



## AGING IN PLACE: A POLICY APPROACH FOR AGING WELL

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FS185E

# Aging in Place: A Policy Approach for Aging Well

The William D. Ruckelshaus Center and the University of Washington Health Policy Center recently partnered on baseline research to examine a critical policy concern facing Washington State today: Are we prepared to meet the health care needs of our aging population? As the baby boom generation advances into its elder years, Washington State is witnessing a striking increase in its older adult population. Policy makers and other stakeholders, including the Ruckelshaus Center and the Health Policy Center, are asking important questions about the health system's ability to support this demographic shift. Their joint research project focused on one such question: What is the capacity of Washington's health care workforce to meet current and future demand of the state's older adults?

The partners' baseline study was designed to discover, assess, and aggregate generally available information and data about:

- Types of health care providers for older adults in Washington State
- Current and anticipated supply and demand for this workforce
- Policy approaches to address capacity gaps

Research activities included in-depth interviews with key stakeholders in health care for Washington's older adults, detailed reviews of 50 health care workforce-related websites for applicable information and data, and aggregate analyses of all collected information and data.

This fact sheet is a product of the study. It presents an overview of key policy concerns regarding older adults' access to health care services, and it describes a community-based approach for supporting both the service providers for this population and the adults who receive their services. A companion fact sheet, *Washington State's Eldercare Workforce*, offers an overview of the growing demand for health care services for older adults in Washington State and presents a broadly inclusive definition of the health care workforce that serves them—the *eldercare workforce*. The companion fact sheet, and the interview script used in the study research, are available from the Publications page of the William D. Ruckelshaus Center's website at <http://ruckelshauscenter.wsu.edu>.

## The "Age Wave" and the Eldercare Workforce

In 2011, the first of America's baby boom generation reached age 65 and our population saw the early ripples of an "age wave" breaking on its shores. These "boomers" will continue to reach age 65 and beyond through the year 2030 (Kinsella and He 2009). Washington State is no exception to this trend.

Today, 14% (about one in seven) of the state's residents are 65 and older. By 2030, with the addition of 700,000 more older adults, that proportion will increase to 20%, or one in five (Washington State Office of Financial Management 2013).

As the population age wave continues, it raises immediate concerns among stakeholders about providing care to older adults. Among these concerns are uncertainty about the capacity of the health care workforce, as measured by its supply and training, to provide services to this growing elder population; how to pay for the increased health care services this population needs; and how to provide these services most effectively and efficiently to support healthy aging for greater numbers of older adults across their elder years. The sooner we prepare for these challenges, the more effectively we can address them.

## Aging in Place: What Is It and Why?

Policy makers, health care practitioners, community-based organizations, and other public and private stakeholders in providing care to older adults have been watching Washington State's age wave with some apprehension. They are grappling with how to meet the health care and social service needs of these new older adults, both now and over the long term.

One contemporary policy approach increasingly favored across the nation is called "aging in place." The Centers for Disease Control and Prevention (CDC), the nation's lead public health agency, defines aging in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level" (2014a). Aging in place is a key policy focus in Washington State.

Policy makers and other stakeholders point to aging in place as a fiscally responsible approach to supporting the health status of older adults as they age. Analyses conducted by private and public-sector researchers show that the costs of health-care-related services are directly related to the setting where an older adult receives them. Nursing home care, which is considered to be "institutional" care, can cost on average \$86,000 per person per year. Comparable care provided in an assisted living facility costs \$60,000. In a person's home or other residential setting, such as an Adult Family Home, comparable care costs \$23,000 (McGill 2013).

In Washington State, Medicaid is the primary public health insurance program that helps finance care for older adults who have income restrictions. The program currently serves about 96,000 older adults (Henry J. Kaiser Family Foundation 2014). Since the mid-1990s, Medicaid has been increasingly structured to explicitly increase the availability of services that support aging in place and to encourage their use.

