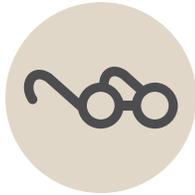

AGING AND ITS FINANCIAL IMPLICATIONS: Planning for housing

Perspective, research and practical insights
created in collaboration with The Center
for Innovative Care in Aging at the Johns
Hopkins University School of Nursing



INVESTMENT PRODUCTS: NOT FDIC INSURED • NO BANK GUARANTEE • MAY LOSE VALUE

A REALISTIC VISION FOR YOUR RETIREMENT



For many, retirement is the much-anticipated culmination of work and savings. Most people envision the part of retirement that is active, and free from the stresses of work and career.

This vision may include travel or volunteering, refining a golf or tennis game, having more time for your family, or checking off experiences on your lifelong “Bucket List,” the list of dreams to fulfill, goals to achieve or places to visit.

In the best case, you may be retired for nearly as long as you worked full time. Longevity brings with it both opportunities and challenges. Have you considered the full set of possibilities for a retirement that lasts 30 years or more? The years spent in retirement may offer a mixed bag of good health and periods of infirmity. There is no question that health issues can interrupt the carefree retirement you may have planned. Age-related changes, such as hearing or vision loss, or reduced energy and chronic health conditions, begin to take their toll on the quality of life and often contribute to declines in everyday functioning.

Your retirement lifestyle could turn out quite differently in later years from what you have envisioned. Beyond the ideal vision of your “golden years,” give some careful consideration to the realities and “what-ifs” of aging. Aging and frailty know no economic boundaries and often bring physical, lifestyle, financial planning, family, psychological and social challenges. When you truly understand the realities of retirement well in advance, you can give financial, emotional and family considerations the proper attention and make appropriate contingency plans.

The challenge

A brave new world greets retirees who may live as long as 30 years or more in retirement. Housing is both a major financial asset on the balance sheet and a significant expense in the household budget. Housing may be the largest expense of retirement income. The time for planning is before a crisis or health event drives a change in housing that is neither budgeted for nor anticipated. Even if the intent is to age in place — that is, live in the home of your choice as you age — you should think through the options in advance of a health crisis. Mobility limitations, a chronic illness or a catastrophic health crisis may give way to a housing move, reshape the best-laid plans and disrupt your financial preparedness.



Legg Mason’s commitment and response

Legg Mason created “Aging and its Financial Implications: Planning for Housing” in collaboration with The Center for Innovative Care in Aging at the Johns Hopkins University School of Nursing, to bring you perspective, research and practical insights to assist you with the challenges of aging. This document is based on third-party data, as well as input from our skilled partners at Johns Hopkins.

Broadening your familiarity with housing options will help you understand more deeply how aging impacts housing requirements. When people weigh current and future housing choices, they often reveal conditions of frailty, reduced capabilities and personal issues that are close at heart. As the conversation continues with family members, we hope this “go-to” source can assist you and your family with decision-making. We have tools to help initiate the conversation, support the dialogue and help prepare for this important life stage.





What's inside

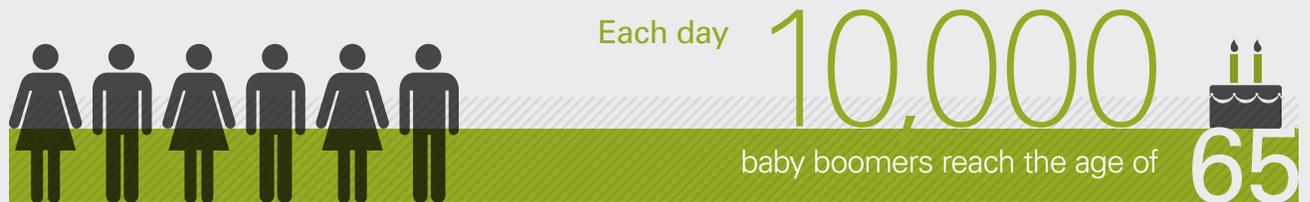
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THE NEW FACE OF AGING

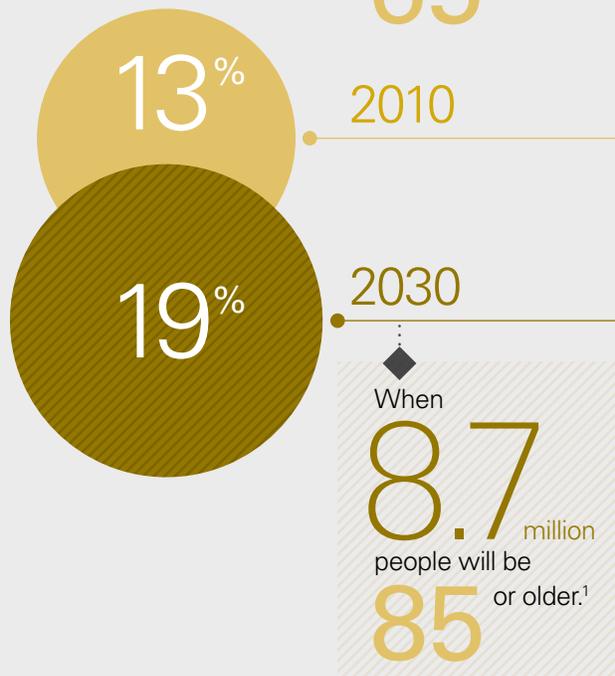
America is aging and everyone is affected by longer life expectancy. As advanced age approaches, people often need to shift the way they live and/or where they live to accommodate age-related discomforts and reduced capabilities. There are a number of trends that impact decisions related to housing during the years of retirement.

PROFILE OF AGING

The aging population (65+) will continue to increase



By **2030** all of the baby boomers will have moved into the ranks of the older population. This will result in a shift in the over **65** population



The effect of life expectancy²

A woman who lives to age 65 today can expect to live an average of 20 years.



A 65-year-old man can expect to live an average of 18 years.



Once a woman or a man reaches 85, there is a good chance their lives will extend another 6-7 years.



¹ U.S. Census Bureau: The Next Four Decades; The Older Population in the United States: 2010 to 2050. Available electronically at: <http://www.census.gov/prod/2010pubs/p25-1138.pdf>

² 2013 National Vital Statistics Report — Deaths: Final Data for 2013. Table 7. Life expectancy at selected ages, by race, Hispanic origin, race for non-Hispanic population, and sex: United States, 2013, www.cdc.gov/nchs/data_access/Vitalstatsonline.htm

Women continue to outlive men as they age³

Percent of women in the 65-and-over population



Percent of women in the 85-and-over population



The effect of marital status on living arrangements³

-  **72%** live w/ spouse
-  **19%** live alone
-  **42%** live w/ spouse
-  **37%** live alone



Older men more often live with their spouse than older women.



Older women are twice as likely as older men to live alone.

Widowhood is a reality. Older women are more likely to remain unmarried than older men.

The effect of aging on living situations⁴

The vast majority of people over 65 live at home

Percentage of Medicare enrollees ages 65 and over in selected residential settings, by age group, 2009



By age 85, only 78% live in traditional communities and the rest live in long-term care facilities and community housing



A move to a full-service facility can be a substantial investment. Will the money be there? The time to factor in the costs of such a move is well in advance of a medical emergency.

³ U.S. Census Bureau, 1900 to 1940, 1970 to 1980, U.S. Census Bureau, 1983, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File; 2000, U.S. Census Bureau, 2001, Census 2000 Summary File 1; U.S. Census Bureau, Table 1: Intercensal Estimates of the Resident Population by Sex and Age for the U.S., April 1, 2000 to July 1, 2010 (US_EST00INT-01); U.S. Census Bureau, 2011, 2010 Census Summary File 1; U.S. Census Bureau, Table 2: Projections of the population by selected by selected age groups and sex for the United States.

⁴ Centers for Medicare and Medicaid Services, Medicare Current Benefits Survey. The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a nationally representative sample of the Medicare population, conducted by the Office of Information Products and Data Analysis (OIPDA) of the Centers for Medicare & Medicaid Services (CMS) through a contract with Westat. **Traditional facilities/communities** refer to aging in place or 55+ independent living communities. **Community housing with services:** Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes and similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation; cleaning or housekeeping services; laundry services; help with medication. Respondents were asked about access to these services, but not whether they actually used the services. **Long-term care facility:** A residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has three or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day a week supervision by a non-family, paid caregiver. For more information, please visit: www.agingstats.gov.

Housing trends

Baby boomers are forging new expectations and approaches to retirement and housing. The aging of Americans is driving housing trends, impacting housing supply and creating new demand for various housing types.

By their sheer numbers, baby boomers have shaped consumer trends at every stage of their lives. Trends suggest that the baby boomers will continue to make highly personalized choices, as they have throughout their lives. Instead of downsizing, roughly 63% do not plan to move, but rather expect to age in place. A significant number will renovate their homes, as 39% plan for major home improvement in the next three years. Even so, their reasons to renovate make style and value a priority over “aging-friendly” features.⁵

When they sell, some baby boomers (46%) are looking for nicer homes and more space, not less. They will have more housing options to buy, sell or modify than ever before. Of those boomers who move, 54% will downsize. Many of those living in larger, more expensive homes are looking for smaller homes with high-end finishes and nearby services and amenities.⁶ Only 1 in 5 “boomer movers” want to relocate to senior-related housing or active adult communities.⁷

The decision to age in place could change as people advance through their retirement years. Throughout a retirement that may extend 30 years or more, many will find their needs change as they age. Three-quarters of boomer households surveyed between the ages of 50 and 69 have already suffered a major health incident or have a chronic health condition. This calls into question just how suitable their homes are for older adults.⁸ Services are growing and industries are being developed to help older adults age in place and meet health and lifestyle requirements.

Where people live and how they live as they age are consequential financial decisions. Housing accounts for a large share of the budget. At age 55–64, the average household spends less than 33% of income on housing. That share rises to 36% of expenses for the 75+ age cohort, even though people of that age are more likely to own a home without mortgages.⁹ Housing is directly tied to a person’s physical or psychological well-being. This is why having a living situation that fits one’s current level of physical and cognitive ability and anticipated future needs is essential.

Baby boomers that expect to age in place

63%

expect to age in place⁵

39%

plan for major home improvement in the next three years⁵



1 in 5



boomer movers want to relocate to senior-related housing or active adult communities.⁷

At age 75+, 36% of one's expenses are likely to go toward housing

36%



even though people at that age are more likely to own a home without mortgages.

75+

⁵ Burbank, Jeremy, Keely, Louise. “Baby Boomers and Their Homes.” Demand Institute. Oct 2014. <http://www.demandinstitute.org/blog/baby-boomers-and-their-homes>

⁶ Burbank, Jeremy, Keely, Louise. “Baby Boomers and Their Homes.” Demand Institute. Oct 2014. <http://www.demandinstitute.org/blog/baby-boomers-and-their-homes>

⁷ America’s Rental Housing Evolving Markets and Needs. Joint Center for Housing Studies at Harvard University, 2013. www.jchs.harvard.edu/americas-rental-housing

⁸ Burbank, Jeremy, Keely, Louise. “Baby Boomers and Their Homes.” Demand Institute. Oct 2014. <http://www.demandinstitute.org/blog/baby-boomers-and-their-homes>

⁹ Bureau of Labor Statistics: Consumer Expenditures in 2013. BLS Reports. Report 1053. February 2015.

In another decade, the oldest members of the baby boomer generation will be in their late 70s, a time when living independently often becomes more difficult. Health and memory issues may intervene. Nearly 70% of people who reach age 65 will ultimately need some form of long-term care, according to the Department of Health and Human Services.¹⁰

By 2025, the large and growing population of seniors is likely to drive up demand for alternative housing arrangements that offer a combination of affordability, accessibility and supportive services.¹¹ This is expected to increase the need for assisted living and nursing homes, among other supportive housing arrangements.

Health trends

Physical health can be a determining factor in living arrangements. Living longer increases the potential for chronic diseases. While the vast majority of people prefer to live at home for the rest of their lives, when health and physical frailty intervene, things can change.

