

Aging in Place: State of the Field, Legislative Landscape, and Policy Recommendations

Introduction

Over the last 100 years, the average life expectancy for American citizens has increased by nearly 25 years (from 54.1 years in 1920 to 78.6 years in 2017).ⁱ At the same time, birthrates have fallen by over 50%, from 3.65 births per woman in 1960 to 1.76 births per woman in 2017.ⁱⁱ These dual processes have resulted in both a growing elderly population and a shrinking youth population. Accordingly, the challenges facing elderly Americans have and will continue to become a significant burden to our nation.

Increasingly, elderly Americans are choosing to remain in their own homes rather than transition to nursing homes or long-term care facilities. This has resulted in increased exposure to in-home fall hazards, which endanger the lives and independence of seniors. Falls are the most common cause of nonfatal trauma-related hospital admissions among older adults.ⁱⁱⁱ Fall-related hospitalizations create over \$50 billion per year in direct medical expenditures.^{iv} Increased access to Aging in Place (AIP) programs that effectively reduce fall risk is crucial, as 30% of adults over the age of 65 experience a fall annually.^v By preventing falls from occurring, AIP programs present a potent and cost-effective means of increasing quality of life and independence for our nation's seniors.

This paper will endeavor to provide an overview of the state of the field, identify consensus best practices, describe several examples of existing AIP models, and discuss both policy initiatives and barriers. First, we will review common best practices of successful AIP programs. Second, we will describe two of the more established AIP models, examining how the services they provide compare to the best practices previously described. Third, we will review the legislative and policy landscape, taking a look at one significant policy challenge to AIP programs and summarizing two examples of proposed legislation that would support AIP programs nationwide. Finally, we will suggest several policy recommendations, reflecting the evidence presented and conclusions drawn earlier in the paper.

Best Practices

Though AIP programs tend to vary in scope and focus, several core practices are common to most programs. By and large, these practices can be grouped into three categories: Education, Home Modification, and Strength and Mobility Training.

Education: Many AIP programs seek to educate participants on how they can adjust their behavior and habits to prevent falls and alleviate the burden of living alone. Education interventions often involve informing participants on the danger of falls and how best to avoid them, though the category is rather broad. Accessible Resources for Independence, a Maryland-based nonprofit organization, helps participants develop “Independent Living Skills” and access resources that allow them to live more independently.^{vi} Independent Living skills can include budgeting, living safely, completing applications, and employment readiness.^{vii} The organization’s goal is to enable participants to make their own decisions about what independence means to them, and assists them in identifying barriers to attaining that independence.^{viii}

Home Modification: Home modification is perhaps the definitive feature of any AIP program. Home environmental hazards are estimated to cause between one-third to half of all falls among older adults.^{ix} Indeed, studies have shown that AIP programs that include home modifications are effective in reducing falls among older adults.^x Accordingly, it is imperative that any AIP program include an in-home hazard remediation component.

Examples of extrinsic risk factors that increase fall risk include obstacles and tripping hazards, poor stairway design, inadequate lighting, clutter, slippery floors, unsecured mats and rugs, lack of stairway rails and bathroom grab bars, and lack of non-skid surfaces in bathtubs.^{xi}

The CMS Innovation Center funds an AIP program in Baltimore that implements Community Aging in Place, Advancing Better Living for Elders (CAPABLE), a model designed to overcome the functional and home environmental barriers of older adults.^{xii} That project identified the 10 most commonly prioritized modifications and repairs:

- Install railings in stairwells
- Install or tighten railings at home entrances
- Install grab bars in tub area
- Install nonskid safety treads for tub or shower floor or supply rubber bathmats
- Improve lighting (repairs, motion sensor lights, bulbs)
- Repair holes, broken tiles, or tears in linoleum flooring
- Install raised toilet seats
- Add chain extensions to ceiling fans and lights
- Install flexible shower hoses
- Install doorbells^{xiii}

Strength and Mobility Training: Some AIP program models incorporate a strength and mobility training component whereby participants work with a physical trainer to improve lower limb strength and balance. One such model, “Stepping On,” relies on evidence that improving strength and balance, increasing environmental and behavioral home safety, and providing regular medication reviews may reduce fall risk in elderly adults.^{xiv} By incorporating strength and mobility training,

AIP programs may enable participants to more safely and confidently move around their homes, reduce fall risk, and allow elderly adults to age in place more securely.

Existing Programs

Aging in Place, as a relatively new and rapidly evolving field of healthcare, is incredibly responsive to studies on its efficacy and the cost-savings it creates. Several AIP models have been introduced to date, each addressing one or more of the practice categories – Education, Strength and Mobility Training, and Home Modification. Stepping On, a group therapy program that emphasizes Education and Strength/Mobility Training, has produced promising results in recent applications. CAPABLE, a more holistic model, has also demonstrated concrete evidence of efficacy. We will take a closer look at these two models, comparing their elements to the best practices described above.