## Aging In Place Definition

Aging in place means living in the residence of your choice, for as long as you are able, as you age. This includes having the services and other support you need to stay in the residence over time as your needs change. ([AgeInPlace.com](http://AgeInPlace.com))

For example, Medicaid emphasizes providing “home and community-based services”—that is, health care and other supportive services provided in an individual’s home or other residential setting. Services can include health care, personal care, meal deliveries, transportation, and other similar supportive services. Medicaid also will cover safety modifications made to a person’s home, such as adding wheelchair access or safety rails. All of these services allow older adults to age in place.

As a result of its emphasis on aging in place, Washington’s Medicaid program is seeing both cost savings and an increased capacity to serve older adult clients. The Washington State Department of Social and Health Services reports that the program has been ranked as one of the most cost-effective systems in the nation, as the state has maintained service utilization rates while simultaneously accruing savings (DSHS 2010). Research reported in the journal *Health Affairs* asserts that states, including Washington State, that expanded home and community-based services programs in the mid-1990s have seen lower rates of total spending on long-term care services than states that did not (Kaye et al. 2009).

For example, a study conducted by the Lewin Group and AARP estimated that Washington State saved \$75 million by limiting nursing facility care and increasing community-based services for clients (Mollica et al. 2009). The *Health Affairs* article also asserts that states are continuing to contain and reduce costs as a result of reduced spending on institutional services (primarily nursing home care) (Kaye et al. 2009). Washington State is following this trend by reducing reliance on institutional care. Between 2006 and 2011, the Medicaid utilization rate of skilled nursing facilities was reduced by over 3% as capacity and availability for care at home and in other community-based settings (excluding nursing homes) increased (Navigant Consulting Inc. 2013).

Aging in place may offer advantages to older adults in addition to keeping money in payers’ pockets—whether the payer is an individual or a public program. Advocates and other stakeholders enumerate the many benefits that accrue to older adults who age in place, including life satisfaction, good health, and self-esteem (Farber et al. 2011).

Studies find that aging in place more closely matches older adults’ own preferences for care. For example, AARP found that 90% of adults over age 65 want to remain in their homes throughout the aging process (Keenen 2010).

## Key Considerations for Successful Aging in Place

Keeping mom or dad happy and healthy at home does sound like a great idea. But what are all the elements policy makers and others need to consider as they strive toward successful aging in place strategies and policies? What are the issues they need to keep in mind as they consider *any* policy approach to meet the long-term health and social service needs of the older adult population?

The research literature and advocacy group publications suggest four areas important to any health care policy planning for older adults:

- Eldercare workforce capacity
- Financing care services
- Land use, transportation, and environmental planning
- Hospital discharge planning and community-based care coordination

Each of these is discussed in more detail below.

### Eldercare Workforce Capacity

When considering issues related to healthy aging, the health care workforce that serves older adults is a key factor. Stakeholders often refer to this workforce as the *eldercare workforce*, and in general consider *elders* to be adults age 65 and older. The eldercare workforce includes individual providers who specialize in older adult health issues, such as geriatricians, as well as other professionals who serve older adults along with their other patients—such as dentists, optometrists, and nurse practitioners.

Professional providers who specialize in hands-on personal services, such as homecare workers and home-health aides, are called *direct-care workers*; they sometimes, but not always, provide these personal services in conjunction with limited health care services. A final group of care providers is *informal caregivers*, who include family and friends. According to the Congressional Budget Office (CBO), they are a substantial source of care for older adults across the nation (CBO 2013). Direct-care workers and informal caregivers are essential to helping aging adults live successfully at home or in other community-based residential settings.

The eldercare workforce also includes the places and organizations that employ health care providers, such as assisted living facilities, home health agencies, and adult day care programs. Finally, the eldercare workforce includes administrators of public programs, such as Medicaid caseworkers, who coordinate the care their programs directly provide to clients.

In Washington State, as across the nation, all of these eldercare workforce providers are directly responsible for the care, and by extension well being, of the older adult population. As we see older adults make up more and more of Washington State's population, policy makers and other stakeholders anticipate that this workforce will struggle to meet the growing demand.