The leading causes of death include many chronic conditions that at first negatively affect quality of life, contribute to declines in function, and hasten the loss of the ability to live independently at home. The leading causes of death include common chronic conditions:¹²

- Heart disease
- Cancer
- Chronic lower respiratory diseases
- Accidents (unintentional injuries)
- Stroke (cerebrovascular diseases)
- Alzheimer's disease
- Diabetes
- Influenza and pneumonia
- Nephritis, nephrotic syndrome and nephrosis
- Intentional self-harm (suicide)

Along with people living longer, there is a rise in the prevalence of cognitive impairment and dementia, both of which interfere with the ability to carry out activities of daily living.

Cognitive impairment:

Cognitive impairment is when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. Cognitive impairment ranges from mild to severe. With mild impairment, people may begin to notice changes in cognitive functions, but still be able to do their everyday activities. Severe levels of impairment can lead to losing the ability to understand the meaning or importance of something and the ability to talk or write, resulting in the inability to live independently. (Source: Center for Disease Control; http://www.cdc.gov/aging/pdf/cognitive_impairment/cogimp_poilicy_final.pdf)

Dementia

Dementia is an overall term that describes a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities. Alzheimer's disease accounts for 60 to 80 percent of cases. Vascular dementia, which occurs after a stroke, is the second most common dementia type. But there are many other conditions that can cause symptoms of dementia, including some that are reversible, such as thyroid problems and vitamin deficiencies. While symptoms of dementia can vary greatly, at least two of the following core mental functions must be significantly impaired to be considered dementia: memory, communication and language, ability to focus and pay attention, reasoning and judgment, visual perception.

People with dementia may have problems with short-term memory, keeping track of a purse or wallet, paying bills, planning and preparing meals, remembering appointments, or traveling out of the neighborhood. Many dementias are progressive, meaning symptoms start out slowly and gradually get worse. (Source: Alzheimer's Association; <http://www.alz.org/what-is-dementia.asp>)

¹⁰ "Who Needs Care?" U.S. Department of Health and Human Services. <http://longtermcare.gov/the-basics/who-needs-care/>

¹¹ "The State of the Nation's Housing 2015": Joint Center for Housing Studies of Harvard University. Page 5. http://www.jchs.harvard.edu/research/state_nations_housing

¹² "Leading Causes for Death." Centers for Disease Control and Prevention. August 21, 2015. <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>

The vast majority of older adults (92%) are living with one chronic disease, and 77% have at least two.¹³ These health issues need to be considered, for not only how they impact you or your family member today, but also throughout the rest of your lives. Chronic conditions lead to predictable declines in mobility, physical health and independent function that may require more supportive housing arrangements.

Lifestyle and health implications

While most people prefer to stay in their homes for as long as possible, they find their needs change as they age. When they do decide to move, it may be for a variety of reasons. They may want less home maintenance to deal with, and so they might choose to sell the family home and move closer to family members, often their children and grandchildren. They may prefer a warmer or drier climate. To stay as independent as possible, they may need to modify their own home, or consider moving to a different housing arrangement that can help keep them healthy and independent. A combination of these factors may also drive their thinking.

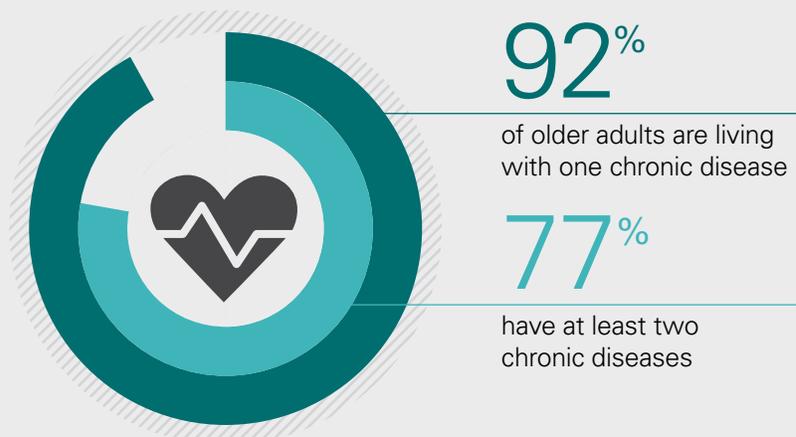
Physical ailments, decline in cognitive function, and mobility limitations also proliferate with age. The ability to carry out everyday activities such as preparing meals or bathing and dressing can be diminished by illness, chronic disease, cognitive impairment or injury. These conditions have important implications for families and greatly influence the housing selection.

Beyond the golden years

Ideally, when you are planning for retirement, you should think long term, and account for changes in your physical health. There is an inherent unpredictability in predicting what that support will entail.

A comprehensive approach that includes addressing the physical and medical needs, social and emotional needs and financial needs of the future (as best as they can be determined), is paramount to ensure that the proper plans are in place. Such an approach will help in selecting the optimal housing option(s) for the years spent in retirement.

The vast majority of older adults are living with one chronic disease, and over three-quarters have at least two¹³



¹³ National Council on Aging, "Healthy Aging Facts." <https://www.ncoa.org/news/resources-for-reporters/get-the-facts/healthy-aging-facts>

MYTHS AND REALITIES OF AGING

In general ... don't generalize guide

It is easy to make assumptions about aging; many people do. This guide may help you to separate fact from fiction, and better understand the aging process. Use this as a tool to generate discussion and make informed decisions.

Myth	Reality
Dementia is an inevitable part of aging.	Dementia is a progressively degenerative disease, and is not a normal part of aging. While age is the most significant risk factor, dementia is not an inevitable part of aging. Approximately one in nine adults age 65 and older have Alzheimer's disease, and an estimated 14% of adults age 71 and older have dementia. ¹⁴
Older adults become more rigid in their thinking and are unable to learn or change.	Learning patterns do change with age, and it may take longer to learn something new. Older adults do not become more rigid, and the basic capacity to learn is retained. ¹⁵
Older adults are alone or lonely and have been abandoned by their families.	Although many people perceive the elderly to be lonely, only 12% of older adults report suffering from loneliness. ¹⁶ Most older adults continue to enjoy the company of their families and close friends as they age, and 52% of grandparents report seeing their grandchildren at least once a week. ¹⁷
Older adults are in poor health.	More than 76% of older adults describe themselves as being in good, very good or excellent health despite having an average of two or more chronic conditions. ¹⁸
Lifestyle changes late in life have no effect on older adults' health and well-being (e.g., beginning to exercise, quitting smoking)	Lifestyle changes including exercise, diet, sleep and other health-promoting behaviors, such as quitting smoking, can positively impact an older adult's well-being regardless of age. Older adults who exercise are better able to fight chronic disease. ¹⁹

¹⁴ "Alzheimer's and Dementia: The Journal of the Alzheimer's Association." Alzheimer's Association, March 2015, 2015 Alzheimer's disease facts and figures. [http://www.alzheimersanddementia.com/article/S1552-5260\(15\)00058-8/fulltext#sec2.2.4.1](http://www.alzheimersanddementia.com/article/S1552-5260(15)00058-8/fulltext#sec2.2.4.1)

¹⁵ "Staying Sharp: Successful Aging and the Brain." 2015, The Dana Alliance for Brain Initiatives, electronically retrieved on June 8, 2015 from <http://dana.org/StayingSharpSuccessfulAging>

¹⁶ "Myths and Stereotypes of Aging." 2012, Oregon Department of Human Services, electronically retrieved on June 8, 2015 from <http://www.oregon.gov/dhs/apd-dd-training/EQC%20Training%20Documents/Myths%20and%20Stereotypes%20of%20Aging.pdf>

¹⁷ "Insights and Spending Habits of Modern Grandparents." March 2012, AARP. http://www.aarp.org/content/dam/aarp/research/surveys_statistics/general/2012/Insights-and-Spending-Habits-of-Modern-Grandparents-AARP.pdf

¹⁸ "Older Americans 2012: Key Indicators of Well-Being." 2012, Federal Interagency Forum on Aging Related Statistics, <http://www.agingstats.gov>

¹⁹ "It's Never Too Late: Five Healthy Steps at Any Age." Johns Hopkins Medicine, electronically retrieved on June 8, 2015 from http://www.hopkinsmedicine.org/health/healthy_aging/healthy_body/its-never-too-late-five-healthy-steps-at-any-age

Myth	Reality
Older workers are less productive.	There is virtually no relationship between age and job performance. In jobs that require experience, older adults may in fact have a performance edge; the older workers seem to know better how to avoid severe errors. ²⁰
Older adults are more likely to become clinically depressed.	Most older adults are not depressed. Depression is not a normal part of growing older, but rather an illness that needs to be treated. ²¹
With age, older adults lose individual differences and become progressively more alike.	The opposite is true. Individual differences appear to increase with age. There is more variety among older adults than among any other age group. ²²
Most older adults end up in nursing homes.	Only 1% of people ages 65-74 and approximately 13% of people age 85 or older live in nursing homes. 80% of older adults who receive some form of care do not reside in an institution. ²³
Most older adults live in poverty.	Only 9% of older adults live in poverty. An additional 26% of older adults are considered low income. ²⁴
With age, most older adults become helpless and cannot take care of themselves.	About 25% of Medicare enrollees age 65 and older report difficulty in performing one or more activities of daily living. Only 12% report difficulty with using the telephone, light or heavy housework, meal preparation, shopping or managing money. ²⁵
Older adults are an economic burden on society, and this takes away resources from the young.	Older adults make significant economic contributions to society. Baby boomers have health care and assisted living needs that will create an increased number of health care jobs over time, and their high rates of travel have resulted in increased spending in the travel industry. ²⁶ Older adults also accounted for more than 3.3 billion hours of community service in 2014, a benefit valued at \$75 billion. ²⁷
Falling is normal with advanced age.	More than one-third of older adults experience a fall every year. However, falling is not an inevitable part of aging. Falls can be minimized by addressing risk factors, such as removing tripping hazards in the home, monitoring medications, and enhancing balance and mobility. ²⁸

²⁰ "Why Everything You Think About Aging May Be Wrong." By Anne Tergesen, November 30, 2014, The Wall Street Journal, electronically retrieved on July 27, 2015 from <http://www.wsj.com/articles/why-everything-you-think-about-aging-may-be-wrong-1417408057>

²¹ "Depression is Not a Normal Part of Growing Older." Centers for Disease Control (CDC), electronically retrieved on June 8, 2015 from <http://www.cdc.gov/aging/mentalhealth/depression.htm>

²² "Myths and Stereotypes of Aging." 2012, Oregon Department of Human Services, electronically retrieved on June 8, 2015 from <http://www.oregon.gov/dhs/apd-dd-training/EQC%20Training%20Documents/Myths%20and%20Stereotypes%20of%20Aging.pdf>

²³ "Selected Long-Term Care Statistics." 2015, Family Caregiver Alliance: National Center on Caregiving, electronically retrieved on July 27, 2015 from <https://caregiver.org/selected-long-term-care-statistics>

²⁴ "Older Americans 2012: Key Indicators of Well-Being." 2012, Federal Interagency Forum on Aging Related Statistics, <http://www.agingstats.gov>

²⁵ "Older Americans 2012: Key Indicators of Well-Being." 2012, Federal Interagency Forum on Aging Related Statistics, <http://www.agingstats.gov>

²⁶ "3 Positive Economic Impacts of Baby Boomers in the U.S." By Colleen Van Horn RN, B.S.N., PHN, CCM, June 23, 2013, Del Mar Times, <http://www.delmartimes.net/news/2013/jun/23/3-positive-economic-impacts-of-baby-boomers-in/>

²⁷ "Value of Senior Volunteers to U.S. Economy Estimated at \$75 Billion." May 20, 2015, The Corporation for National and Community Service, <http://www.nationalservice.gov/newsroom/press-releases/2015/value-senior-volunteers-us-economy-estimated-75-billion>

²⁸ "Falls and Older Adults." NIH SeniorHealth, electronically retrieved on July 27, 2015 from <http://nihseniorhealth.gov/falls/aboutfalls/01.html>

FINANCIAL PLANNING AND OTHER IMPLICATIONS

Anticipating the realities of aging enhances your ability to make better decisions for the future.



