

**Reframing “Aging in Place” to “Aging in Community”:  
Exploring Innovative Models to Support Aging in Place in British Columbia**

by  
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## Abstract

British Columbia (B.C.) currently has the fastest growing rate of seniors compared to any other jurisdiction across Canada. While the senior population is diverse, a commonality that exists among seniors is their desire to continue to age within their homes and communities. However, the accessibility and availability of home support services, as well as issues in housing are creating barriers, and continue to contribute to premature placement into residential care, caregiver burnout, and overuse of acute care services. A literature review was conducted to assess the current state of home support and housing in B.C., and possible solutions are explored drawing on two innovative community based models of aging in place (Village model and Naturally Occurring Retirement Communities, Supportive Service Program). Reframing ‘aging in place’ to ‘aging in community’ by emphasizing social capital offers possible solutions to support B.C seniors to age healthily and safely within their homes and communities.

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## 1.0 Introduction

The senior population (individuals 65 years+) is steadily increasing across British Columbia (B.C.). According to the B.C. Ombudsperson, the number of individuals aged 65 and over grew by 18 percent within B.C. between 2001 and 2008 (Barnes, Vogt, Bradbury, & Flanders, 2012). In particular, the number of seniors aged 85 and over grew by 43% during that period (Barnes et al., 2012). B.C. currently has the fastest growth rate of seniors compared to any other province in Canada. In 2015, there were 820,000 seniors living in the province, making up 17.5% of the population (Office of the Seniors Advocate, 2015d). Further, the senior population is projected to make up close to a quarter of B.C.'s total population in 2031 (Office of the Seniors Advocate, 2015d).

In a survey conducted by the B.C. Seniors Advocate (Office of the Seniors Advocate, 2015a), results indicated that the majority of seniors have expressed their wishes to continue living independently and safely, also known as aging in place. While not all seniors may need the same level of supports and services to do so, in general, there is an increasing number that do require some level of home health services, as well as the support from caregivers (Health Council of Canada, 2012).

While the B.C. the Ministry of Health (2014) has recognized the need to shift investments from acute care to the community, there are significant systemic barriers that are creating difficulties in fulfilling these wishes. Specifically, the accessibility and availability of home support services across the province, coupled with the affordability, accessibility and availability of housing (Office of the Seniors Advocate, 2015d), have significant implications on seniors' ability to age in place. As a result of these barriers, research indicates that seniors are being placed prematurely into residential care, caregivers are facing increased distress, and seniors are not receiving the support they need to age healthily and safely within their homes and communities (Office of the Seniors Advocate, 2015a, 2015b, 2015c, 2015d).

The concept of social capital has been used widely across disciplines, and have shown to have significant benefits in multiple areas, including health and well-being (Policy Research Initiative [PRI], 2005). While there are multiple definitions of social capital, this paper adopts the PRI's "network approach" in understanding this concept. Within this context, social capital "refers to the networks of social relations that may provide individuals and groups with access to resources and supports" (PRI, 2005, p.6).

## 2.0 Purpose

The purpose of this paper is to explore how shifting from a reliance on services provided under a publicly subsidized health care system to greater investment in social capital may bridge some of the existing gaps that prevent seniors from aging within their homes and communities. The first portion of this paper provides a review of the current state of home support and housing, and the specific implications it has on aging in place for B.C. seniors. The second portion will provide a comparative analysis of two community based models of aging in place, including the Village model, and the Naturally Occurring Retirement Communities-Supportive Services Program (NORC-SSP), and the possible solutions they provide in helping seniors age within their communities.

## 3.0 Methodology

To fulfill this purpose, a literature review was conducted using both academic and grey literature. The grey literature review component consisted of retrieving relevant policy documents and reports from previously identified provincial and federal nongovernmental organizations including: The Office of the Seniors Advocate, Canadian Institute of Health Information (CIHI), Canadian Centre for Policy Alternatives (CCPA), Office of the Ombudsperson, and governmental sources including the Health Council of Canada, Government of Canada, and the B.C. Ministry of Health. Documents published

between the years of 2005 to 2016 were selected based on their relevance to home health services and aging in place in Canada and B.C.

Academic literature was retrieved from two databases, Ageline and CINAHL (for full search terms refer to Appendix A). To be included articles were required to be published between 2005-2016, and have a focus on aging in place and aging in community, with particular emphasis on articles referring to the Village and NORC-SSP model. Based on this search, eighteen articles were retrieved. A further search of key existing articles' reference lists was conducted, and additional articles were retrieved. At this point, findings from the review were reaching high levels of consistent of themes, and it was concluded that saturation was reached. The final total sample included in the literature review was twenty-two academic articles.

#### 4.0 Social Capital and Seniors

Keating, Swindle and Foster (2005) illustrates the significant role of social capital in improving the health and well-being of seniors across the aging process. According to Keating et al., (2005), networks among seniors include social, support and care networks, with each type of network differing by the structure and resources they provide. Among seniors, building social capital can occur through bonding- within social networks with those of similar backgrounds, bridging- by forming relationships with those of different backgrounds, and linking -by building relationships with individuals in positions of power (Keating et al., 2005). All of these methods illustrate how networks can be built on various levels to facilitate improved accessibility and availability of resources through relationships, and ultimately improves a senior's ability to age in place.