Stepping On: Stepping On is a seven-week multifactorial, multifaceted, community-based AIP program that prioritizes improved health outcomes, cost-effectiveness, socialization benefits, and operational flexibility.^{xv} The program is designed to address three interrelated public health challenges—falls, aging-in-place, and social isolation.^{xvi} Although the model is often paired with a home modification program to maximize effectiveness, the Stepping On prototype focuses primarily on the Education and Strength Training practice categories.^{xvii}

At its core, Stepping On is a group therapy program that relies on evidence that falls can be effectively prevented by improving lower limb strength and balance, increasing environmental and behavioral home safety, and providing regular medication reviews.^{xviii} The program is led by a certified Stepping On trainer with guest experts—physical therapists, pharmacists, vision specialists, and EMS first responders—each leading individual sessions with participants in their respective areas of expertise.^{xix}

One implementation of the Stepping On program in the Cincinnati Metropolitan Area produced promising results. Participants were asked to complete a survey before and after participation in the program. Among its participants, the program reported a 67% decrease in participants who reported difficulty moving throughout the home, a 50% decrease in participants who reported difficulty using the toilet, and a 70% decrease in participants who reported difficulty bathing or showering.^{xx} Additionally, the program reported a 133% increase in participants who responded “strongly agree” to the prompt, “I can move around outside my home safely,” and a 71% increase in participants who responded “strongly agree” to the prompt, “I can exit my home safely.”^{xxi} Finally, the percentage of participants that “strongly agree” that they are “relaxed when they are home” increased from 27% to 38%.^{xxii} Accordingly, the Stepping On program has confirmed that Education and Physical Strength practices produce meaningful results when included in an AIP model.

CAPABLE: Community Aging in Place—Advancing Better Living for Elders (CAPABLE), developed by Johns Hopkins Medicine, is an AIP program that takes a holistic approach to addressing in-home hazards. The program leverages the expertise of a registered nurse, an occupational therapist, and a licensed handyman, who work directly with participants to identify and achieve individuals' self-described needs and goals.^{xxiii}

The CAPABLE program requires at most 10 in-home sessions, which are spaced over a 5-month period and each last 60-90 minutes.^{xxiv} During these sessions, clinicians work with participants to improve their ability to more safely age in place. The occupational therapist works with the participant to identify personal challenges and makes note of any hazards within the residence.^{xxv} The occupational therapist also observes and evaluates the participant's ability to function within their own home.^{xxvi} The registered nurse works with the participant primarily to identify whether and how pain, depression, strength and balance, medication management, and the ability to communicate with a primary care provider affect their daily functionality.^{xxvii} For example, the registered nurse may work with the participant to improve strength and focus on pain management to enable the participant to more easily and safely climb a staircase inside the home.^{xxviii} Finally, the handyman completes projects within the residence, as identified by the participant and occupational therapist.^{xxix} These physical modifications to the home improve safety and ease of mobility for participants.

Legislation & Policy Landscape

The current legislative and policy landscape presents both adversity and opportunity for organizations that administer AIP programs. On the one hand, federal policies like Estate Recovery serve to disincentivize elderly Americans from seeking long-term care. Abrogation or amendment of these policies would produce a much friendlier regulatory environment and encourage participation in AIP programs. On the other hand, the federal government has recognized the need for more comprehensive and widespread care for elderly Americans, as is evidenced by numerous examples of pro-AIP legislation. These bills, if enacted, would directly fund AIP efforts and represent a broader effort by the federal government to expand Medicare and Medicaid coverage to cover these services.

Estate Recovery: The Omnibus Budget Reconciliation Act of 1993 (OBRA-93) was signed into law by President Bill Clinton on August 10, 1993.^{xxx} OBRA-93 was conceived as part of a national effort to reduce the national debt.^{xxxi} Faced with an aging population and rising nursing home costs, its drafters sought to reduce the burden placed on the government by individuals who required, but could not pay for nursing home care.^{xxxii} As a result, OBRA-93 requires that states try to recover the cost of Medicaid benefits from the estates of certain nursing home residents and older persons

that receive home- and community-based services.^{xxxiii} This policy, known generally as “estate recovery,” is enforced nation-wide and, as described below, serves to reduce participation by elderly Americans in AIP and other long-term care programs.^{xxxiv}