Financial planning considerations

As you know, no amount of wealth can forestall the aging process; the real advantage comes from preparation. What you can do is get out in front of the potential issues you may face and become familiar with the landscape you could encounter in the advanced stages of aging. This will equip you to work through various scenarios with your Financial Advisor and shock-test your financial plan.

It's important to anticipate the financial impact of a health crisis on your financial plan, whether it occurs in your 70s, 80s or 90s. It may be difficult to imagine today the unintended financial consequences of a major illness, lack of mobility or other health issue. For example, it may be necessary to maintain a separate residence for one spouse while the other lives in a skilled nursing facility.

Additional costs may include in-home care, transportation or a move to another type of housing. Some changes can arise from these common occurrences: chronic illness; the loss of a spouse; memory problems symptomatic of dementia; changes to eyesight or other limitation to driving; or loss of physical mobility. If you decide a move is the best option for you, you will need to be financially prepared.

Another important consideration is inflation. Inflation has the potential to erode a retirement lifestyle that spans 30 years or more. A "what if" scenario can help you gauge the impact of inflation on buying power in your later years. Home values will fluctuate with economic conditions, as we saw in the 2008 real estate recession. Those who count on their homes as a source of wealth often need the money from the sale of their home to afford to move somewhere else.

Fortunately, if you are financially prepared and a move becomes necessary, the range of housing options has never been greater, and it is expected to expand in the next decade. Some people plan to move to independent living to enjoy the amenities. Many others will only consider a future move when forced by poor health or the loss of a spouse. Developing a plan that includes more lifestyle support in declining years is essential. Only then can you feel secure about maintaining control and dignity as you age.

Fortunately, if you are financially prepared and a move becomes necessary, the range of housing options has never been greater, and it is expected to expand in the next decade.

Planning to preserve control, dignity and safety ... come what may

For all the talk about “retirement planning,” there is little focus on the stage after the healthiest and most active years. If you have faced the health crisis of a parent or loved one, you have renewed respect for the benefits of proactive planning, rather than waiting for a crisis to drive an immediate decision. Through careful preparation in partnership with a Financial Advisor and other trusted professionals, you can increase the chances of maintaining control over the most important decisions related to your future. With a realistic view of the future, you have the ability to develop a comprehensive plan that takes into account “what if,” and ensures that you will have control over the decisions affecting where you will live, your comfort and care.

By giving careful consideration to all of the facets of aging, you can also proactively address the myriad of related family issues and decisions, such as, “Who will make medical decisions on your behalf?” And how much capacity do children and grandchildren have to provide care, support and transportation when help is needed?

It is important to explore these questions before a crisis occurs. When you facilitate a frank discussion about your plans for the future, you have the opportunity to prepare the next generation to understand and help you execute your plans. In doing so, you may deepen your relationship with family members who care about you and are inexperienced with these matters.





Family dynamic implications

Any move from the family home is significant. Sometimes as you grow older, you need help from family members to evaluate such a move. Family members have to know that you value your independence and your own preferences. Understanding what is most important to you is paramount, whether that is the opportunity to maintain social ties, proximity to your doctors or access to the outdoors and other activities. When family members are consultative in their approach and you are careful to seek input, you can move forward together.

Unless your immediate health and safety are at risk, you, rather than your family members, will make the final determination about moving. Often the adult children may be more anxious to initiate the move than their parents, and their parent's health and safety are paramount. Use the discussion guidelines on page 17, "Assessing your housing needs," to evaluate the priorities and preferences that will guide the housing selection. This may ease the conversation from leaving a home that is comfortable, familiar and potentially full of a lifetime of memories to gaining certain functionality and convenience that is more suitable to your needs.

When a family member (or designated beneficiary) concludes that his/her loved one's safety is at risk as a result of living without support, it may be time to make a difficult decision and consult the primary physician, other professionals, and family and friends to assist in the conversation.

Considerations for long-term care insurance vs. self insurance

Everyone needs to have a strategy for covering the cost of long-term care in their later years. Some people buy long-term care insurance to protect their assets from the cost of an extended illness, home care, assisted living and skilled nursing care. Others will self-insure based on the assets they have accumulated. It is important to have a detailed planning conversation with your Financial Advisor to evaluate your own personal situation and needs, and to explore the various types of long-term care insurance available.



Resources

Given the wide range of housing choices available, you will want to take your time to think about, and financially prepare for, the option that is most appropriate for you and your family. Please reference our "Assessing your housing needs discussion guide," or download your own copy at: www.leggmason.com/aging.

HOUSING OPTIONS

There are a range of housing options for retirees. Current and future housing needs are a key component of long-term retirement planning. There are a number of considerations that go into making a housing decision. Many people in the same stage of life take divergent paths — from staying in their own home or long-term residence, to moving to a facility that offers more support. Each choice has significant financial considerations. We focus on the most common housing choices available for older adults and their families, and some of the factors and considerations that may guide housing selection.

AGING IN PLACE

There is no place like home. Given the choice, the vast majority would rather remain in their homes for the rest of their lives.



Your home furnishings and treasured possessions are often connected to a lifetime of memories. Perhaps you raised your family there and remember happy times that emotionally tether you to the home. Staying at home also means a more independent lifestyle to many; that's why 63% of baby boomers indicate that they do not want to move or plan to move.²⁹

“Aging in place” refers to the decision to live at the home of your choice as you age. Aging in place recognizes that physical functions decline with age and certain tasks — such as climbing stairs, bending and lifting — become more challenging. Aging in place in your long-term residence may not be right for you, as it is not appropriate for everyone. To age in place, one may need to make changes to a home to enhance its safety and convenience. This may entail modifications to accommodate needs as circumstances change.

Being proactive and creating a plan for aging in place can help you prepare for unforeseen events that would compromise your ability to live independently. Sensible preparation calls for thinking through the safety and convenience of the home and accessibility of services to make life easier. Consider the potential costs of home modifications, support services and home care as you put your plan together. Because your safety and well-being are vital, it is essential to revisit this decision periodically to determine if the current living arrangements are still the most suitable option.

Resources

For a full recap of the resources listed in this section, please leverage our worksheet, “Aging in place resources,” or visit our website: www.leggmason.com/aging.

Taking care and staying safe

Your ability to stay where you live — now and into the future — will depend on your physical health, cognitive function and ability to navigate and maintain your living space as well as your social support network. Staying safe and avoiding injury are essential to staying independent. Simple precautions can help you to prevent accidents or incidents that could lead to a disabling injury, such as a fall. In order to accommodate the physical, sensory and cognitive changes that occur with advancing age, home modifications may be necessary. A home safety assessment will help you determine where to start.

Many professionals are prepared to help you with a home safety assessment. Geriatric care managers, nurses or occupational therapists can be hired to assist you. Your local area agency on aging can refer you to resources to contact regarding a home safety assessment. In this guide, under the “Tools and resources” tab, you will find a comprehensive “Home safety assessment checklist,” which can assist you in conducting your own home safety assessment.

When necessary for your comfort and safety, you may be able to make home modifications, bring in home care services, hire support services and use a range of assistive devices and other technologies to help you continue to do the things you would like to do. It is also important to keep on top of basic home repairs. Loose railings, cracked cement or floors and uneven stair cases can all pose safety hazards as one ages. We will discuss some of the tools that can enable aging in place and can help you stay in your home longer, should that be your preference.

²⁹ “Baby Boomers and Their Homes.” Demand Institute. www.demandinstitute.org/blog/baby-boomers-and-their-homes

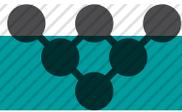


Key requirements for aging in place



Generally in good health

People who are healthy, mobile and active are good candidates for aging in place.



Part of a social network and have family support

Those who have a circle of family and friends who live nearby and can check on them, stop by and be a resource are generally the best candidates. The network may include a spouse, family living nearby and a network of good friends.



Living in a home with a favorable floor plan

While a home's floor plan can be modified, some dwellings are not ideal for aging in place. Homes that have steep driveways or are accessed only by a large number of steps, or have living space on multiple levels may not be suitable if one ages with mobility challenges. The wrong layout may isolate you from friends and older visitors, as well as impact your own mobility in later years.



Ability to drive and/or access to transportation

Having a driver's license or easy access to public transportation are essential to independence. When eyesight or reflexes diminish, driving capability or driving is curtailed for other reasons, it often becomes a trigger for rethinking aging in place.



Benefits

Enjoyment of the comforts of home and continuity of residence.

No change in geography that could disrupt medical and social relationships.

Could be cost effective if home is suitable for aging in place.



Preparing for aging in place: Key considerations

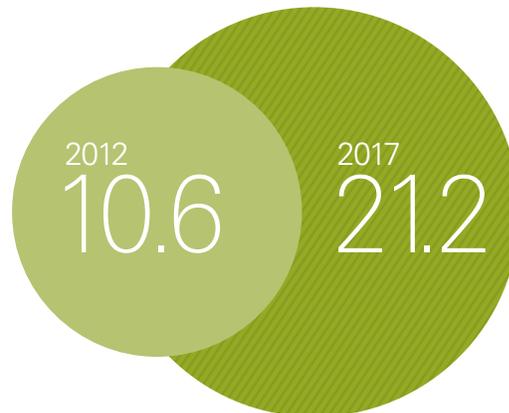
Home services and maintenance

Putting some labor-saving services in place makes good sense. As you get older, it can be challenging to think ahead and anticipate future needs. Family members can help by discussing these needs with you, offering to identify companies or service providers who can help. With a bit of advanced planning, you can have contractors in place in advance of the need. The most commonly needed services include lawn care, snow removal and assistance with home maintenance and housekeeping.

In certain regions of the country, winter snowstorms are a common occurrence. Unless there is a snow removal contractor in place, you may find yourselves stranded for a few days or more. Waiting for a blizzard to put a snow removal contractor in place is too little too late. In other places, neighborhoods lose power or encounter emergency flooding during hurricanes and tropical storms. Getting stranded during a power outage without a backup generator can be a serious situation. These examples illustrate how advanced planning is directly related to safety and maintaining control and independence.

Market for remote monitoring³⁰

\$ billions



³⁰ www.kaloramainformation.com



Aging in place technology

Technology can be a lifesaver when it comes to aging in place. Advances in new and emerging digital applications and “smart devices” add to the ability to meet individual needs and help residents stay connected with others, remain healthy and stay safe.

New innovations help to address the struggles older adults encounter at home and attempt to make many aspects of daily living easier and more convenient. As needed, technology can provide the ability for children, loved ones and heirs to monitor health and check on a family member’s safety. These tools encourage and support nutrition and health, safety and security, and communication for sociability. (For example, devices to remind an older person to take medication.) These advances can help keep residents in their homes longer and provide comfort to their families.

As we age as a society, assistive technology is becoming a fast-growing industry. For example, the market for remote monitoring alone is expected to grow to \$21.2 billion in 2017, up from \$10.6 billion in 2012, according to research firm Kalorama information.³⁰

The tools listed below and on the following pages are examples of what is available. However, they are not to be taken as endorsements or recommendations by Legg Mason, your Financial Advisor or The Center for Innovative Care in Aging at the Johns Hopkins University School of Nursing.

Health and wellness

Medication management and reminders

Ex: MedMinder, MedFolio Wireless pillbox

Medication management systems and devices can remind an older adult when to take medication and send alerts on missed medications. “Smart-pill dispensers” set alarms, send notifications through text, email and phone calls, identify correct pill compartments with blinking lights, and wirelessly send data to online reports accessible by users and caregivers.

Systems for monitoring chronic diseases, like diabetes or congestive heart failure.

Allow patients to stay on top of their health and provide vitals to caregivers or doctors.

- **Health Harmony by GE/Intel:** <http://resources.careinnovations.com/health-harmony>
- **WaveSense Diabetes Manager by AgaMatrix:** www.agamatrix.com/products
- **dLife Diabetes Companion mobile app:** www.dlife.com/dlife_media/mobile

Additional devices and senior-oriented non-medical aids for help with daily living, bathroom safety and more:

- **Gold Violin:** www.goldviolin.com; Catalog of helpful products and safety items for independent living
- **CarePathways.com:** www.carepathways.com; Nationwide database of home care, adult day care, and nursing homes.

