfered with their activities in the past month 14. Percentage of people age 65+ who report being in good to excellent health ● Opportunities for physical activity are available and used 15. Percentage of people age 65+ who participate in regular physical exercise ● Obstacles to use of necessary medical care are minimized 16. Percentage of people age 65+ with a usual source of care 17. Percentage of people age 65+ who failed to obtain needed medical care 18. Percentage of people age 65+ who had problems paying for medical care 19. Percentage of people age 65+ who had problems paying for prescription drugs 20. Percentage of people age 65+ who had problems paying for dental care ore eyeglasses ● Palliative care services are available and advertised 21. Percentage of people age 65+ who know whether palliative care services are available 	<ul style="list-style-type: none"> ● Transportation is accessible and affordable 22. Percentage of people age 65+ who have access to public transportation ● The community service system enables people to live comfortably and safely at home 23. Percentage of people age 65+ with adequate assistance in activities of daily living (ADL) 24. Percentage of people age 65+ with adequate assistance in instrumental activities of daily living (IADL) ● Caregivers are mobilized to complement the formal service system 25. Percentage of people age 65+ who provide help to the frail or disabled 26. Percentage of people age 65+ who get respite/relief from their caregiving activity 	<ul style="list-style-type: none"> ● Residents maintain connections with friends and neighbors 27. Percentage of people age 65+ who socialized with friends or neighbors in the past week ● Civic, cultural, religious, and recreational activities include older residents 28. Percentage of people age 65+ who attended church, temple, or other in the past week 29. Percentage of people age 65+ who attended movies, sports events, clubs, or group events in the past week 30. Percentage of people age 65+ who engaged in at least one social, religious, or cultural activity in the past week ● Opportunities for volunteer work are readily available 31. Percentage of people age 65+ who participate in volunteer work ● Community residents help and trust each other 32. Percentage of people age 65+ who live in "helping communities" ● Appropriate work is available to those who want it 33. Percentage of people age 65+ who would like to be working for pay
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Table 2. Sample Characteristics

Characteristic	Percent¹
Gender	
Male	42
Female	58
Age	
65-74	50
75 and over	50
Race	
White	97
Other	3
Marital Status	
Married	65
Not Married	35
Education	
High School or Less	51
Some college or higher	48
Poverty Status²	
Less than 200% of poverty	24
200% of poverty or above	54
Income not reported	22
Health Status	
Excellent/very good/ good	85
Fair/poor/very poor	15
Activity of Daily Living Limitations	
None	84
One or more	16
Instrumental Activity of Daily Living Limitations	
None	92
One or more	8
Living Arrangements	
Lives Alone	28
Lives with others	71
Home Ownership	
Owns own home	84
Rents	13
Other	3
Number of Years in the Community	
Less than 10	22
10 or more	78
Number of friend in the community	
None	34
Some/quite a few	65
Employment Status	
Works part or full time	13
Not working	87

¹ Percentages may not equal to 100% due to rounding and/or missing data

² According to the 2002 federal guidelines for poverty, a person in a one-person household was considered below 200% of poverty if her/his annual income was below \$17, 720.

Table 3: Percentages of Participation for Selected Indicators

Indicator	Percentage
Neighborhood satisfaction	81
Health screening in past year:	
Blood pressure	95
Physical examination	67
Mammogram	64
Prostate Specific Antigen (PSA) test	64
Participate in cultural, religious, recreational activities	90
Do not know whom to call about services	20
Physically active three or more days per week	50
Seldom or never exercise	25
Volunteer	27
Spend more than 30% of income on housing	30
Have one or more unmet care needs	56
Primary transportation is driving/riding in car	96
Problems in neighborhood	
Heavy traffic	49
Limited access to public transit	28
Poor street lighting	26
Walk/wait signs too fast	21
Retired, but want to work	14