This predicament is intensified by two key factors. The first is the expanded health care needs of aging individuals: in the US, older adults use a disproportionately high proportion of all health care services and as this population grows, so will its share of use (Bardach and Rowles 2012). The second factor is insufficient health care provider *capacity*, which is measured by the supply of providers and their level of training in how to care for older adults. Current capacity shortages within the overall health care workforce are well documented. When considering eldercare in particular, however, shortages of specific providers are amplified.

For more detailed information about the people, places, and organizations providing health care services to older adults, see the companion Washington State University Fact Sheet, *Washington State's Eldercare Workforce*.

### **What Can Be Done?**

Success in any policy approach for supporting healthy aging, including aging in place, requires accessible, appropriate, and well-trained health care services for older adults. Without an adequately trained workforce, keeping older adults healthy and independent will be a challenge. Although aging in place is an approach that largely emphasizes provision of community-based health care and supportive services, effective care in these settings often relies on diagnoses and treatment that take place in clinical care environments. Older adults need to be able to rely on clinical health care professionals to accurately diagnose and understand their conditions in order to set up an appropriate at-home care plan. Once in their place of residence, elders need trained, reliable caregivers to provide needed services and supports.

*Washington State is at the forefront of community-based care. Providers really try to ensure that services and care are adequate and comprehensive at the community level.*

– Washington State Eldercare Stakeholder

The research literature and publications of state and local governments and advocacy groups agree on two key policy approaches for improving the capacity of the eldercare workforce:

- Increase the supply of physicians and other health care providers who are trained specifically in geriatric care.
- Increase, train, and stabilize the supply of direct-care workers to serve the needs of older adults at home and other community-based residential settings.

Approaches proposed to support these two strategies include amending education requirements to include increased training in issues specific to older adults, and offering new or enhanced training incentives to focus on geriatric care. Strategies specific to the direct-care workforce include increasing training requirements and opportunities, increasing wages and improving benefits, stabilizing working hours, and providing career advancement opportunities.

### **Care Service Financing**

Two publicly sponsored programs, Medicaid and Medicare, account for two-thirds of all spending in the US related to care and services for older adults (CBO 2013). Yet federal funding for both programs is threatened by the size of the growing older adult population. Medicaid is a joint federal-state program that matches federal funding with state funds for specific covered services and populations. Federal law establishes the minimum services offered and the required populations to cover, but states can use their own dollars to expand both services and populations.

Although Washington State's Medicaid program has been recognized as one of the most cost-effective in the country, sustainable and adequate state funding for its age-related care and services is an ongoing concern. The Washington State Plan on Aging reports that shortfalls in the state budget in recent years have led to significant cuts in state-paid Medicaid services and provider reimbursement rates, limiting options in care for consumers statewide (DSHS 2010).

***We need to get realistic: look at the numbers! We need to come up with long-term care financing products at the federal level, but more likely, states will need to start to get the ball rolling.***

– Washington State Eldercare Stakeholder

Medicare is financed through a federal payroll tax (Federal Insurance Contributions Act, or FICA, which also supports Social Security). Over its history, this entitlement program has been supporting more and more beneficiaries with fewer and fewer contributors. In 1965, there were about 4.6 workers per Medicare beneficiary (United States of America 2007). By 2013 the ratio had dropped to 3.2 to 1, and by 2030 it is expected to hit 2.3 to 1 (Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 2014). For several decades the program's trustees and administrators have explored and experimented with policies to stretch a continuously diminishing source of funding.

Not all age-related care and services are financed with public dollars. In many cases, Medicare and Medicaid are not sufficient to assist older adults in financing the care they need. Although all adult US citizens age 65 and older are entitled to health care coverage through Medicare, many health care services, especially those that are provided over the long term, are either not covered by Medicare at all or only partially covered. An older adult using services not covered by Medicare must find other sources of financing to cover costs.

In many cases, Medicare beneficiaries will deplete their assets so that they become eligible for Medicaid, which has broader coverage of long-term health care services. (Medicaid eligibility is based on strict income requirements currently set in Washington State's program at 138% of the federal poverty level.) But if a Medicare beneficiary is ineligible for Medicaid, services not covered by Medicare must be paid for using either private insurance or out-of-pocket "cash." The Congressional Budget Office (CBO) reports that in 2011, out-of-pocket spending accounted for about 20% of all spending on age-related care and services nationwide, and private insurance accounted for less than 6% of spending (2013).