Assistive technology

New innovations are available to assist older adults with everyday tasks.

Health and wellness:

- Medication reminders
- Pill dispensers
- Health management
- Nutrition guides
- Fitness tools
- Brain games

Safety and security:

- Home monitoring systems
- Medical alert systems (traditional and mobile)
- GPS tracking systems

Communication:

- Simplified computers
- Computer-free emails
- No-contract cell phones
- Amplified cell phones
- Video chats

Source: Care.com: Using Technology to Age in Place; <https://www.care.com/a/using-technology-to-age-in-place-1303050121>



Aging in place technology (continued)

Health and wellness (continued)

Fitness tracking devices

Ex: Microsoft Band or Fitbit

A variety of portable fitness tracking devices can monitor physical activity, including heart rate, daily steps, and quality of sleep. Either a mobile application or a watch-like device can send the user's information to an online dashboard for easy tracking.

Nutrition guides

Ex: MyFitnessPal or GoMeals

Meal planning may be an impediment to proper nourishment. Free or low-cost mobile apps track nutrition needs and food intake. Senior nutrition technology is leading to simple methods like touchscreen technology to allow you to measure food intake, mood, cognition and physical function.

Safety and security

Medical alert systems

Ex: Philips Lifeline, Life Alert, ADT Medical Alert

Personal emergency response systems allow a senior to call for help in an emergency. A senior wears a small pendant or watch-like device with a radio transmitter. In case of emergency, such as a fall while home alone, the senior pushes a button on the wearable device to call for help. The transmitter sends a signal to a console connected to the senior's phone, and an emergency response center monitors calls and sends help.

Wireless monitoring systems

Ex: Lively

Wireless monitoring systems are more frequently being used as an unobtrusive way to keep track of activity at home. Small wireless sensors can be fixed to doors, pillboxes and even refrigerators to keep track of how often an individual leaves the house, takes medication, and opens the refrigerator to eat. Information can be accessed through an online profile, and alerts are sent to family and caregivers when the system detects unusual behavior.

Smart home security systems

Ex: Quiet-Care, GrandCareSystems, BeClose

Newly developed home security features include smart locks and home monitoring systems. Smart locks use personalized codes or fingerprints instead of keys and automatically lock a few minutes after being opened, decreasing the risk of getting locked out or forgetting to lock up the house at night. Home monitoring systems use specialized sensors to detect movement, daily activities and even leaks or floods. Some systems also feature communication options such as texting, email and phone contact, to check in with family members and caregivers.

Communication

Simplified computers and tablets

Ex: AARP RealPad, Telikin

Those who struggle with technology may benefit from simplified computers and tablets. Devices often come with customer support, built-in instructional videos and easy-to-use applications to keep in touch with families and friends online.

Computer-free emails

Ex: Presto Email Machine

Computer-free email machines allow those who do not own computers (or those who are unable to use computers) to send and receive email.

Telephones for older adults

Ex: Jitterbug, ClarityLife C900

- Cell phones for older adults feature amplified sound, large keys to aid dialing, bright displays and safety features. A medical alert cell phone connects to health and safety experts.
- Those who already own a smartphone can turn up the volume by downloading amplification apps.

Finally, to address concerns over wandering, GPS tracking systems, using cellular and satellite technology, can accurately communicate the location of the device wearer, right to a computer, cellular phone or smartphone.



Safety inspection

Note to family members:

Careful conversations with your loved one may help them understand the precise benefit of a new device to keep them safe and connected. Importantly, remember to tie the benefit back to the goal of keeping older adults safely at home for a longer period of time.

There are many common hazards that can be addressed by a home safety inspection. Most homes were built for growing families and not for people who may be less steady on their feet, have limited visual clarity and cannot bend as far as they once could. The risk of tripping and falling is greater and the prospect of a serious injury is dire. There are many common hazards that can be addressed by a home safety inspection. A safety inspection should turn up the need for home modifications to accommodate physical needs and minimize the risk of falls. For example, assistance such as mobility aids, sturdy grab bars and other home modifications help older people navigate their home better in order to maintain their independence. Please refer to the “Home safety assessment checklist” under the “Tools and resources” tab for further details.

After a safety inspection and more reflection about your home layout and what you need, you may conclude that your current home does not meet your physical needs in retirement. In this case, you may want to learn more about a new form of home design called “Universal Design” — which is driving accessible home construction for people of all ages.

The Americans with Disabilities Act (ADA) provides a set of design standards that guides the Universal Design movement. Communities of architects and builders who are interested in Universal Design have begun to contribute to best practices and learn from each other.



Universal Design

Resources

For more information about **Universal Design**, please visit: www.universaldesign.com or the National Association of Home Builders at www.nahb.org.

Universal Design refers to the movement that encourages accessibility and mobility for all people. Universal Design encompasses broad-spectrum ideas meant to produce buildings, products and environments that are convenient and easy to navigate. A home with Universal Design makes life easier for everyone, regardless of age or mobility.

The common design elements in Universal Design include:

No-step entry: At least one step-free entrance into your home, for safer entry.

Single-floor living: A bedroom, kitchen and full bathroom with plenty of room to move around is a common feature.

Wide doorways and hallways: Doorways are at least 36 inches wide; hallways are 42 inches wide and free of hazards.

Reachable controls and switches: Anyone can reach light switches that are from 42–48 inches above the floor, thermostats no higher than 48 inches, and electrical outlets 18–24 inches off the floor.

Easy-to-use handles and switches: Lever-style door handles and faucets, and lower light switches make opening doors, turning on water, and lighting a room easier for people of every age and ability.

Other Universal Design features may include:

Raised front-loading clothes washers, dryers and dishwashers

Side-by-side refrigerators

Easy-access kitchen storage (adjustable-height cupboards and “Lazy Susans”)

Low or no-threshold stall showers with built-in benches or seats

Non-slip floors, bathtubs and showers

Raised, comfort-level toilets

Multi-level kitchen countertops with open space underneath, so the cook can work while seated

Windows that require minimal effort to open and close

A covered entryway to protect you and your visitors from rain and snow

Task lighting directed to specific surfaces or areas

Easy-to-grasp D-shaped cabinet pulls

AGING IN PLACE: FREQUENTLY USED SERVICES



With the aging in place option, it is important to understand the resources, such as caregivers and service workers, that may be required at home.

Managing a 'network of support'

Aging in place works best in healthy households. The arrangement grows more challenging as residents grow older and need more help. Family members may or may not be able to lend a hand, helping with driving and errands, reviewing contractors' bids, or filling in when a caregiver fails to show up. It is helpful to have family members who check in regularly and manage the bumps in the road and unexpected challenges, whether that involves driving someone to the doctor or negotiating with a neighbor over a fallen tree. Keep in mind, if aging in place involves nursing care, a family member may have to coordinate the schedule, line up the medical or non-medical care and arrange for any reimbursement from insurance providers. This may become an added burden on family members who may work, have children of their own or live farther away.





Geriatric care managers

Resources

For more information on **geriatric care managers**, please visit:

Aging Life Care Association
(formerly the National Association
of Professional Geriatric Care
Managers): www.aginglifecare.org

Caring.com: www.caring.com

National Care Planning Council:
www.longtermcarelink.net

When it is time to bring in help to the household, and a loved one's health and mobility has declined, a geriatric care manager may be extremely beneficial to the process of researching, finding and securing support. Geriatric care managers are specifically trained to conduct an assessment of an individual's current health and status to determine appropriate solutions for care. Geriatric care managers typically have a minimum of a bachelor's degree or substantial equivalent training in gerontology, social work, nursing or counseling. They are best described as "liaisons" or "consultants" who can provide valuable input and guidance at a time when you may not be able to research all of the local options on your own. They can also conduct thorough due diligence on service providers. The cost of a geriatric care manager ranges between \$50.00 and \$200.00 an hour. There may also be an option to get a flat fee that includes an assessment and a plan (Source: National Care Planning Council), and in some cases, long-term care insurance may cover the cost of a care assessment (please verify with your long-term care provider).

Here are just some of the tasks that a geriatric care manager can help with:

Perform an assessment to identify the areas for need/attention

Interview, organize and oversee in-home help or other services

Discuss concerns (financial, legal, medical or other) and if the situation warrants, provide a referral to a specialist

Serve as a contact for a crisis

Facilitate a move to a retirement community or facility, if needed

**2015 cost for a
geriatric care manager**
National median hourly rate

 **\$50-200**



Home care services

Home care services

There are a number of options for in-home care and support — some medically-related and some related just to the general maintenance and upkeep of one’s current home.

Homemaker

A homemaker can assist with light household duties such as laundry, meal preparation, general housekeeping and shopping. Homemaker services are directed at maintaining one’s household and helping with daily chores, rather than providing hands-on assistance with personal or medical care.

Home health aide

A home health aide can provide more hands-on care and will typically assist with basic health-related tasks such as getting out of bed, bathing, dressing and feeding. These individuals typically have state-approved advanced training and would help to monitor someone in their home and report any/all more serious medical concerns to a physician. In some cases, a home health aide may receive more advanced or complex training and could provide even further care.

For more information on hiring home care or a home care agency, please refer to the “Hiring a home care agency” worksheet under the “Tools and resources” tab.

The national median annual rate in 2015 for homemaker services or home health services is \$45,760 (based on a \$20 national median hourly rate multiplied by 44 hours per week multiplied by 52 weeks. Source: Genworth: 2015 Cost of Care Survey). Most home health care is not covered by Medicare. However, Medicaid does cover the cost for those who are eligible. Additionally, the Veterans Administration (VA) will cover some costs for veterans. Please speak to your local VA social worker for more information in your area.³¹

Resources

For more information on **home care services**, please visit:

National Association for Home Care & Hospice: www.nahc.org

Care.com: www.care.com

The Visiting Nurse Associations of America: www.vnaa.org

American Physical Therapy Association: www.apta.org

Please also refer to the “Hiring a home care agency” worksheet under the “Tools and resources” tab.

2015 cost for home health aide services

National median annual rate



³¹ www.medicare.gov, www.va.gov



Home care services (continued)

Visiting nurse

A visiting nurse can offer skilled nursing care and may assist with items such as taking vital signs, addressing ongoing medical conditions, administering medications, treating wounds or bed sores, changing catheters and performing other medical services. Visiting nurses are typically available through an agency. In-home visits by a nurse may help one avoid the need for emergency room trips, and may allow one to stay in one's home. Intermittent skilled nursing care to assist with one's personal and medical needs may be covered by Medicare. In order for this type of care to be covered by Medicare, an individual typically has to be homebound, and has to have visited with a physician in the last 90 days.

Physical therapist

A physical therapist can help individuals as they are recovering from surgery (e.g., a knee or hip replacement) or a major health event (e.g., a stroke). Physical therapists are focused on strength and mobility and trying to help individuals stay as healthy and independent as possible. They are licensed, and many are practicing in, or are affiliated with, a hospital. Typically, physical therapy is prescribed by a doctor and would be covered by insurance as a result of surgery or a major health event. Physical therapy may be administered at home, in a hospital setting, or in some cases, a rehabilitation center.

Occupational therapist

An occupational therapist works with clients to help them achieve a fulfilled and satisfied state of life through the use of purposeful activity, or interventions designed to achieve functional outcomes that promote health, prevent injury or disability and which develop, improve, sustain or restore the highest possible level of independence.

Speech-language pathologists

Speech-language pathologists (sometimes called speech therapists) assess, diagnose, treat, and help to prevent communication and swallowing disorders in patients. Speech, language, and swallowing disorders result from a variety of causes, such as a stroke, brain injury, hearing loss, developmental delay, a cleft palate, cerebral palsy or emotional problems.



Adult day services

Caregiving for an older adult with chronic illness can be taxing and absorb a considerable amount of time and energy. For those who work or are responsible for the full-time care of an older adult, juggling can be difficult. Adult day services are designed to give caregivers respite by providing a safe and friendly environment for the older adult. Adult day services are provided through centers that serve as community-based programs allowing older adults to live at home longer, and to receive some assistance such as personal care, social integration and companionship in a group setting (usually during the work week).