## 5.0 What is Aging in Place?

Aging in place means being able to live safely and independently for as long as possible in one's home and community, with the necessary health and social supports and services (Government of Canada, 2016). The Centre for Disease Control's (2013) definition is more specific, and states that aging in place is the ability to live independently and safely within one's home and community, "regardless of age, income and ability level." Seniors across B.C. want to have the ability to make their own choices in determining how they wish to age, where they wish to live, as well as the types of services that are available to them (Office of the Seniors Advocate, 2015b; Wiles, Leibing, Guberman, Reeve, & Allen, 2011).

The central premise of aging in place centres on the ability to facilitate continuity of both the physical and social environment, enable seniors to maintain their independence, improve social inclusion, and maintain a sense of security and safety (Barrett, Hale, & Gauld, 2012; Stones & Gullifer, 2016; Wiles et al., 2011). Wiles et al. (2011) suggests that aging in place is a complex process, not only related to the attachment to a physical space like a home. Rather, it involves enabling seniors to continue to "reintegrate with places and renegotiate meanings and identity in the face of dynamic landscapes of social, political, cultural, and person change" (Wiles et al., 2011, p.358). While research on aging in place has traditionally focused on the benefits of enabling seniors to age within their dwellings, research is increasingly shifting the focus to examining the impact of neighbourhoods and communities, as they serve as resources in contributing to the success of healthily aging in place (Blanchard, 2013; Cohen & Franko, 2015; Gardner, 2011; Thomas & Blanchard, 2009; Wiles et al., 2011).

## 5.1 Benefits of Aging in Place

There is a plethora of research that illustrate the positive physical, mental, and social impacts of aging in place on the health and well-being among seniors (Cohen & Franko, 2015; Grimmer, Kay, Foot,

& Pastakia, 2015; Stones & Gullifer, 2016; Wiles et al., 2011). On the individual level, a senior's home not only represents the physical infrastructure in which one resides, it also represents a sense of personal identity, independence, and control, which have been cultivated through memories and experiences (Stones & Gullifer, 2016). Seniors experience significant transitions and losses throughout the aging process, and maintenance of a sense of personal control has been well documented as a protective factor against adverse psychological outcomes such as feelings of powerlessness, loss of identity and feelings of instability (Black, 2008; Stones & Gullifer, 2016).

Enabling seniors to age in place also facilitates the ability to maintain social networks and social support, which is independently related to mortality (Wiles et al., 2011). Cohen and Franko (2015), illustrate that enabling seniors to maintain social connections allows them to develop resiliency, overcome adversity and gain strength. Further, facilitating a senior's ability to maintain connections with their social environment prevents social isolation, which can lead to many negative health outcomes including increased likelihood of depression, cognitive decline, progression of physical disabilities, poor nutrition, and lower immunity (Black, 2008; Cohen & Franko, 2015). Bacsu et. al's (2014) study on rural seniors in Canada's perceptions of healthy aging indicated that social interaction was identified as a key contributor to healthy aging, as the mutual caring nature of friendships lead to the benefits of socialization and mutual support.

On a systems level, enabling seniors to age within their homes and communities with the appropriate supports and services have been shown to avoid high costs associated with the utilization of acute care services such as emergency room visits, hospital admissions, and an increased risk of nosocomial infections and falls, where the bulk of health care spending in B.C. occurs (McGrail et al., 2008; Wiles et al., 2011). Within the province, there is consensus among senior advocates, researchers, and the Ministry of Health that providing resources to help seniors age in place, is the most cost-

effective and appropriate method of supporting the growing needs of the aging population (Cohen & Franko, 2015).

## 6.0 The Public Health Problem

### 6.1 Defining Home Health Services, Home Care and Home Support

In B.C., the term *home health services* is the umbrella term that encompasses all professional and nonprofessional health services that are provided to individuals within their homes (B.C. Ministry of Health, 2015c). *Home care* typically refers to the services that are provided by health care professionals such as nurses within the health authorities (Cohen & Franko, 2015). *Home support* typically refers to the non-medical services provided by community health workers, such as supports with activities of daily living (ADLs) that are intended to help seniors age within their homes and communities as safely and as long as possible (Barnes et al., 2012). Assistance with ADLs can include mobility, nutrition, bathing and dressing, grooming and toileting and nutrition (B.C Ministry of Health, 2015d). While there are gaps in home health in general, this paper focuses primarily on the gaps in home support services and innovative models that may be adopted to mitigate these gaps.

### 6.2 Home Support's Role in Aging in Place

It is well known that home support can help facilitate healthy aging, independence and prevent premature placement into residential care (Cohen, 2012). Ensuring adequate home supports for seniors is essential in ensuring seniors have the ability to age in place. On the individual level, providing adequate home and community supports and services can focus on preventive measures and result in positive outcomes such as improved mobility and cognitive function, which significantly impacts a seniors' ability to maintain independence (Cohen, 2012). On a systems level, increasing access to these supports and services can help mitigate unnecessary visits to the emergency room and admissions into hospital, which lead to issues of overcrowding and waitlists (Cohen, 2012).