Many older adults in Washington State may be unprepared to cover out-of-pocket costs associated with necessary age-related care. Working-age adults don't necessarily understand the costs associated with the health care they might need or the quality of life they intend to maintain into their old age. Additionally, many do not have access through their employer to retirement savings mechanisms, such as a 401(k) plan.

According to the Small Business Majority, 78% of Washington small businesses do not offer retirement plans, and only 5% of employees who don't have access to workplace-based retirement savings plans take the initiative to set one up on their own (2014). Although long-term care insurance is an appropriate private insurance option for covering care related to aging over the long term, this form of insurance is expensive and relatively few individuals purchase it. Just 50 policies per 1,000 people age 40 years or older were active in Washington State in 2010, ranking the state 18th in the nation (Houser et al. 2012).

AARP reports that in 2013, 66% of Washington workers had saved at least some money for retirement—but this is down from 75% in 2009 (2012). Currently, the Washington State Legislature is considering legislation that would make it easier for small businesses to create and offer basic retirement options for their employees. The national Elder Economic Security Initiative and the Washington Area Agencies on Aging are working to educate adults on the real costs associated with aging, including understanding levels of income required to meet basic needs without public, private, or informal assistance.

### ***What Can Be Done?***

As our demographics shift, more and more individuals will need access to age-related health care services as well as assistance in paying for them. In turn, this will increase pressure on public programs to remain economically viable. Researchers and advocates alike recommend several approaches for financing eldercare into the future. For example:

- Continue to focus state health care spending for older adults on efficient, evidence-based approaches to care.
- Create financial incentives in the marketplace that increase opportunities to age in place within residential communities, including converting and building new brick-and mortar residences and increasing the supply of care in homes and other residential settings.
- Develop educational and financial incentives that support adults in engaging in advanced retirement financial planning, especially for health care needs into old age.
- Provide reimbursement or enhanced respite services for unpaid, informal caregivers, including family and friends, in both public and private health insurance coverage.

### ***Land Use, Transportation, and Environmental Planning***

Aging at home requires that communities have accessible businesses, open spaces (such as parks), walking routes, and public transportation.

This requires land use and transportation planning that considers the age demographics of the population (among other characteristics). When older adults choose to age in place, they may be faced with an inability to adequately or reliably access basic and supportive services and resources in the community.

For example, essential establishments such as grocery stores, medical centers, or pharmacies might be accessible only by driving, and not all older adults can drive, have cars, or have access to public transportation. A lack of transportation also can lead to social isolation if an older adult cannot visit friends and relatives and if community spaces, such as parks or community centers, are not within walking distance. Finally, as the majority of older adults live on fixed incomes, affordable housing within communities is an important need (AARP 2012).

In addition to community land use and transportation planning, aging in place requires that the interiors and exteriors of residents' homes are designed to support older adults' needs as they age. A home where an adult has lived for decades might be unsuitable at some point if not retrofitted with safety features designed for older adults, such as accessible showers, interior and exterior enforced hand railings, and outside access ramps.

Many interior and exterior retrofits are designed to prevent or reduce falls, as they are a particular, significant, and costly risk for older adults. One in three adults aged 65 and older falls each year (CDC 2014b). The CDC reports that in 2012, the direct medical costs of falls among adults age 65 and older was \$30 billion, and this cost may reach \$67.7 billion (in 2012 dollars) by 2020 (2014b). Finally, a fall can affect an adult's ability to remain mobile and independent living at home or a similar residential setting (CDC 2014b).

### **What Can Be Done?**

The fundamental principle of aging in place is that adults can live safely, independently, and well in the residence of their choice. If neighborhood and home environments work against such outcomes, the success of aging in place will be limited. Policy recommendations from the research and advocacy literature for creating community and home environments that support aging in place include:

- Engage in community land use planning that improves access to resources, including but not limited to affordable housing and public transportation, and that promotes social and cross-generational interaction.
- Develop public and private policies such as tax incentives and rebates that support homeowners in creating physical improvements to address safety concerns for older adults.