In general, there are three types of adult day centers^{32,33}

Please note: These three options may not be available in all locations.

- **Adult day services** provide attendees with activities, social interaction, recreation and meals. They often do not provide medical attention.
- **Adult day health care** may be appropriate for those who need more assistance. Adult day health care typically requires a health assessment and offers physical, occupational and speech therapy. An adult day health care facility is also likely to be staffed with a Registered Nurse (RN) and other health professionals.
- **Adult day care services** are specifically designed to support and care for patients with Alzheimer's or dementia. Adult day care programs typically provide socialization, reminiscing, recreational exercise, counseling, support groups, information, nutritious meals and snacks, health monitoring and art/music therapy. Some day centers offer nursing, occupational therapy, physical therapy and personal care.

There are more than 4,600 adult day care centers in the United States, and each state provides their own guidelines for operations (Source: [Helpguide.org](http://helpguide.org)).

The daily costs for adult day services vary greatly. The national median annual rate for adult day health care in 2015 is \$17,904 (based on a \$68.86 national median daily rate multiplied by five days per week, multiplied by 52 weeks. Source: Genworth: 2015 Cost of Care Survey). Regular adult day care would be less.

Resources

For more detailed information, or to find **adult day services** in your area, please visit:

HelpGuide.org:
www.helpguide.org

National Adult Day Services Association: www.nadsa.org

AssistGuide Information Services:
www.agis.com

Administration on Aging:
www.aoa.gov

Please refer to the "Evaluating adult day services" worksheet under the "Tools and resources" tab.

2015 costs for adult day health care National median rates



³² <http://nadsa.org/learn-more/about-adult-day-services>; "About Adult Day Services"; website for the National Adult Day Services Association.

³³ <http://helpguide.org/articles/caregiving/adult-day-care-services.htm>; "Adult Day Care Services: Finding the Best for Your Needs."



Adult day services (continued)

Companion care services

Companion care services refer to non-medical staff hired by the hour to provide companionship and comfort to individuals who, for medical and/or safety reasons, should not be left at home alone. Some companions should assist clients with household tasks, but most are limited to providing sitter services.

Social services

The hospital may assign a social worker if additional support is recommended after a hospital stay. A social worker can help you navigate the process and paperwork for available services or find support groups or mental health services to fit your needs. Please check your local town government website, or visit the Town Hall for information on age-related resources and services available in your community.



READY TO CONSIDER AGING IN PLACE?



Think long term about housing

Consider how the progression of a chronic condition, a major life event, or a sense of isolation may affect the ability to age in place. Think beyond current health conditions and identify the triggers or life events that may require changes in housing.

Family members are often the first to notice changes that necessitate a move. Recognize some of these triggers that may foreshadow the need for a move:

- Major life event, such as losing a spouse
- Changes in memory function, weight loss and physical changes
- Challenges brought on by illness and decline in physical function
- Lack of friends and social activities
- Desire for simpler lifestyle and a growing need for help with meal preparation and other activities of daily living
- Safety concerns by resident or her family
- Loss of transportation or driver's license

Be alert to these triggers that may signal it is time to move to a more supportive community. It is also important to consider the observations of close family members and friends in making the final decision.





2015 costs for home health aide services
National median rates



Financial considerations

Modifications to a home to accommodate the needs of an older adult living in their own residence and services to lessen burden of home ownership should be considered. Changes may be minor — such as \$2,000 to equip the bathroom with grab bars, add a shower bench and adjust the shower entry. Or, changes could be more substantial, and include renovations to widen doorways to accommodate wheelchair access, or create a first-floor master suite, which could add-up to hundreds of thousands of dollars. Another option may be to bring in care to the home. The national median annual rate in 2015 for homemaker services or home health services is \$45,760 (based on a \$20 national median hourly rate multiplied by 44 hours per week multiplied by 52 weeks. Source: Genworth: 2015 Cost of Care Survey).



Family considerations

If family members live in the area, it may be possible for them to assist with transportation to medical appointments and running errands. However, some people find that family members are either not always available or have other responsibilities like work or family. Placing additional responsibilities on family members is something that needs to be proactively discussed. If you do not reside near family members, how would you get around if you were to lose the ability to drive? You may become isolated, which could lead to loneliness and depression.



Lifestyle considerations

Driving and transportation are important factors for ensuring the success of aging in place. Many simple household tasks can be handled by service providers. Arrangements for shoveling snow, handyman tasks, preparing meals and housekeeping can be made as needed.



Health care considerations

Healthy residents who can drive or who have transportation can keep up with regular doctor visits. As you get older, you can bring in home health care services to provide assistance with medical and non-medical care.

Aging in place snapshot

Aging in place may be an appropriate option for people in relatively good health who are able to drive or who have reliable public transportation to get to appointments and activities.

Aging in place is a dynamic process and it is important to revisit the arrangement periodically to be sure it works for the resident. Family and social support is essential to the physical, mental and emotional well-being of those aging in place.

A safety inspection can determine if your floor plan, functionality and location are appropriate to aging in place. Modifications can be made, and cost is a factor if modifications to a floor plan are deemed advisable.

Those who choose to age in place may need to arrange a wide range of essential services, most commonly home repair, housekeeping, lawn care and snow removal. Medical and non-medical care can also be arranged.

Additional resources

You can locate home health care agencies by zip code through the Medicare site. Click on the Forms, Health & Resources tab, then choose “Find & Compare doctors, plans, hospitals, suppliers and other providers” at www.medicare.gov/homehealthcompare.

If you decide it is appropriate to bring in home care, you may find it helpful to reference the worksheet entitled, “Interviewing a caregiver” under the “Tools and resources” tab.



55+ INDEPENDENT LIVING COMMUNITIES



55+ independent living communities offer independent, relatively maintenance-free living, often with services and amenities specific to the needs of engaged, older adults. The “age restriction” or “age target” is typically age 55 or older, but may vary by community.

These communities, which may include owner-occupied homes or high-end rental apartments, do not provide any medical care and offer appealing well-constructed housing options for nearly every budget.

How does an “independent living community” differ from a 55+ or active adult retirement community?

An independent living community is not synonymous with a 55+ community or active adult retirement communities. These communities do not offer services and their residents are generally in their 60s-70s. In contrast, an independent living community provides services that are included in the monthly rent, with standard amenities being a meal plan, housekeeping, linen service and transportation.

Housing options include:

- Single-family homes
- Condominiums
- Townhomes
- Senior apartments
- High-rise buildings

While the category includes both active adult communities as well as other age-restricted residential options, there are many 55+ independent living communities that go beyond real estate. Many are lifestyle communities which have a vacation/resort environment and offer residents social and cultural activities. Amenities may include golf, tennis, marinas, equestrian clubs, fitness centers, hiking/biking trails, dining and many other types of clubs and social activities.

As you conduct your own research on 55+ independent living communities, you may also find references to 55+ retirement communities, independent living communities, active adult communities, lifestyle communities and retirement communities. Keep in mind that there are no regulatory guidelines around the naming conventions for these types of communities. Services and amenities will vary for each community/location. So, as you visit them, please make sure to inquire about all fees/costs associated with living in the community and determine what is/is not included.



Suitable for:

Active, healthy, 55+ adults who desire a leisurely, hassle-free lifestyle with access to extra services and features that they would enjoy or find helpful.

Benefits to residents:

- Variety of housing options for older adults
- Freedom from external home maintenance and a floor plan designed for older active adults
- Access to a range of amenities
- Social and cultural activities
- Opportunity to engage with others in the same stage of life



“We gave up the yard work and moved into a more manageable property. Now that we’re retired, we are free to strike up a mid-week golf game and meet up with neighbors for dinner.”

Other unique housing options for independent living

The village concept:

The village concept refers to not-for-profit organizations that coordinate the delivery of services to members who live within a geographic region or neighborhood considered part of the village’s service area; services and membership fees vary. The village concept enables older adults to remain in their homes while receiving assistance.

Naturally occurring retirement communities (NORCs):

NORCs refer to geographic areas or multi-unit buildings that are not restricted to persons over a specified age, but which have evolved over time to include a significant number (typically, over 50%) of residents who are age 60 and over. Some NORCs then organize services for older residents. Services vary widely and may include things such as obtaining and vetting handymen or other home repair services.



**2015 cost of renting
in an independent
living community**
Average monthly rate



Financial considerations

There is great variability in the cost to purchase a home in a 55+ independent living retirement community. The cost to buy is often comparable to local real estate values, depending on what type of home you want and where you are buying. There are also monthly resident fees that vary depending on the types of services offered by the community.³⁴ Some people choose to rent versus buy a home after reviewing their budget and assessing the cost of ownership net of taxes and the unplanned costs associated with home ownership. For detailed costs by state, please visit www.seniorhomes.com.

In 2015, the average cost of renting in an independent living community is \$2,417/month (representing an average range of \$1,399–\$4,002 per month), plus applications fees.³⁵



Family considerations

Family members, including grandchildren, may visit and stay in the home with the residents. Some communities have restrictions on how long visitors under age 55 may stay. In a situation where one spouse becomes a caregiver for the other, the couple may live together in the residence while bringing in home health aides to assist in care.



Lifestyle considerations

These communities offer residents a simplified lifestyle, built-in social outlets and recreational facilities. Neighbors often share a common lifestyle and a common stage of life. It is important to ask about the demographics of the community to see if it is the right fit for you.



Health care considerations

Doctors' offices are often located close to these communities. Policies vary, but residents may bring in medical or non-medical care, but usually not skilled nursing care.

³⁴ "Independent Living Community: Facts & Figures". 2015. SeniorHomes.com. <http://www.seniorhomes.com/p/independent-living-costs/>

³⁵ "Independent Living Community: Facts & Figures". 2015. SeniorHomes.com. Data does not include the state of Alaska. <http://www.seniorhomes.com/p/independent-living-costs/>



55+ independent living snapshot

Ideal for fully independent residents who require no medical care or medical staff on-site. Should their medical needs change, they can bring in home health care at their own expense or move to a different type of facility if assisted living, memory care, or skilled nursing care is required.

Hassle-free lifestyle — suitable for those who wish to simplify their lifestyle, with no home maintenance and freedom to travel.

Social activities with other people in similar stage of life.

Additional resources

For more information on 55+ independent living communities, please also visit: www.seniorhomes.com.

Please also refer to the “Making the grade — 55+ Independent Living Communities” worksheet under the “Tools and resources” tab.

CONTINUING CARE RETIREMENT COMMUNITIES (CCRCs)

A continuing care retirement community (CCRC), or life care community, offers maintenance-free housing and a multi-dimensional lifestyle, along with a contract for care for health care services.



A CCRC is distinct in three important ways from other types of retirement communities:

CCRCs offer a combination of living accommodations and a “continuum of care” for the remainder of the resident’s life.

The continuum of care encompasses different levels of service all at one location — from independent living, to assisted living, to skilled nursing. These services are either pre-funded or provided on a fee-for-service basis, for the remainder of the resident’s lifetime.

CCRC residents sign a contract that involves the right to live in a specific place, and the intent to purchase services.

The typical entry point for all residents is independent living in a community location, most often in a home-like townhome or an apartment-style residence. Some communities offer cottages/villas or single-family homes. These services are offered through a contract that typically includes an entry fee along with a monthly maintenance fee.