Under current federal policy, states are required to recover the costs of nursing facility and other long-term care services from the estates of Medicaid beneficiaries.^{xxxv} States are required, at minimum, to file claims in probate court against the estates of deceased Medicaid beneficiaries that qualify under OBRA-93.^{xxxvi} States must recover the cost of care for (a) individuals who were 55 years of age or older when they received Medicaid assistance and (b) individuals in nursing facilities, intermediate care facilities for the mentally disabled, or other medical institutions who pay a share of the cost as a condition of receiving Medicaid assistance and who cannot be reasonably expected to be discharged.^{xxxvii} This eligibility criteria is subject to a narrow “undue hardship” exception, which was included primarily to avoid recovery where the property is the sole income-producing asset of the survivors.^{xxxviii} States administrate this policy by filing claims in probate court against the estates of eligible deceased Medicaid beneficiaries.^{xxxix} This requirement, however, is the floor, not the ceiling; states have the option to recover payments for all other Medicaid services for individuals over the age of 55.^{xl}

Estate recovery rules, though effective at reducing cost to the government, disincentivize elderly low-income Americans from participating in valuable AIP programs. Medicaid’s core mission is to provide comprehensive health coverage to low-income people to create access to the healthcare services they need.^{xli} Estate recovery rules run counter to that mission by requiring Medicaid recipients to repay the cost of nursing home and long-term care after death. According to the CHOICES program, an organization providing in-home services to seniors 65 years of age and older, estate recovery policies place hardship on low-income families by stripping them of ownership and wealth.^{xlii} Estate recovery policies force seniors to choose between accepting in-home care and preserving an inheritance for their descendants.^{xliii}

Accordingly, estate recovery rules operate as an impediment to the intergenerational wealth transfer in low-income communities. With less inherited wealth, low-income Black and Brown communities suffer from suppressed economic mobility and lesser access to quality education.^{xliv} As a result, low-income seniors that qualify for the CHOICES program often decline to participate in order to avoid estate recovery.^{xlv} Though the undue hardship exception was intended to avoid this problem, eligible seniors nonetheless decline to participate frequently,^{xlvi} perhaps to avoid the strain of contesting a potential claim in probate court.

Additionally, estate recovery policies prioritize short-term budgetary goals at the expense of long-term health outcomes and future Medicaid expenditures. As was noted earlier, fall-related hospi-

talizations create over \$50 billion per year in direct medical expenditures.^{xlvii} Aging in Place programs are effective at reducing future fall incidents, thus reducing the financial burden on Medicaid.^{xlviii} Simply put, participation in AIP programs today leads to financial sustainability in the future. Removing barriers to that participation ought to be a top legislative priority.

S.3238 – The Preventive Home Visit Act: The Preventive Home Visit Act, introduced on January 28, 2020, represents a significant step towards funding AIP activities using Medicare.^{xlix} Sponsored by Sen. Angus King (I-ME), the bill expands Medicare coverage to include biennial preventive home visits.ⁱ During these visits, a qualified professional conducts a risk assessment of the home, identifying health and fall risks.ⁱⁱ Then, the professional provides a referral for interventions or home modifications to reduce fall risk, enhance physical mobility, and improve nutrition for the resident.ⁱⁱⁱ The Preventive Home Visit Act, if passed, would essentially represent the codification of AIP Home Modification services as a part of the Medicare suite of services. Under current Medicare rules, many aspects of a holistic AIP program are either partially covered or not covered. For example, under current policy, only skilled nursing and occupational therapy needs can be reimbursed – this prohibits AIP like CAPABLE from conducting preventive visits.ⁱⁱⁱⁱ Whereas skilled nursing and occupational therapy services typically are reactive to an acute event, CAPABLE visits are designed to optimize the individual’s residence to remove hazards and maximize person-environment fit.^{liv}

Under the Preventive Home Visit Act, elderly citizens could reimburse a broader suite of preventive services under their Medicare coverage. Increased access to AIP programs that effectively reduce fall risk is crucial, as 30% of adults over the age of 65 experience a fall annually.^{lv} Further, falls are the most common cause of nonfatal trauma-related hospital admissions among older adults.^{lvi} Fall-related hospitalizations create over \$50 billion per year in direct medical expenditures.^{lvii} Accordingly, investment in prophylactic, preventive AIP programs that reduce fall rates will serve to reduce the financial burden that falls place on our healthcare system.

H.R. 6379 – The Take Responsibility for Workers and Families Act: The Take Responsibility for Workers and Families Act, introduced on March 23, 2020, is a far-reaching bill that responds to the COVID-19 pandemic and its impact on the economy.^{lviii} Notably, the bill expands Medicare and Medicaid eligibility for a wide range of programs and policies, including the Aging and Disability Services Program.^{lix} The bill provides for an additional \$1,205,000,000 for the Aging and Disability Services Program, which shall remain available until September 30, 2021.^{lx} Of that amount, \$1,070,000,000 is reserved for activities under the Older Americans Act of 1965 (OAA).^{lxi} The OAA, which authorizes a range of services that enable older Americans to remain independent and safe in their own homes, provides for supportive services such as case management, senior center services, in-home services, transportation, and information and referral.^{lxii} Accordingly, the Take

Responsibility for Workers and Families Act would funnel \$1.07 billion in funding towards AIP programs, by way of the OAA.