The CDC recommends that local governments prioritize “intentional community planning” to increase accessibility of community amenities and promote social interaction and physical activity. Improvements to consider include transportation and pedestrian access, such as sidewalks, crosswalks, and streetlights, as well as zoning revisions to create public spaces such as parks, libraries, and community centers. Community planners also can implement policies that support creating diverse types of housing that support a range of household incomes. The Healthy People 2020 Initiative, sponsored by the US Department of Health and Human Services, urges states to invest in programs and services that prevent injury, such as retrofitting homes with safety features (Healthypeople.gov 2014). Local public and private organizations can create programs to support such changes as well.

### **Hospital Discharge Planning and Community-Based Care Coordination**

Although aging in place is intended to reduce reliance on institutional settings for older adult care, hospitalization or a stay in a skilled nursing facility (such as a nursing home) can be necessary. After older adults are hospitalized, however, the risks are high for three negative outcomes: re-hospitalization soon after discharge, entering a nursing home, or experiencing permanent disability.

In the *New England Journal of Medicine*, for example, Jencks et al. report that in 2003-2004, one in five hospitalized Medicare beneficiaries was readmitted within 30 days after discharge and over one in three were readmitted in 90 days (Jencks et al. 2009). Studies show that after transitioning home from a hospital stay, older patients can be at increased risk for illness, difficulty conducting activities of daily living—such as bathing, dressing, or eating—and prolonged disability (Chapin et al. 2014; Preyde and Brassard 2011).

Poor outcomes after hospitalization are directly related to the quality of discharge planning and coordination of care after discharge (Chapin et al. 2014; Preyde and Brassard 2011). Both activities require the input of patients, hospital-based discharge planners, and professionals in community-based organizations to assess the patient's needs, provide patient and caregiver education, and link patients to appropriate resources and services in the community (Chapin et al. 2014).

Patient assessment tools are a critical part of this process, but there is a shortfall in comprehensive and evidenced-based discharge assessment tools specifically for older adults (Preyde and Brassard 2011). Limited access to and sharing of patient data between health care settings—such as a hospital, provider clinic, and pharmacist—also impedes effective discharge planning and post-hospitalization patient care coordination (Mancuso et al. 2012).

In October 2012, the Patient Protection and Affordable Care Act (ACA) began to reduce payments to hospitals with excess readmissions—defined as re-admissions within 30 days—for specific conditions, which currently include acute myocardial infarction, heart failure, and pneumonia (CMS.gov 2014). As a direct outcome of this policy, hospitals are examining and implementing measures to improve discharge practices so that they contribute to improvements in post-discharge care, with the ultimate goal of reducing patient re-hospitalization rates.

For any older adult living at home, linking with community-based supportive services such as home health care, visiting nurse services, transportation services, and meal services can be critical to successful recovery from a hospitalization and successful long-term aging in place. Without access to these systems of support, older adults who are discharged to a home environment are at an increased risk of harm and negative outcomes (Preyde and Brassard 2011). Along with effective discharge planning, access to and coordination of home-based care is critical for recovery from a hospital stay.

### **What Can Be Done?**

Research and advocacy organizations suggest several policy approaches that support effective hospital discharge planning as well as community-based care coordination whether or not a client has had a recent hospitalization:

- Develop public and private policies, such as the ACA's fiscal disincentive approach, and hospital discharge system redesign, to ensure adequate and appropriate discharge planning.
- Develop policies that assist public and private health care and social services providers in sharing patient and other applicable data, to support care and service coordination for older adults living in residential settings.
- Develop policies that increase the availability and capacity of community-based care services and coordination.

### **What's Next?**

Aging in place has earned its position as a key policy approach to aging well in Washington State. Considered fiscally responsible and preferred by many older adults, this approach has much to offer stakeholders across the state and beyond.