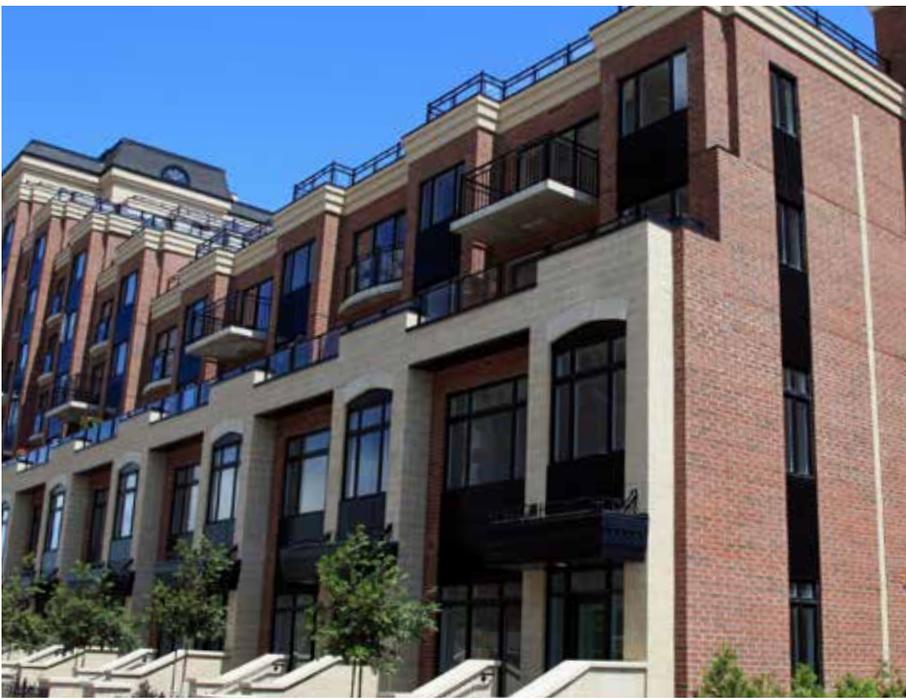
Background

The CCRC housing concept has evolved over a very long period of time, with the earliest communities dating back more than a century. Today, there are 1,900 CCRCs around the country. Not-for-profit organizations, often with faith-based affiliations and/or catering to affinity groups, sponsor the majority of CCRCs. In fact, 51.8% of all the CCRCs in the country are faith-based.³⁶ Some of the largest CCRCs include those run by Presbyterian, Methodist and Lutheran affiliations.

Suitable for:

Residents who can be admitted as healthy adults, who have the financial resources for the entry fee and monthly service fees, and are looking for a comprehensive housing solution for the rest of their lives. Residents know that regardless of their health, their needs will be covered as they age.

³⁶ Faith and the Not-for-Profit Provider. 10 Sept 2014. http://www.leadingage.org/Faith_and_the_Not_for_Profit_Provider.aspx



Benefits to residents:

- Active lifestyle with social interaction, activities, programs and events.
- Services that may include meals, housekeeping, transportation and on-site medical care.
- Many newer communities (and some established ones) have lifestyle amenities such as pools, fitness centers, golf, etc.
- Residents may remain and not have to leave the community when they require health care and supervision. They are entitled to access assisted living and skilled nursing care provided by and within one community. Some facilities offer memory care units and the rehabilitation facilities often required after a hospital stay.
- For those who can afford the entry and all-inclusive fees, CCRCs provide lifetime housing and increased tiers of care and service as health needs change.

This is a popular senior living arrangement. According to a survey of residents in 250 CCRCs, 86.6% of residents would recommend a CCRC to family and friends and 84.1% rated their long-term confidence in the CCRC as good or excellent.³⁷



“We thought we’d live at home for the rest of our lives, but we decided to sell our home and move on. Here, everything is included, even access to doctors. We meet new friends over dinner in the dining room, or attend a concert scheduled in the Art Center. When we need more help, it’s all available on the same campus. This way, we don’t have to rely on our families and we can stay independent for as long as possible.”

³⁷ CCRCs Today: The Real Deal About Retirement Communities, Jan. 17, 2012. Satisfaction data for CCRCs gathered by Holleran, a senior living research firm; http://www.leadingage.org/How_to_Respond_to_Media_Inquiries.aspx

Contract types

The type of contract you choose when moving into a CCRC determines how you will access health care and whether costs will be out of pocket. An outline of the various contract types is shown below. Please pay close attention to the variability of health care access and notice that only Type “A” is all-inclusive. Many offer some degree of refund or repayment of the entrance fee if the resident moves out or dies, in which case it is paid back to the estate. It’s important to check on the financial strength of each organization you visit (you could live there 10, 15, 20+ years).

CCRC major contract types			
	A	B	C
Contract type	Type “A” all-inclusive — sometimes called life care agreements, include housing, residential services and amenities and unlimited, specific health-related services with annual budgeted increases	Type “B” modified housing — residential services and amenities; limited health care services	Type “C” fee for service — includes housing, residential services and amenities, but no health care, for an established fee. The consumer may pay established fee-for-service rates for priority access to health care
Entrance fee	Yes. Refundability varies — common options include 90%, 50% or 0%	Yes. Refundability varies — common options include 90%, 50% or 0%	Generally, no. (Or, very small)
Monthly fee	Yes. Generally dependent on home size	Yes. Generally dependent on home size	Yes. Generally dependent on home size
Access to health care	Unlimited. Short-term or long-term	May be limited (i.e., limited number of days in skilled nursing)	Limited
Insurance portion 1–90 days	Health care services at price of monthly service fee (MSF) for unit	Health care services at price of monthly service fee (MSF) for unit	Health care services at market rate
Insurance portion 90 days +	Health care services at price of monthly service fee (MSF) for unit	Health care services at market rate	Health care services at market rate
Other services	Housekeeping, dining, maintenance, transportation, etc.	Housekeeping, dining, maintenance, transportation, etc.	Varies

Please note: Some communities offer a “Type D” contract, which is a rental agreement that provides, but does not guarantee, access to health care services paid on a fee-for-service basis. In addition, there could be variations on any of the contract types listed above. Depending on the type of CCRC contract, the monthly fee increases may or may not increase as the level of care increases.

Source: RiverWoods Retirement Community; CARF Consumer Guide to Understanding Financial Performance and Reporting in CCRCs.

CCRC snapshot

The most comprehensive of all housing options, CCRCs go from independent living to a continuum of care for the remainder of the resident’s life. Residents can remain in the community to continue existing relationships with a spouse and friends, and receive health care, should it be needed.

Ideal for people who want a flexible and comprehensive housing community with access to increased care as health needs change, and who have the financial resources for the entry fee and monthly service fees.

Premium entrance fees plus service fees. A variety of contract options and entrance fee choices, from fully refundable, to partially refundable or nonrefundable.

Not a real estate purchase. The contract is an agreement to provide service and the right to live in a particular place. Complicated financial contracts should be reviewed by a skilled attorney.

Additional resources

You can find a listing of CCRCs by city and state at: www.seniorliving.net/TypesOfCare/ContinuingCareRetirementCommunity

To understand some key concepts regarding the financial performance of CCRCs and the issues to contemplate when considering a move into a CCRC, review the Consumer Guide to Understanding Financial Performance & Reporting, produced by CARF International, the accrediting body for CCRCs. www.carf.org/financialperformanceccrcs/

Please also refer to the “Making the grade: Continuing Care Retirement Communities” worksheet under the “Tools and resources” tab.

2015 CCRC costs

Average rates



Financial considerations

The financial strength of the CCRC is critical, due to their obligation to provide housing, health care and other services to its residents for the rest of their lives. CCRCs are financially complex and often incorporate actuarial principles into their pricing methodology.

Based on 2015 data, the national average entrance fee is \$282,230 and the national average monthly fee is \$2,874.³⁸ There is enormous variability in **entrance fees** and we have seen them in excess of \$1,500,000.³⁹ The size of the **monthly fees** and the structure of the fees will vary among communities. Some communities will establish the fee when you move in, and that fee will only be subject to annual cost of living adjustments no matter what phase you are in. Other communities may have a graduated fee schedule based on the phase (independent, assisted living or skilled nursing). It is important that you clearly understand the fee schedule of any community you are considering. Additionally, entrance fees and monthly fees vary depending on type of contract, geographic location, and size or type of residence chosen. Many CCRCs offer some degree of repayment of the entrance fee if a resident moves out or dies. CCRCs have detailed, multi-tier contracts and should be reviewed by a skilled attorney before making a commitment. The IRS, under Section 213 of the Internal Revenue Code, may recognize a percentage of both the entrance fee and the monthly service fee as a prepaid medical expense deduction. [Legg Mason does not provide tax advice.]

Long-term care coverage

While policies may differ, long-term care insurance may pay for a portion of the monthly fee when you are in assisted living or skilled nursing care as long as you meet any other requirements of the policy. The entrance fees and the monthly fees for independent living are not covered by long-term care insurance.



Family considerations

Often couples find themselves in a situation where one spouse becomes a caregiver for the other. In a CCRC, couples can receive individualized care, while still living within close proximity of each other (e.g., on the same campus).



Lifestyle considerations

CCRCs provide 24-hour security, social and recreational activities, attractive dining options, housekeeping, transportation, and wellness and fitness programs and potential lifestyle amenities.



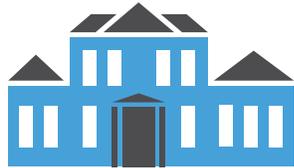
Health care considerations

Every level of care is offered, from independent through skilled nursing care. The resident usually must be able to live at the independent level of care at the time he/she moves in. As the resident's health care needs change, assisted living and skilled nursing care are available.

³⁸ Source: NIC MAP® Data Service. As of Q3 2015. © 2016 National Investment Center for Seniors Housing & Care (NIC). All rights reserved. Data believed to be accurate, but not guaranteed; subject to future revision. This report is a part of the NIC MAP® Data Service (NIC MAP). Distribution of this report or any part of this report without prior written consent or license by NIC is prohibited. www.nic.org.

³⁹ Vi at Grayhawk, Scottsdale, AZ; <https://grayhawk.viliving.com>

ASSISTED LIVING FACILITIES



Assisted living facilities are designed for individuals who want to be as independent as possible, but may need help with some activities of daily living (ADLs).

Basic ADLs consist of self-care tasks, including:⁴⁰

- Feeding
- Toileting
- Selecting proper attire
- Grooming
- Maintaining continence
- Putting on clothes
- Bathing
- Walking and transferring (such as moving from bed to wheelchair)

Instrumental activities of daily living (IADLs) enable older adults to remain independent in their own residence and in the community. These activities include:

- Housework
- Preparing meals
- Taking medications, as prescribed
- Managing money
- Shopping for groceries or clothing
- Use of telephone or other form of communication
- Transportation within the community

Assisted living facilities provide social and community interaction, and will monitor residents' activities to ensure health, safety and well-being. They do not provide 24-hour medical or skilled care. Instead, assistance with the activities of daily living (ADLs) is provided primarily by health aides and nurses' aides. Some assisted living facilities offer specialized round-the-clock supervision and therapeutic activities for residents suffering from dementia or cognitive impairment.

The incidence of residents entering assisted living facilities with cognitive impairment or becoming cognitively impaired is on the rise.⁴¹

The industry is responding to this concern by developing special care units; however, availability varies by geographic region and the type of care provided, even within a single community.

Assisted living facilities are state-licensed, and services may vary from state to state. Some offer independent apartments or units with studios or one- or two-bedroom apartments, usually with a living room and kitchenette. Others offer a private bedroom and bathroom with a communal area. Dining options may be offered; often some or all meals are included, and family and friends may participate at an additional cost. These facilities provide a supported living environment to those needing some assistance with daily living tasks. If a resident's health deteriorates and 24-hour nursing care is required, the patient will likely need to move to a skilled nursing facility.

⁴⁰ "Activities of Daily Living: What Are ADLs and IADLs?" Leslie Kernisan, M.D., Caring.com, <https://www.caring.com/articles/activities-of-daily-living-what-are-adls-and-ialds>

⁴¹ "Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes." 2009 Alzheimer's Association. www.alz.org/national/documents/brochure_DCPPhases1n2.pdf



Suitable for:

Older adults who are still performing some or all daily living tasks on their own, and do not require 24-hour monitoring or skilled care. Residents typically stay unless their health deteriorates and a higher level of care, such as memory care and/or skilled nursing care, is needed.

Benefits to residents:

Assistance with personal care (bathing, dressing, etc.), medication, mobility, transportation or specialized supervision. Appropriate for people who need some assistance with personal care and medication management, and are looking to engage socially with others.



“My husband used to lend a steady hand with meals and shopping, before he passed away. Then my arthritis started limiting my ability to walk. My children helped me find a more supportive place to live. Now, I can get a little extra help with dressing and preparing for the day, and it’s wonderful to get my meals served three times a day.”