### 6.3 Changes to Home Support in B.C.

Home support in B.C. has existed since the 1950s, where it was initially delivered through the Department of Rehabilitation and Social Improvement, and recognized as a health program by government in the late 1970s (Barnes et al., 2012). Throughout the 1980s, home support was subsidized and included services such as assistance with groceries, household tasks, cleaning, and assistance with ADLs, many of which are not accessible or available under today's publicly funded health care system in B.C. (McGrail et al., 2008). While there was already recognition for the need to transfer resources from hospital to the community, as recommended by the Seaton Commission (B.C.'s Royal Commission on Health Care and Costs), cuts to the federal health transfer in the early 1990s led to significant changes to home support, which eliminated many services such as meal preparation, housekeeping and transportation (Barnes et al., 2012; McGrail et al., 2008).

In the late 1990s home support became increasingly restricted to clients with high needs who would otherwise be institutionalized (McGrail et al., 2008). The home and community care program underwent redesign in the 2000s, at the same time as the introduction of regional health authorities, and in 2002, the model of assisted living was created (McGrail et al., 2008). Recognizing the need for more home support, the Seniors' Healthy Living Secretariat was introduced in the late 2000s in order to further explore and develop non-medical home support models (Barnes et al., 2012). Subsequently, the Secretariat created the Community Action for Seniors' Independence (CASI) program to work alongside partners to create non-medical home support models of care. While the province was considered a leader in home support service delivery in the 1980s, reduced federal funding in the 1990's significantly diminished investments towards home and community support services (Barnes et al., 2012).

Today, depending on a seniors' eligibility, home support services may be available and publicly subsidized. These support services are delivered by regional health authorities under the home and

community care program, or by companies who are under a contract with health authorities (Barnes et al., 2012). The Choice in Supports for Independent Living (CSIL) program is another alternative where recipients are given funding and the opportunity to manage their own home support services depending on their needs (B.C Ministry of Health, 2015a).The amount of subsidization received form the health authorities vary depending on an individual's income tax form the previous year, and as result, around 71% of clients receiving home support services are fully covered, while the remaining portion are required to pay for some costs (Barnes et al., 2012). Those who do not meet the eligibility criteria typically access home support services through private agencies by paying out of pocket (Barnes et al., 2012), or simply go without (Cohen, 2012).

#### 6.4 Gaps in Home Support

With the constant changes in home and community care coupled with underfunding and restrictions over the last decade, the accessibility and availability of high quality home support is not adequate in meeting current needs (Cohen, 2012). The range of services have narrowed, and access to services such as housekeeping<sup>1</sup> have become difficult (Cohen & Franko, 2015). Currently, services such as housekeeping, grocery shopping and transportation are not services that are offered through B.C.'s home support program (Barnes et al., 2012), unless it is deemed necessary to client safety (Cohen & Franko, 2015). This serves as a significant issue, as these services encompass what is most needed by seniors to continue aging in place (Health Council of Canada, 2012).

While B.C. has the fastest growing senior population within Canada, compared to other jurisdictions, the province has the most restrictive criteria for accessing basic homemaking services (Cohen & Franko, 2015). Nine provinces across Canada have demonstrated the benefits of having a

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<sup>1</sup> Housekeeping includes “cleaning, laundry, meal preparation, and by exception, transportation, banking or shopping” (Byrne & Woods, n.d.)

broader range of non-medical services made available to seniors (Barnes et al., 2012). In many cases, seniors have access to home support services only after they have experienced a medical emergency or crisis that has led to a hospital visit (Cohen, 2012). As a result of these restrictions, seniors with lower to moderate needs have limited access to supports and services that could reduce the likelihood of future hospital visits and premature placement into residential care (Cohen, 2012).

Cohen (2012) reports that a method of tracking the impact of reduced access to acute care services, which is influenced by the accessibility and availability of home support, is to assess the number of acute care beds occupied by alternate level of care (ALC) patients.<sup>2</sup> Between 2005/2006 to 2010/2011, the number of hospital beds across B.C. that were occupied by ALC patients increased by 35.5% (Cohen, 2012). To further illustrate the minimal investment and growth of home support in B.C., the number of individuals receiving home support in 2013-2014 was the same compared to 2001-2002 (Cohen & Franko, 2015). Not only has the narrow range of non-medical services contributed to premature institutionalization, understaffing of community health workers has also led to reduced availability and quality of home support (Office of the Seniors Advocate, 2015c).

## 6.5 Issues in Housing and its Impacts on Aging in Place

While there are significant gaps in home support, issues related to housing can also create challenges to aging in place. Housing in B.C. can be conceptualized in three categories including independent housing, assisted living and residential care (Office of the Seniors Advocate, 2015b). According to the Seniors Advocate (2015b), approximately 93% of B.C seniors are living in independent housing. 80% of these seniors are homeowners, 20% are renters, and 26% live alone (Office of the Seniors Advocate, 2015b). While the majority of seniors live in independent housing, it is only an

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<sup>2</sup> ALC patients, which are largely made up of seniors, are those who are residing in hospitals due to the lack of residential care, and home support (Cohen, 2012).

appropriate option, when the necessary supports and services are available and accessible (Office of the Seniors Advocate, 2015d). Seniors living in independent housing also face considerable costs related to home repairs and maintenance (Office of the Seniors Advocate, 2015d). Considering these high costs, with the lack of home support available, seniors who individually pay out of pocket for these services may continue to struggle and forgo needed supports to safely age in place.