For aging in place—or any policy approach for healthy aging—to succeed, however, an array of related issues must be considered. These include eldercare workforce capacity; care service financing; land use, transportation, and environmental planning; and hospital discharge planning and community-based care coordination.

*We don't yet have all the planets aligned to support living at home without having an eye across the system to coordinate services for older adults.*

– Washington State Eldercare Stakeholder

Other policy concerns intersect with these issues, and stakeholders will need to hold multi-disciplinary discussions and analyses to collaboratively address approaches to ensuring that aging in place is effectively and appropriately implemented for Washington State's growing older adult population.

Washington State's universities are well suited to help advance solutions in eldercare policy by convening diverse and multi-disciplinary stakeholders for collaborative problem solving. With access to information, ideas, and resources from top researchers and academic leaders from every discipline involved in this complex issue, the state's universities can readily fuel a meaningful conversation that looks toward finding solutions. Combining Washington State University and University of Washington expertise and perspective into an effective, university-based neutral third party may help to address eldercare policy issues that involve diverse stakeholders, such as:

- State public health and social service agencies and departments
- State legislators and their committee staff
- Health care providers and professional associations
- Public and private-sector payers, including insurers and health plans
- Consumer advocates
- Labor unions
- Foundations and other community partners

The new era of health care reform ushered in by the ACA encourages new care delivery, coordination, and payment methods, as well as a need for collaborative innovation. University-based centers such as the William D. Ruckelshaus Center and the University of Washington Health Policy Center are uniquely poised to act as neutral conveners to help stakeholders share ideas, address conflicts, and build innovative and effective public policy solutions.

### **Disclaimer**

This report was prepared in part by the William D. Ruckelshaus Center, whose mission is to act as a neutral resource for collaborative problem solving in the Pacific Northwest.

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## References

- AARP. 2013 [Washington State Aging Agenda](#) [Internet]. Seattle (WA): AARP; 2012 [cited 2013 Nov 25].
- Bardach, S.H. and G.D. Rowles. Geriatric education in the health professions: Are we making progress? *Gerontologist*. 2012 Jan; 52(5): 607-618.
- Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. [2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 49th Report](#) [Internet]. Washington (DC): Boards of Trustees, 2014 Jul 28 [cited 2014 Sep 24].
- Centers for Disease Control and Prevention [Internet]. Atlanta (GA): Centers for Disease Control and Prevention; c2014. [Falls Among Older Adults: An Overview](#); 2014 Sept 22 [cited 2014 Sept 25].
- Centers for Disease Control and Prevention [Internet]. Atlanta (GA): Centers for Disease Control and Prevention; c2014. [Healthy Places Terminology](#); 2013 Aug 14 [cited 2014 Sept 25].
- Chapin, R.K., D. Chandran, J.F. Sergeant, and T.L. Koenig. Hospital to Community Transitions for Adults: Discharge Planners and Community Services Providers' Perspectives. *Soc Work Health Care*. 2014 Apr 9; 53(4): 311-329.
- CMS.gov [Internet]. Washington (DC): Centers for Medicare & Medicaid Services; c2014. [Readmissions Reduction Program](#); 2014 Aug 4 [cited 2014 Sep 24].
- Congress of the United States, Congressional Budget Office. [Rising Demand for Long-Term Services and Supports for Elderly People](#) [Internet]. Washington (DC): Congressional Budget Office; 2013 June [cited 2014 Sep 25].
- Farber, J.D., D. Shinkle, J. Lynott, W. Fox-Grage, and R. Harrell. [Aging in Place: A State Survey of Livability Policies and Practices](#) [Internet]. Washington (DC): National Conference of State Legislatures and the AARP Public Policy Institute; 2011 [cited 2014 Aug 4].
- Healthypeople.gov [Internet]. Washington (DC): Office of Disease Prevention and Health Promotion US Department of Health and Human Services; c2014. [2020 Topics and Objectives: Older People](#); 2014 Oct 3 [cited 2014 Oct 3].
- Henry J. Kaiser Family Foundation [Internet]. Menlo Park (CA): Kaiser Family Foundation; c2014. [State Health Facts Washington: Distribution of Medicaid Enrollees by Enrollment Group](#); FY 2010 [cited 2014 Oct 3].
- Houser, A., W. Fox-Grage, and K. Ujvari. [Across the States: Profiles of Long-Term Services and Supports](#) [Internet]. Washington (DC): AARP Public Policy Institute; 2012 [cited 2014 May 6].
- Institute of Medicine Committee on the Future Health Care Workforce for Older Americans. *Retooling for an Aging America: Building the Health Care Workforce*. Washington (DC): National Academies Press; 2008.
- Jencks, S.F., M.V. Williams, and E. Coleman. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. *N Engl J Med*. 2009 Apr 2; 360: 1418-1428.
- Kaye, S., M.P. LaPlante, and C. Harrington. Do noninstitutional long-term care services reduce Medicaid spending? *Health Affairs* 2009; 28(1): 262-272.
- Keenen, T.A. [Home and Community Preferences of the 45+ Population](#) [Internet]. Washington (DC): AARP; 2010 [cited 2014 Aug 28].
- King County Caregiver Support Network [Internet]. [Seattle \(WA\): Aging and Disability Services, The Area Agency on Aging for King County](#); 2012 [cited 2014 Sept 22].
- Kinsella, K. and W. He. [An Aging World: 2008](#). US Government Printing Office: P95/09-1 [Internet]. Washington (DC): US Census Bureau; 2009 June [cited 2014 Sept 22].
- Mancuso, D., B. Court, and B.E.M. Felver. [Patterns of Hospital Readmissions and Nursing Facility Utilization among Washington State Dual Eligibles: Opportunities for Improved Outcomes and Cost Savings](#). Research and Data Analysis Division Report 11.175 [Internet]. Olympia (WA): WA State Department of Social and Health Services; 2012 Aug.
- McGill, N. [Senior population grows, Aging in Place gains popularity: Communities conducting outreach](#). *Nations Health* [Internet]. 2013 Oct [cited 2014 Aug 5]; 43(1): 16.