2015 assisted living costs

National median rates



Financial considerations

Three common sources are used to pay assisted living costs: private funds, some veteran benefits or certain long-term care insurance policies, although the older adult must qualify (e.g., is unable to perform at least two ADLs) and this varies by policy.⁴² In 2015, the national median monthly cost for a one-bedroom, single-occupancy room is \$3,600, and the range is \$600–\$11,250. The national median annual rate is \$43,200.⁴³



Family considerations

Family gains peace of mind from knowing that their family member is not alone and has support to carry out activities of daily living.



Lifestyle considerations

Social engagement with others in a more supported living environment.



Health care considerations

Health care supervision ensures that medical needs are being met either through on-site staff or periodic medical visits. Patients can be referred if health deteriorates or a higher level of care is required.

⁴² <http://www.seniorhomes.com/p/paying-for-assisted-living/>

⁴³ "Genworth 2015 Cost of Care Survey." Genworth. March 2015.



Assisted living facility snapshot

Individuals who need help with some activities of daily living — such as bathing and dressing, mobility, transportation or specialized supervision — can access assisted living and the social/community interaction offered.

Residents typically stay unless their health deteriorates and a higher level of care, such as skilled nursing care, is needed.

Each state has its own licensing requirements for assisted living and it's important to check to see what services may be provided.

High monthly cost; some long-term care insurance policies will cover it, but Medicare will not.

Additional resources

You can search for assisted living facilities by zip code:

<http://www.assistedlivingfacilities.org/>

You can also browse monthly assisted living fees by state for all 50 states and Washington, D.C.:

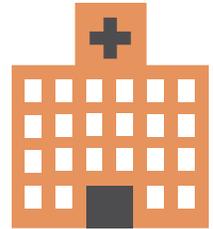
<http://www.seniorhomes.com/p/assisted-living-cost/>

<http://www.genworth.com>

Please also refer to the "Making the grade: Assisted Living facilities" worksheet under the "Tools and resources" tab.

SKILLED NURSING FACILITIES

Skilled nursing facilities are medical facilities that offer full-time physicians, on-site nurses and nurse practitioners, social workers and dietitians.



These facilities, also known as nursing homes, provide the highest level of medical care, with 24-hour nursing care for residents with serious medical conditions and/or advanced dementia or cognitive impairment.

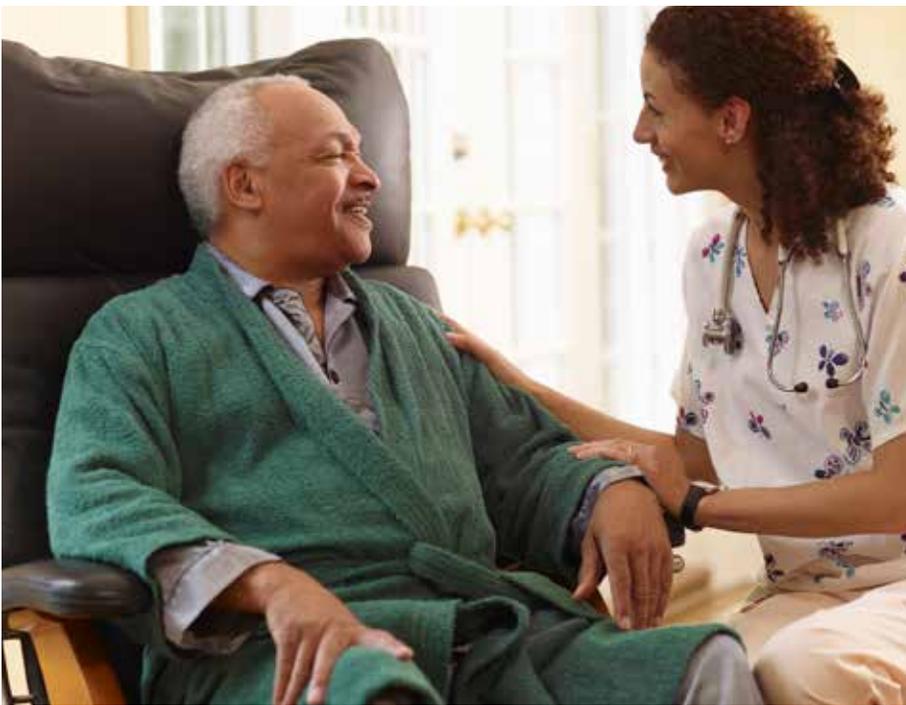
Medically qualified adults are admitted when they need skilled care above and beyond the ADLs. Skilled nursing may be appropriate for short- or long-term care up to the final stage of life.

At a skilled nursing facility, a licensed physician supervises each patient's care and a nurse or other medical professional is always on the premises. In addition to skilled nursing care, skilled nursing facilities may offer rehabilitation, medical services and protective supervision, as well as assistance with ADLs.

When chronic illness or advanced age takes its toll, full-time nursing care may be required.

Suitable for:

Individuals who require around-the-clock nursing care, a protective environment and other services. Skilled nursing facilities are often the next step when an individual's medical needs can no longer be met at home or in another facility. Residents of skilled nursing facilities usually need 24-hour supervision. Some nursing homes have specialized memory care units for dementia patients.



Security level

Elevator, wheelchair and bed alarms may be in place to protect patient safety. Ask about evacuation procedures.

Alzheimer's/dementia care

Memory Care units within a care facility are designed for older adults with dementia who require oversight and supervision as well as activities that meet their abilities. More than half (56%) of the nursing homes MetLife surveyed provide Alzheimer's or dementia care.⁴⁴

More than half (55%) of those providing Alzheimer's or dementia care have separate units or wings; 2% report that the whole facility provides Alzheimer's care. There are various ways that these units are secured — 83% are locked, 9% are unlocked but have alarms on the doors, and 7% provide monitors for residents to wear. The remaining 1% have other security measures in place or none at all.⁴⁵

Many skilled nursing facilities charge more for memory care and often have waiting lists, so make sure that you ask questions about how they manage their waiting list.

Costs for memory care

MetLife reports that approximately 80% of the nursing homes that offer Alzheimer's or dementia care charge the same rate as their customary care, while some charge more. In 2012, the average daily cost of a private room in a dedicated memory care unit was \$261 for a private room and \$230 for a semi-private room (or, approximately \$7,938 monthly for a private room and \$6,995 monthly for a semi-private room) according to the MetLife: Market Survey of Long-term Costs.⁴⁶



“Mom had a few falls and was hospitalized with congestive heart failure. She now requires constant monitoring. She isn't able to live on her own, and she needs more help than an in-home health aide or an assisted living community can handle. Both her physician and family believe skilled nursing is the best way to keep her health condition under control. She's staying in a place that has access to skilled nursing care 24/7 and assistance with the activities of daily living (ADLs).”

⁴⁴ Source: MetLife: Market Survey of Long-term Care Costs 2012.

⁴⁵ Source: MetLife: Market Survey of Long-term Care Costs 2012.

⁴⁶ Of nursing homes that report a different rate for individuals with Alzheimer's or dementia. Source: MetLife: Market Survey of Long-term Care Costs 2012.

2015 skilled nursing facility (private room)

National median rates



Skilled nursing facilities snapshot

Skilled nursing facilities provide the highest level of medical care prescribed by a doctor

Licensed health care professionals administer physical, speech, occupational therapies

Duration is usually long term

Operate like medical facilities, including set times for visiting hours, medications and meals, and 24-hour skilled nursing care for those with serious medical conditions and/or advanced dementia

Daily activity schedule for those who wish to participate

Close supervision to prevent risk of falls or wandering



Financial considerations

In 2015, the national median cost of a private room in a skilled nursing facility is \$250 daily or \$91,250 annually. The national range on a daily basis is a minimum of \$101 and a maximum of \$1,255.⁴⁷ Medicare covers only a limited amount of the cost, up to 100 days after a hospitalization.⁴⁸ Long-term care insurance coverage varies by policy.



Family considerations

These facilities provide full-time skilled nursing care that may be difficult for the family to provide in the home. Family members may visit or arrange to pick up a resident for a home visit, if the medical condition permits.



Lifestyle considerations

Communities are designed to provide on-site access to services, including activities for residents, all meals and medical care.



Health care considerations

Medical and nursing care on-site; can often meet the health care needs of patients for the rest of their lives; some facilities offer separate memory care units for dementia patients.

Additional resources

Each state's Department of Health Services does an annual inspection of skilled nursing facilities in the state. The results are posted on the Internet at the Centers for Medicare & Medicaid Services website, www.cms.gov

If you are considering a nursing home for your loved one, you can learn how to choose the facility for your particular needs by going to the following website: <http://www.helpguide.org/articles/senior-housing/guide-to-nursing-homes.htm>

Please also refer to the "Making the grade: Skilled nursing facilities" worksheet under the "Tools and resources" tab.

⁴⁷ "Genworth 2015 Cost of Care Survey." Genworth. March 2015.

⁴⁸ "Your Medicare Coverage: Skilled nursing facility (SNF) care." <https://www.medicare.gov/coverage/skilled-nursing-facility-care.html>

SUBACUTE REHABILITATION



Subacute rehabilitation often follows a hospital stay, where the patient is medically fragile and requires services and rehabilitation to rebuild strength and return to home.

Subacute rehabilitation uses a multi-disciplinary, coordinated approach (nurses, doctors/specialists, physical therapists and occupational therapists).

Services can be provided in a facility that specializes in subacute rehabilitation only, or in nursing homes and hospitals that have specialized units in place; occasionally it is offered in the home. The selection of rehabilitation facility is often based on availability at the time the service is needed.⁴⁹



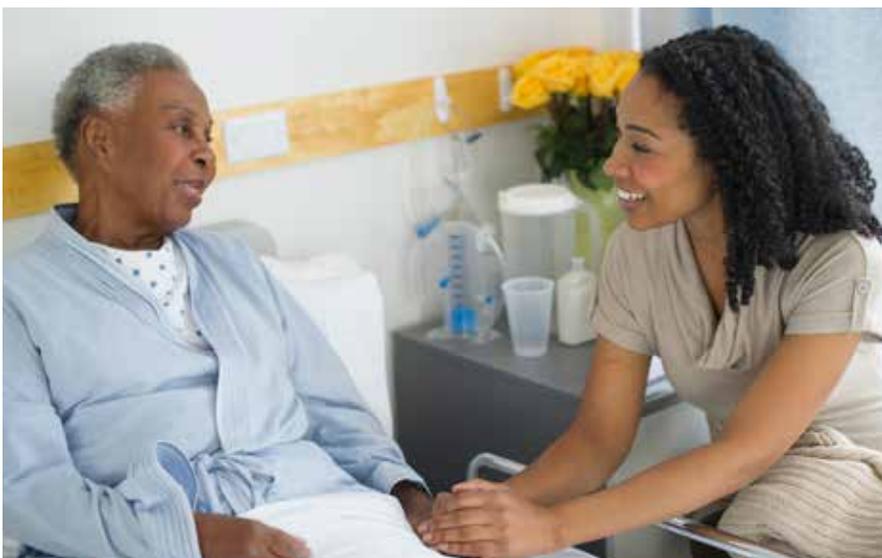
Financial considerations

Typically, Medicare or private insurance cover the cost of short-term rehabilitation, until the patient returns to a maximum level of independence.



Additional resources

Choosing a subacute rehabilitation facility may be planned a bit ahead of time when you or a loved one are facing an elective operation (such as a joint replacement, heart surgery or abdominal surgery), or while your loved one is unexpectedly hospitalized and a discharge is anticipated. Keep in mind, your choice will be limited by which facility has space available when you need it. You can read how to select a subacute rehab facility here: http://www.seniorsbluebook.com/articles/Professional_Services_and_Resources/Rehabilitation/how-to-Select-a-Subacute-Rehabilitation-Facility-142.php



⁴⁹ www.rehabilitations.org, www.parentgiving.com, and the National Rehabilitation Information Center: www.naric.org

COST AND SERVICE COMPARISON SUMMARY

Comparing costs: Can you afford what you need?⁵⁰

The charts featured on these two pages are meant to provide you with a comparison of the costs involved with bringing in home care, leveraging adult day services or going to a senior living facility.