In addition, the bill would provide additional funding for other supplemental programs, such as nutrition and long-term care services. More specifically, the bill would provide \$720,000,000 for nutrition services under subparts 1 and 2 of part C of title III of the OAA; \$30,000,000 for nutrition services under title VI of the OAA; and \$100,000,000 for support services for family caregivers.^{lxiii} Through support for auxiliary services, the Take Responsibility for Workers and Families Act provides comprehensive support for the entire suite of AIP services. Though tailored to address the COVID-19 pandemic, these funds are needed now more than ever and the bill, if enacted, may serve as a catalyst for future investment in the space.

Policy Recommendations

As the nation ages, the challenges facing elderly Americans and the costs of long-term care will continue to increase dramatically. Accordingly, it is crucial that we invest today in AIP programs to reduce the burden of tomorrow. First, governments should invest in research and development in Aging in Place. While several effective AIP models exist today, they are adapted and refined in response to scientific studies on their efficacy and cost-savings. Models like Stepping On and CAPABLE derive their credibility from the quantifiable results that they produce. Investment in the research and development of these models will produce better optimized and well-crafted programs. Second, governments should fund the administration of AIP programs nationwide. AIP programs serve as a prophylactic measure against falls, which create over \$50 billion per year in direct medical expenditures.^{lxiv} Third, legislators should remove policy barriers that disincentivize participation in AIP programs. For example, estate recovery policies promote short-term budgetary goals at the expense of long-term health outcomes. Removing these barriers will increase participation, thereby reducing future financial strain on the Medicaid system. By investing in preventative measures today, we can create future savings.

CONCLUSION

Facing a growing elderly population and a shrinking youth population, the U.S. must act now to support its seniors or suffer the inevitable financial toll. Through increased funding and a greater emphasis on research and development, the federal government could set up AIP programs for success for the foreseeable future. Equally, striking down antiquated policies like estate recovery would remove powerful disincentives to participation in AIP programs. As a prophylactic measure, AIP asks that governments invest on the front end to realize greater savings in the future. Indeed, our leaders would be wise to remember the words of Benjamin Franklin, who famously posited, “An ounce of prevention is worth a pound of cure.” Our government’s response to the nation’s aging population today will dictate the public health and economic outcomes of the future.

About the Green & Healthy Homes Initiative

The Green & Healthy Homes Initiative (GHHI) is a national nonprofit organization dedicated to breaking the link between unhealthy housing and unhealthy families. Formerly known as the Coalition to End Childhood Lead Poisoning, GHHI provides evidence-based direct services and technical assistance to create healthy, safe, and energy efficient homes. GHHI's end goal is to improve health, economic, and social outcomes for low-income families while reducing public and private healthcare costs. To learn more, please visit ghhi.org and follow us @HealthyHousing.

ⁱ [Developing Sustainable Financing Models to Scale Aging-in-Place Programs](#), p.2; Arias, E., & Xu, J. (2019). United States life tables: 2017. National Vital Statistic Report68(7). Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_07-508.pdf

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^{iv} [Developing Sustainable Financing Models to Scale Aging-in-Place Programs](#), p.2; National Council on Aging. Get the Facts: Falls Prevention Facts. Retrieved from <https://www.ncoa.org/news/resources-for-reporters/get-the-facts/falls-prevention-facts/>

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^{xiv} [Developing Sustainable Financing Models to Scale Aging-in-Place Programs](#)

^{xv} [Developing Sustainable Financing Models to Scale Aging-in-Place Programs](#), p.8

^{xvi} [Developing Sustainable Financing Models to Scale Aging-in-Place Programs](#), p.8

^{xvii} [Developing Sustainable Financing Models to Scale Aging-in-Place Programs](#), p.8

^{xviii} [Developing Sustainable Financing Models to Scale Aging-in-Place Programs](#), p.8; Clemson, L., Cumming, R. G., Kendig, H., Swann, M., Heard, R., & Taylor, K. (2004). The effectiveness of a community based program for reducing the incidence of falls in the elderly: A randomized trial. *Journal of the American Geriatrics Society*, 52(9), 1487–1494. Retrieved from <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1532-5415.2004.52411.x>

^{xix} [Developing Sustainable Financing Models to Scale Aging-in-Place Programs](#), p.8

^{xx} [Developing Sustainable Financing Models to Scale Aging-in-Place Programs](#), p.10

^{xxi} [Developing Sustainable Financing Models to Scale Aging-in-Place Programs](#), p.10

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