Another key issue that has impacted seniors' ability to age in place in B.C., is the prescribed services model, under the *Community Care Assisted Living Act*. Under this model, assisted living operators are only permitted to offer two of six prescribed services<sup>3</sup> under the model. As a result, seniors who require additional services, or require a service that is not offered often go without, or become prematurely placed into residential care (Office of the Seniors Advocate, 2015d). In 2016, the Ministry of Health announced that it would make amendments to this Act, increasing the amount of services seniors could access in assisted living. While this will increase some seniors' ability to live within their communities, and decrease premature placement into residential care, increased support within the community is also needed, as not all seniors will have access to publicly subsidized services. Further, while seniors will be able to access more than two prescribed services in assisted living, innovation is needed in overcoming existing challenges in health human resources.

## 6.6 Implications on Caregivers

The current state of home support is also contributing to increased caregiver distress and burnout (Canadian Institute of Health Information [CIHI], 2010). Caregivers, sometimes referred to as informal caregivers, include a care recipients' family, friends or others who are providing unpaid care (Health Council of Canada, 2012). According to the CIHI (2010), in Canada, one in six informal caregivers

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<sup>3</sup> The six prescribed services include medication management, assistance with activities of daily living, therapeutic diets, financial management, behavioural management and intensive rehabilitation therapy (Office of the Seniors Advocate, 2015d)

experience distress through their role. Caregivers in B.C. play a significant role in helping seniors age in place, and provide the bulk of care for seniors within their homes and communities. The Office of the Seniors Advocate (2015d) indicates that around 30,000 seniors in B.C. are able to age in place, as a result of the support provided by their caregivers. Currently, around 97% of seniors receiving home support are also receiving caregiver support (Office of the Seniors Advocate, 2015d).

While home support services are meant to complement the care provided by caregivers, the lack of access is increasingly leading to physical, mental, emotional and financial stress among caregivers (Health Council of Canada, 2012). As reported in the Canadian Community Health Survey (CCHS) in 2008/2009, many caregivers are often required to reduce or modify their work hours, and use sick days or vacation days to accommodate their caregiver role (Health Council of Canada, 2012). In 2015, the Office of the Seniors Advocate estimated that the unpaid labour of caregivers in B.C. amounted to approximately \$4.1 billion.

With the lack of home support, and shift away from acute care to the community, caregivers are facing increased demands to help seniors age in place. The CCHS in 2008/2009 indicated that most assistance provided by caregivers were related to non-medical activities, where transportation, household tasks and meal assistance were the top activities supported by caregivers, respectively (Health Council of Canada, 2012). Further, while supports such as respite care and adult day programs exist, access to these services continue to be difficult (Office of the Seniors Advocate, 2015b). As a result, the increasing burden among caregivers has significant implications on seniors' ability to age in place.

## 7.0 Reframing Aging in ‘Place’ to Aging in ‘Community’

The current gaps in home support and challenges with independent housing make it difficult for seniors to comfortably age in place. A survey conducted by the Office of the Seniors Advocate (2015a) indicated that over half of B.C seniors believed they would be required to move out of their homes and

communities as a result of housing and health care needs. Further, a third of respondents believed that they would not be able to age in place as a result of issues related to accessibility, transportation, the distance away from their support systems and affordability (Office of the Seniors Advocate, 2015a).

As mentioned, there has been a shift among researchers in exploring beyond the benefits of maintaining seniors within their dwellings, and the advantages of aging within their neighbourhoods and communities (Blanchard, 2013; Gardner, 2011; Thomas & Blanchard, 2009). Taking into consideration that many seniors who need support may only have low to moderate needs, and that a significant portion of B.C. seniors do not receive publicly subsidized home support services, there is significant potential in exploring how seniors themselves, can work collaboratively, with support, to bridge the existing gaps.

The current emphasis on aging in place has led to a “dwelling centric approach” which places high reliance on professionals in initiating and delivering services and supports (Thomas & Blanchard, 2009). Aging in community shifts the discussion, and emphasizes collaboration, civic engagement, and social capital among seniors in providing mutual support, while promoting personal control, interdependence and autonomy; and accessibility and sustainability of supports and services (Greenfield, 2014; Thomas & Blanchard, 2009).

Aging in community utilizes a social capital lens and emphasizes concepts such as relationships, specifically, non-kin relationships such as friends, and their ability to facilitate aging in place (Gardner, 2011). Moreover, this paradigm is grounded in principles of reciprocity and trust among seniors’ natural and informal neighborhood networks (Gardner, 2011). Within the context of aging, there are many benefits of investing in social capital including the ability to access informal health care and social services, increased access to information, greater emotional support, increased ability to promote positive behaviours and increased access to services (PRI, 2005).

Models of aging in place or community that utilize a social capital lens do exist in other jurisdictions, and have shown positive impacts on healthy aging and the ability to assist seniors in aging within their communities. Specifically, two popular models that promote aging in place in the United States (U.S.), including the Village model and Naturally Occurring Retirement Communities-Supportive Services Program (NORC-SSP) offer promising solutions to bridge the current gaps in B.C.