Mollica, R.L., E. Kassner, L. Walker, and A. Houser.  
[Taking the Long View: Investing in Medicaid Home and Community Based Services is Cost-Effective](#) [Internet]. Washington (DC): AARP Public Policy Institute; c2014. Insight on the Issues: 12. 2009 Mar [cited 2014 Oct 3].

Navigant Consulting, Inc. [Washington Department of Social and Health Services Aging and Disability Services Analysis of The Washington Nursing Facility Medicaid Payment Methodology](#) [Internet]. Location unknown: Navigant Consulting; 2013 Mar [cited 2014 Sept 4].

Preyde, M. and K. Brassard. Evidence-based risk factors for adverse health outcomes in older patients after discharge home assessment tools: A systematic review. *J Evid Based Soc Work*. 2011 Oct 28; 8(5): 445-468.

Skillman, S.M., M.A. Fordyce, W. Yen, and T. Mounts.  
[Washington State Primary Care Provider Survey, 2011-2012: Summary of Findings](#) [Internet]. Seattle (WA): WWAMI Center for Health Workforce Studies; 2012 Aug [cited 2014 Aug 16].

Small Business Majority. [Opinion Poll: Small Businesses Believe Washington Needs to do More to Help Workers Prepare for Retirement, Support Legislation Doing So](#) [Internet]. Washington (DC): Small Business Majority; 2014 Jan 22 [cited 2014 Oct 1].

United States of America. Economic Report of the President: Transmitted to the 110th Congress February 2007. H. Doc. 110-2. Washington DC: United States Government Printing Office; 2007.

Washington State Department of Social and Health Services [Internet]. Olympia (WA): Aging and Long-Term Support Administration; c2013. [Washington State Plan on Aging 2010-2014](#); 2010 July 1 [cited 2013 Dec 5].

Washington State Office of Financial Management [Internet]. Olympia (WA): Office of Financial Management; c2012. [State Population Forecast, Data Tables, Population by age and sex](#); 2013 Nov [cited 2013 Dec 6].



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