## 8.0 Village Model

The Village model is a grassroots, community based model that is driven by its members, the seniors (Scharlach, Graham, & Lehning, 2011). As a result of the restrictions on eligibility for public social and health programs in the U.S., a group of seniors of the Beacon Hill neighbourhood in Boston came together to find solutions in accessing affordable non-governmental supports and services (Greenfield, Scharlach, Lehning, Davitt, & Graham, 2013; Scharlach et al., 2011). Beacon Hill village was the first village formed under this model and currently, there are over 190 villages across the U.S., Australia and the Netherlands, with 150 in development (Village to Village Network, 2016). The overall goal of the village model is to be able to offer a “one stop shop” of services and supports that exist in assisted living facilities without requiring seniors to move out of their homes (Bookman, 2008). Villages are not necessarily confined to a neighbourhood, and existing research indicates that many villages serve an entire town or city (Greenfield et al., 2013).

Known as a “consumer-driven model” (Scharlach et al., 2011), village networks exist outside of the existing health and social service systems, and seniors are responsible for initiating, governing and operationalizing the program by coordinating access to non-professional and professional services, which are often received at discounted prices (Greenfield et al., 2013; Scharlach et al., 2011). Members of a village are often involved in the overall organizational development, as well as providing education, guidance and support to fellow members (Scharlach et al., 2011). As a result of the structure of this model, research and evaluation of this model indicates that it is generally more appropriate for seniors

who are younger, in better health, and of higher socioeconomic status (Greenfield et al., 2013; Ivery, 2014).

In general, this model focuses on two main functions including the delivery of supportive services such as transportation, technology assistance, home maintenance and companionship; and acting as a linkage between members and community services that are already existing (Graham, Scharlach, & Price Wolf, 2014; Greenfield et al., 2013). The village model has been well accepted as a result of its ability to combine the strengths of care management, information and referral services, consumer review lists and collective bargaining associations (Scharlach et al., 2011). Further, the ability for seniors to govern and administer their services provides an opportunity to target the needs of the neighborhood or community, rather than succumbing to a “one size fits all” approach, often exhibited with publicly subsidized programs.

### 8.1 Village Model: Funding and Delivery of Services

The village model relies primarily on membership fees rather than government funding or assistance from other organizations (Greenfield et al., 2013). Funding for village models also come from philanthropic donations and charitable donations (Greenfield et al., 2013; Scharlach et al., 2011). In a study conducted by Scharlach et al. (2011), annual dues for individual members ranged from \$35 to \$900, and a household between \$75 to \$1,200 in the U.S. Services are primarily delivered by the village members through volunteerism, and at times, through paid providers from external agencies and organizations which have been assessed by the village staff and members (Scharlach et al., 2011; Bookman, 2008).

### 9.0 Naturally Occurring Retirement Communities- Supportive Service Program (NORC- SSP).

The term “Naturally Occurring Retirement Communities (NORC)” was originally coined by a Michael Hunt, a professor in the School of Human Ecology at the University of Wisconsin (Guo & Castillo,

2012). This was a result of the observation that many regions across the U.S. were made up of greater than 50% of seniors (Guo & Castillo, 2012). A NORC is defined as a housing development that is not intentionally planned or designed for seniors, but over time, has come to house largely older adults (Bookman, 2008). Consequently, the purpose a NORC is to take an unintentional concentration of seniors and turn it into an intentional community of seniors (Bookman, 2008; Guo & Castillo, 2012). The NORC-SSP model began in 1986 in New York City, which was funded by the United Hospital Fund, to respond to the growing needs and challenges of seniors that were effecting their ability to age in place (Bookman, 2008; Greenfield et al., 2013).

There are currently approximately 100 NORC-SPP programs across the U.S, which is a result of the securement of both private and public funds by advocates of this model (Greenfield et al., 2013). It is typically used in large apartment buildings that house a large portion of seniors with low to moderate income (Ivery, 2014; Greenfield et al., 2013). While this model was initially intended to serve older adults who met age and place of residence requirements, this model has shifted to serve those who have greater functional and economic requirements (Ivery, 2014; Greenfield et al., 2013). As the model has developed, the NORC-SPP has been increasingly appropriate for seniors who are marginalized, as a result of the structure of delivery of services (Greenfield et al., 2013). Research also indicates that existing NORC-SSPs compared to villages consistently report that their participants have greater needs with personal care and household work as a result of low socioeconomic status (Greenfield et al., 2013).

NORCs can differ depending on the demographics of the neighborhood, as well as the building structure (Black, 2008). The NORC-SSP can be implemented in both vertical and horizontal structures. Vertical NORCs usually include buildings such as high rise apartments, multiple complexes and condominiums, where there is a clear geographic boundary that is self-contained, and as a result, has a single recognizable group (Bronstein & Kenaley, 2010). In contrast, horizontal NORCs are often low rise buildings that are spread out, and more effort is needed to create a sense of community (Bronstein &

Kenaley, 2010). Due to the differences in structure, services provided in horizontal NORCs are not onsite like the vertical NORCs (Bronstein & Kenaley, 2010). Further due to the containment of vertical NORCs, there is often the capacity to have onsite management, while management of services in horizontal NORCs may take more collaboration among participants (Bronstein & Kenaley, 2010).

Key components of the NORC-SSP model include being formed in a geographical location where seniors live closer together, but have no social connections (Bookman, 2008). Similar to the village model, one of the strengths of the NORC-SSP is the paradigm shift away from the traditional provider centric care (Bedney, Goldberg, Josephson, & Joyce, 2010). Rather than furthering the power imbalance and hierarchy that exists between care providers and seniors, this model views seniors as essential partners in determining what services and supports are needed, and how they are provided (Bedney et al., 2010). Further, similar to villages, these models work to mitigate a culture of ageism, by viewing seniors as an asset rather than a problem (Guo & Castillo, 2012).

### 9.1 NORC-SSP: Funding and Delivery of Services

Unlike the village model, the NORC- SSP does not solely comprise of seniors in governing and maintaining the program. A key aspect of NORC-SSP is the involvement of partners with seniors including building owners and managers, service providers such as health care providers, home repair and adaptation partners, and other partners within the community which creates a network of services, as well as opportunities for volunteerism (Greenfield et al., 2013). Many health care providers involved in this model are also trained to work with marginalized populations (Greenfield et al., 2013). Further, this model aims to decrease the fragmentation that exists in health and social services for seniors that exist with publicly subsidized programs (Bookman, 2008).

Taking into consideration the populations that the NORC-SSP serve, Greenfield et al. (2013) finds that the NORC-SSP model typically offers more traditional health and social services such as assistance with meals, services and supports related to health care, health promotion and social services. However,

similar to the village model, depending on the geographic region, each NORC-SSP will differ depending on the needs of seniors within a community as well as the availability of resources (Bedney et al., 2010). Funding for NORCS-SSP programs are generally through public-private partnerships, which consists of government funding, community partners, and philanthropic contributions (Greenfield et al., 2013). Similar to the village model, Guo and Castillo (2012) indicate that the model is based on economies of scale, where the large concentrations of seniors and their need for accessing services increases purchasing power.

## 10.0 Challenges

One of the challenges that exist for the village model, is the uncertainty of the capacity to provide more intensive health and social services as members age and experience greater functional impairments (Graham et al., 2014). Scharlach et al. (2011) suggests that due to the structure of this model, it may be only appealing to seniors of greater socioeconomic status. Further, the emphasis on volunteerism among members may potentially limit access to professional expertise in areas such as financial management, service delivery and organizational development (Greenfield et al., 2013). Challenges may also arise in recruiting volunteers, funding and differences due to diversity and geography (Scharlach et al., 2011).

For the NORC-SSP, challenges may include inadequate service providers, the availability of affordable and appropriate housing, access barriers and unpredictability of funding (Guo & Castillo, 2012). In the U.S, there has been limited support from the government to invest in community based aging. However, in the context of B.C., the Ministry of Health (2014) has listed the shift of health care from acute care to community care as one of eight priorities for improving a quality and sustainable service delivery system. Other challenges include the limitation on volunteerism by participants due to

their increasing needs, as well a shift in focus to seniors' vulnerabilities rather than strengths, as a result of some reliance on paid staff (Greenfield et al., 2013).

## 11.0 Discussion

While challenges do exist within each model, there are several implications that may help bridge existing gaps to help seniors age in community successfully. Many of the aspects of the village and NORC-SSP may be a solution to mitigating the existing individual and systems level issues that are impacting B.C. seniors' ability to successfully age within their communities. Both models can be relevant within the context of B.C., and would provide an opportunity to target unique needs. Considering the diversity of the senior population across the province, the relevancy of each model will depend on the availability and accessibility of resources, both on an individual and systems level.

### 11.1 Shifting the Culture of Aging

Perhaps the most important aspect of these models is the ability to reframe how health care providers, families, decision makers and society as a whole, perceives aging (Bedney et al., 2010; Austin, Des Camp, Flux, McClelland, & Sieppert, 2005). Aging within society has been socially constructed as a negative process, whereby seniors have been assigned the "sick role", leading to medicalization of aging (Bedney et al., 2010; Austin et al., 2005). Both the village and NORC-SSP models shift the culture of aging, and utilize a strength based approach (Thomas & Blanchard, 2009; Greenfield, 2014). By emphasizing social capital, community capacity and participation, seniors become recognized as valuable resources in improving their aging experience (Austin et al., 2005).

### 11.2 Sustainability

The B.C senior population continues to grow, and it is unlikely that publicly subsidized health and social services will have the ability to provide high quality care for every single senior across the province. Focusing on the concept of social capital, and the building of relationships among seniors, and

their service providers, research does suggest that this approach has the potential to lead to greater access to appropriate services, as well as greater utilization, responsiveness and coherence (Greenfield, 2014; Austin et al., 2005). Blanchard (2013) suggest that due to the informality of relationships, as well as the culture of reciprocation, they may be more sustainable in the long run. Greenfield (2014) also suggests that the long term relationships that are built among seniors, with service providers and professionals within these models may improve the access to community based services and supports. Further, seniors who are more involved and aware of their needs are typically more likely to anticipate and plan for their future health and social needs (Ivery, 2014).

### 11.3 Targeting Local Needs

A key component of these models is to assist seniors with missing supports and services such as transportation, meal preparation, grocery shopping, housekeeping, and health and social services. There is significant diversity among B.C. seniors, and the neighbourhoods in which they reside. Depending on the characteristics of each neighbourhood or community, including various financial, cultural, and personal needs, one model may be more appropriate than the other. While there are key components of each model, research does suggest that villages and NORC-SSPs should vary depending on each community (Bedney et al., 2010).

### 11.4 Improving Health and Well-Being

As a result of the participatory approach, seniors may be more empowered to take control of their own health and well-being. Research indicates that community participation as well as social engagement leads to improved health as well as increased success in aging in place (Graham et al., 2014). Due to the consumer driven approach and engagement of seniors, these models provide seniors with a sense of “cooperative ownership” which increases a sense of community, social connectedness,

and mutual responsibility (Scharlach et al., 2011). Blanchard (2013) argues that the current focus on the physiological and safety needs of seniors fails to consider the necessity of other aspects of basic human needs such a sense of belonging and self-esteem. Research also suggests that volunteerism and engagement among seniors is associated with increased functional health, improved psychological well-being, increased satisfaction, and self-reported health (Graham et al., 2014; Ivery, 2014; Bedney et al., 2010).

Black, Dobbs, & Young (2015) suggest that meaningful involvement, mobilization, social inclusion, and communication and information are key components of aging with dignity and independence, all of which are embedded in the village and NORC-SSP model. Grimmer et al. (2015) indicates that elements of successful aging in place include support for self-management, accessible and affordable transportation, keeping physically and mentally active, availability of practical supports and accessibility of professionals and information, which have been shown to be adequately provided through these two models. One of the greatest strengths of the Village model and NORC-SSP is the ability to mitigate social isolation among seniors, which has significant physical and mental health outcomes. Further, social support serves as a protective factor in healthy aging (Black, 2008; Gardner, 2011). While family members are often identified as the most important caregiver among seniors, there is increasing recognition on the complementary role of non-kin caregivers such as friends and networks within a neighbourhood throughout the aging process (Gardner, 2011).

With the use of these two models, seniors are able to form organic relationships with their service providers, which may be other seniors within their own neighbours. By focusing on the strengths of natural neighborhood networks, Gardner (2011) states that it shifts the focus from independence to interdependence, and support to sociality. These models also suggest the limitations on the term aging in 'place.' While being able to age in place has many proven benefits, if there is a lack of social interaction, issues such as feelings of loneliness and helplessness, which are often felt by seniors in

residential care remain (Blanchard, 2013). As a result, an additional advantage of these models is that it provides a high level of social interaction and mutual support (Blanchard, 2013). Through empowerment and self-determination of seniors, these models help cultivate a positive perception of health, well-being and usefulness among seniors (Guo & Castillo, 2012).

### 11.5 Patient Centered Care

There is a considerable amount of research that indicates the benefits of empowerment amount individuals who are actively involved in managing their health conditions and needs (Bacsu et al., 2014; Baldwin & Willett, 2013). Bedney et al. (2010) also indicates that research has found that the needs of seniors are often different when asked, in comparison to what others perceive their needs to be. Perhaps these models truly capture the need to abide by the famous phrase of “nothing about me, without me.” Patient care in B.C., and across Canada, has been traditionally provider centric rather than patient centred. Seniors want to be part of the decision making process in determining the type of service and supports they receive, as well as how they are delivered. The overall premise of these models serve to work towards the shift towards patient centered care (Bacsu et al., 2014), which has been recognized by the Ministry of Health, as a key priority moving forward (B.C. Ministry of Health, 2015b).

### 11.6 Increased Access to Home Support Services

In B.C., many basic supports and services that help seniors age in place, such as the ones mentioned above, cannot be accessed currently through publicly funded programs delivered by health authorities. Currently, to be eligible for services, a B.C. senior must meet a strict eligibility criteria which excludes a large portion of B.C. seniors. Many seniors with low to moderate needs, or with incomes slightly higher than the indicated cut-offs are not eligible for public subsidization. Further, many seniors

and their families are already paying privately for services and supports, or choosing to go without (Cohen, 2012). Those who receive publicly funded home support services also pay an assessed client rate (B.C Ministry of Health, 2015d). In addition, the amount time spent with seniors by community health workers and other care providers has decreased (Office of the Seniors Advocate, 2015c). As a result, many seniors are not able to access services that are offered by the public health care system, and those that do, receive limited amount of services and supports.

Consequently, considering that many B.C. seniors have the capacity to age in place with just minimal to moderate support, many of the services that seniors in B.C. are not receiving may be accessed by participating in these models that promote aging in community. In addition, considering that the medium income of B.C. seniors is \$24,000 (Office of the Seniors Advocate, 2015d), the increased purchasing power of these networks may be beneficial compared to seniors paying individually for home support services (Scharlach, 2011). Specifically, since the majority of seniors currently reside in independent housing, financial assistance through increased purchasing power for home maintenance costs and other services may be particularly beneficial. Further, due to the fragmentation of health and social service providers, and piecemeal approach to service delivery, these models may mitigate some of these issues by increasing communication among seniors and their own service providers (Bacsu et al., 2014).

As mentioned, a significant portion of seniors in B.C. only have low to moderate needs. Many are capable of living within their homes and communities, and the inability to access basic supports and services such as transportation or grocery shopping can lead seniors to premature hospitalization and use of emergency rooms. The writer's professional experience as a registered nurse can corroborate these findings, as many seniors are often given the diagnosis of "failure to thrive", and admitted to hospital, not as a result of a medical condition, but rather as a result of these gaps in supports and services. By leveraging existing resources, there is potential for B.C. to utilize seniors' untapped potential

as the solution to helping seniors age within their communities. Moreover, this also aligns with B.C. Ministry of Health's 'Towards a comprehensive policy and planning framework for seniors in B.C' (2005) in promoting health and preventing illness, disease and injury by "enabling people to increase control over and improve their health" (p.12).

### 11.7 Increased Support for Caregivers

Much of the care that seniors receive such as support with ADLs, housework, shopping and transportation are done by caregivers (CIHI, 2010). Many seniors across B.C. have reported distress within their role, which has significant implications on the seniors they care for, as well as the health care system, as a whole. Through the social capital perspective, the building of relationships among seniors and service delivery providers, as well as emphasis on volunteerism have the potential to decrease caregiver distress. As mentioned through the CCHS (2009), caregivers often provide the most assistance with non-medical activities, and the services typically provided through the village and NORC-SSP do bridge these gaps.

### 11.8 Cost Effectiveness

Some evidence from the U.S suggest that these models lead to cost effectiveness within the health care system (Guo & Castillo, 2012; Elbert & Neufeld, 2010). Cost effectiveness has been achieved through a decrease in adverse health outcomes, hospitalizations, re-admissions, and increased awareness and access to supports and services within the community (Guo & Castillo, 2012; Elbert & Neufeld, 2010). However, more research is needed within the Canadian context to establish a clear association between the utilization of both models and its impact on costs within the Canadian health care system.

## 12.0 Limitations

The main limitation to this paper includes the lack of current research within the Canadian context. While these models have been proven to be successful in improving seniors' ability to age in their communities in the U.S., generalizations have been made to the B.C. context, where the funding and delivery model of home support services is fairly different. Further, several questions still need to be answered in terms of the diversity, geographical differences, and what types of service delivery providers would be involved.

## 13.0 Conclusion

It is clear that the current state of home support services is not meeting the needs of seniors. As a result, B.C. seniors will continue to face significant challenges in comfortably aging within their homes and communities. This has significant implications on both the physical and mental health of seniors as well as their caregivers. As a result, by shifting the dialogue to focus on the existing resources within the community, specifically the networks within the community, seniors will not only be able to access the supports and services they need, they will also receive many benefits to their health and well-being, and become an integral part of this process.

As the PRI (2005) illustrates, social capital may be an "important, underestimated ingredient in the well-being and participation of individuals and groups in the social, political, and economic life of their community" (p.1). Utilizing a social capital lens has been seen as being particularly useful when working with individuals or groups at risk of social exclusion as well as those experiencing transitions throughout their life, such as seniors (PRI, 2005). As a result, shifting the focus from sole reliance of publicly subsidized services to greater investment in social capital allows for policy makers better to understand the potential and capacity of forming linkages and networks to facilitate healthy aging and aging in place.

Although challenges with the village and NORC-SSP models do exist, the available research suggests that they have the ability to bridge existing gaps in a variety of areas, and are able to facilitate aging in community by using social capital through social, support and care networks. While further research must be conducted within the Canadian context in order to assess the viability, this paper provides an explanation of how aging can be reconceptualised, as well as an introduction to the possibilities that exist outside of the current publicly subsidized services and supports to enable seniors to age comfortably, safely and healthily wherever they wish.

#### 14.0 Critical Reflection

As a registered nurse and public health practitioner, I am well positioned to address this complex issue in the area of seniors' health and healthcare. Combining my lived experiences in caring for seniors facing these issues, with results from the literature review has provided me with a comprehensive understanding of how the current state of home support is a result of path dependence, and that solutions to these problems must require innovation. Tackling such a problem requires several competencies that I have gained through my training as a public health practitioner. Broadly speaking, I have come to appreciate the necessity of adopting upstream population health promotion approaches to create sustainable solutions to health and well-being. Specifically, as a public health practitioner, I have come to realize that shifting the paradigm of aging in place to aging in community truly requires the utilization of the five components under the Ottawa Charter for Health Promotion.

Throughout this process, I have gained an even stronger passion and drive for improving the health outcomes of seniors, and an obligation to challenge societal stereotypes of seniors and aging, as well as mitigate issues such as ageism. Further, I have gained a solid understanding of the population health perspective, with an increased ability to think critically on a systems level, as well as an understanding of the interrelatedness between factors that affect populations. Utilizing the concept of

social capital and aging has also increased my awareness of the interrelatedness of this concept with the social determinants of health, specifically social environments and social support networks. With this work, I hope to further the discussion on how shifting the paradigm of aging can influence health policy and health care delivery for seniors.

## Appendix

The following were key search terms used to identify academic articles.

- “Aging in place”
- “Aging in place” AND “village model”
- “Aging in place” AND “naturally occurring retirement communities”
- “Village model”,
- “NORC-SSP”
- “Naturally retirement community”
- “Aging in community” AND “village” AND “NORC”
- “Aging in place” AND “social networks”
- “Aging in place” AND “neighbourhood”
- “NORC” AND “cost effective”
- “Village model” AND “cost effective”

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