Price ranges by housing type (\$)

	Type of rate	Minimum	Rate range median	Maximum	Median annual rate	Five-year annual growth
Home 						
Homemaker Services	Hourly	\$8	\$20	\$40	\$44,616	1.61%
Home Health Aide Services	Hourly	\$8	\$20	\$40	\$45,760	1.03%
Community 						
Adult Day Health Care	Daily	\$10	\$68.86	\$242	\$17,904	2.79%
Facility 						
Assisted Living Facility	Monthly	\$600	\$3,600	\$11,250	\$43,200	2.48%
Nursing Home (Semi-Private Room)	Daily	\$90	\$220	\$1,255	\$80,300	3.53%
Nursing Home (Private Room)	Daily	\$101	\$250	\$1,255	\$91,250	3.95%

Additional resource

For state-specific information on housing costs, please refer to the Genworth Cost of Care Survey, <https://www.genworth.com/>. This survey is updated annually.

⁵⁰ "Genworth 2015 Cost of Care Survey," Genworth. March 2015.

Services by housing type⁵¹

	Life stage	55+ independent	Continuing care retirement community (CCRC)	Assisted living	Skilled nursing
	Active	●	●	●	
	Healthy	●	●	●	
	Social	●	●	●	●
	Help with daily living		●	●	●
	Medical care		●		●
	Daily living and medical care		●		●

⁵¹ Source: The Center for Innovative Care in Aging at the Johns Hopkins University School of Nursing.



THE RETIREMENT HOUSING PUZZLE

Case
studies

The years spent in retirement will differ for each of us.

There is not a single pathway to aging; many different factors contribute to how you age. Your financial, health, education, social, emotional and home and neighborhood profiles all play a role in how you age. When it comes to health, certain cues can signal a level of chronic disability or acute need that requires suitable resources.

The four cases that follow illustrate four distinct and common scenarios of aging. The common financial implications in each scenario, include housing, transportation, health care, home and social services and access to socialization. These examples illustrate that each person's situation is unique.

1

BOB AND SHEILA

Healthy, aging in place,
preparing for the future



They are still able to take care of their home but realize that it will be increasingly difficult as they get older.

Bob and Sheila, a retired engineer and a homemaker, are both in their early 70s and live in the home they have owned for 30 years. Their two grown children and three grandchildren live nearby.

Bob and Sheila are fairly healthy and active in their community. Bob has hypertension and high cholesterol that are controlled with medications. Sheila has hypertension and arthritis that are also controlled by medications. They attend the local gym regularly and watch their grandchildren after school. Sheila volunteers at the library and the church soup kitchen. Bob volunteers with Meals on Wheels and plays golf whenever he can. They are still able to take care of their home, but realize that it will be increasingly difficult as they get older. They are looking into a lawn care service and housekeeping to assist with the larger jobs. They have grab bars in their master bath, but they want to adapt their home so that they can age in place. They both drive, but they have concerns about their future if one or both are unable to drive.



Financial considerations for Bob and Sheila

- Transportation
- Health care
- Home modifications and assistive devices
- Home repair and home maintenance
- Future health care and social service needs



Other considerations

- What is the Plan B when Bob and Sheila can no longer drive to their activities or to see family or friends?
- Can the current home be easily modified for aging in place?
- Could either spouse live in the house alone if the other one passes away?
- What are the financial considerations for a move to a retirement community?
- What estate planning issues do Bob and Sheila still need to address?

Action steps that Bob, Sheila and their family can take

Arrange to schedule a safety review of residence to identify potential safety hazards

Identify any modifications to the floor plan, bath and/or kitchen to accommodate advanced age

Arrange for contractor's cost estimate

Explore local transportation options

Discuss suitability of the residence for living alone

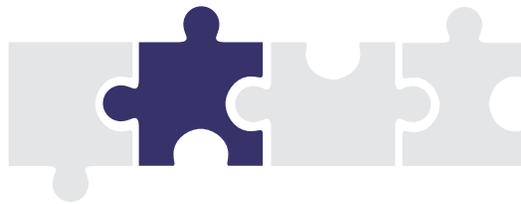
Address financial planning impact

Revisit estate plan

2

KATHLEEN AND JACK

Planning for a long
and comfortable retirement



Their home is designed for their safety as they age. They plan to bring in health care and home maintenance services as one or the other needs help.

Kathleen and her husband, Jack, are a professional couple in their 50s, with no children or close family members. They realize that they have the resources to last the rest of their lives.

They find comfort in knowing they will not have to rely on others to make decisions about their future care. They are designing a home in a gated community with a swimming pool, golf course, marina and clubhouse, where they hope to live out their retirement in comfort. The new home will employ Universal Design features, such as wide doorways and single-floor living. Their home is designed for their safety as they age. They plan to bring in health care and home maintenance services as one or the other needs help. This is important because Alzheimer's runs in Jack's family. Should they need skilled nursing care, Kathleen has arranged for long-term care policies to cover those expenses.



Financial considerations for Kathleen and Jack

- Independent living
- Universal Design
- Socialization outlets
- Home health care
- Skilled nursing care for final days



Other considerations

- What is the plan, in the event that one spouse requires skilled nursing care or passes away, for the surviving spouse? What happens if they both need assistance?
- How will they maintain the home as they age?
- Have Kathleen and Jack considered a continuing care retirement community? Do they have the financial resources for that option?
- Who will serve as medical power of attorney/advance health care directive for the surviving spouse? Are there nieces, nephews or cousins to assist in this capacity?
- What estate planning issues do Kathleen and Jack still need to address?
- Is their estate plan as well planned as their housing and lifestyle arrangements?

Action steps that Kathleen, Jack and any family members can take

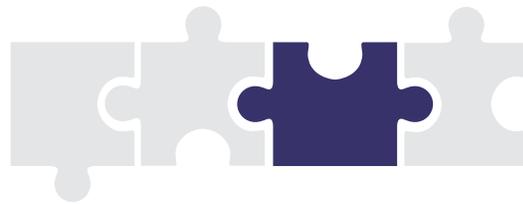
Review estate plan annually

Research which expenses are covered under their long-term care policies, should skilled nursing care or memory care be required

3

MARY

Getting older, chronic illness and a need for socialization and support



She has looked into home services to help her, but now with increasing vision problems, she is considering moving to a community where she can receive meals and have access to transportation, social activities and medical care.

Mary is a widow in her late 70s who lives in the home that she and her late husband have owned for 35 years. She is fairly healthy, but has macular degeneration that is starting to impact her ability to drive.

Mary was always very active in her community, but without being able to drive or rely on public transportation, she has dropped many of the activities she once enjoyed. Mary was a librarian and until recently had volunteered in the library at the local elementary school. She participated at the local senior center, often attending classes and going on trips. She is starting to feel lonely and isolated. She has two adult children and five grandchildren, but they live some distance away and cannot assist her on a daily basis. The house is paid off but she is finding it increasingly difficult to take care of the home and lawn.

She has looked into home services to help her, but now with increasing vision problems, she is considering moving to a community where she can receive meals and have access to transportation, social activities and medical care. One consideration would be moving to an assisted living facility.



Financial considerations for Mary

- Transportation
- Medical care
- Eye care
- Home adaptations for vision loss
- Home repair and maintenance services
- Home care services
- Assisted living costs
- Relocation/moving costs



Other considerations

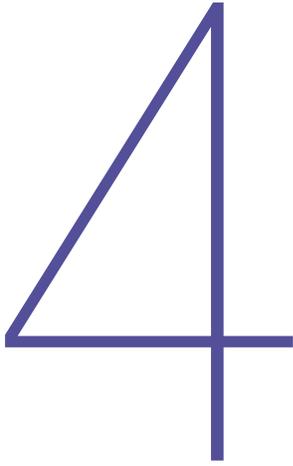
- How will Mary's vision problems affect her living requirements in the next two to five years?
- What kind of medical care will be needed, and is proximity to her doctors an important consideration? How will Mary travel to medical appointments?
- Can she financially afford another housing option, such as assisted living?
- Has Mary put an estate plan in place?

Action steps that Mary and her family can take

Determine monthly budget and assets available for more supportive housing alternatives

Investigate local adult day care programs with transportation, as well as on-site activities for residents of local retirement communities

Revisit estate plan



ANN

Chronic illness, functional decline
and need for in-home care or relocation



The family believes that Ann can no longer safely stay in the home alone, so they are looking into bringing in a home health aide or relocating Ann to assisted living.

Ann is a widow in her early 80s who has been living in her home for more than 40 years. She is suffering from dementia.

Always very sociable and a bridge player, Ann has dropped these activities due to the change in her cognition. Two of Ann's children and three grandchildren live close by, but because of work and school, they are not able to stay with her 24 hours a day. Ann's family took away her car last year after a minor accident. Her days are happy, as she has been attending an adult day care center for the past six months, but her family cannot stay with her at night. Several recent incidents have concerned the family. She left the stove on and a hand towel caught fire.

Also, she wandered out of the house and was found by a neighbor several blocks away, agitated and confused. The family believes that Ann can no longer safely stay in the home alone, so they are looking into bringing in a home health aide or relocating Ann to assisted living.



Financial considerations for Ann

- Care coordination
- Home health care
- Home modifications
- Relocation to assisted living
- Socialization outlets



Other considerations

- Will a home health aide likely meet Ann's needs well into the future?
- Has Ann assigned an advance health care directive to a family member?
- Does Ann have long-term care insurance?
- Can Ann afford a memory care assisted living facility?
- Could assistive technologies prolong her independence?

Action steps that Ann and her family can take

Determine monthly budget and assets available for more supported housing alternatives.

If remaining in the home:

- Consider adult day care programs that provide transportation to patients with Alzheimer's
 - Arrange to schedule a safety review of residence to identify potential safety hazards
 - Identify any modifications to floor plan, bath and kitchen, to accommodate advanced age
 - Arrange for contractor's cost estimate
 - Explore local senior transportation options
 - Discuss suitability of residence for living alone
 - Address financial planning impact
 - Explore assistive technologies
-

Revisit estate plan



Where do you go from here?

These scenarios point to some of the issues and considerations that impact housing selection and financial planning. No single answer applies when it comes to personal preferences for independence, socialization or allocating financial assets. The important thing is to uncover the multiple variables that factor into your housing preferences, such as family, health and financial considerations. Family members may present options to their senior members and let them make the final decision.

Use the Tools and Resources in the next section to thoroughly explore a variety of options for housing and care.



TOOLS AND RESOURCES

We have developed comprehensive worksheets for you to use as you begin to explore options for care or housing. To access the worksheets, please click on the titles below or visit our website at: www.leggmason.com/aging.

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- Assessing your housing needs discussion guide 
 - Home safety assessment checklist 
 - Selecting a geriatric care manager 
 - Hiring a home care agency 
 - Interviewing a caregiver 
 - Evaluating adult day services 
 - Aging in place resources 
 - Making the grade: 55+ independent living communities worksheet 
 - Making the grade: Continuing care retirement communities worksheet 
 - Making the grade: Assisted living facilities worksheet 
 - Making the grade: Skilled nursing facilities worksheet 
-



STEPS TO TAKE TODAY

Put a plan of action into place
to better control your destiny.

Steps to take today

1

Discuss retirement with spouse and/or family

Include aging as a key topic in financial planning conversations and intergenerational relationships by incorporating the discovery tool, checklists and general knowledge into family meetings. Understand the special challenges we will all face, such as current concerns about older family members, family history of chronic disease, or the prospect of facing advanced age without family member support.

2

Determine your wishes and desires for retirement

Be realistic about the prospect of living into your 80s or 90s, and the housing and financial implications of ill health and limited mobility.

3

Research local housing costs

To find the costs associated with retirement housing in your local area, please visit: www.genworth.com and look for their latest Cost of Care Survey under the "Research" section.

4

Locate local facilities

Visit websites such as www.aplaceformom.com for the names of facilities in your geographic location. Visit the communities you are interested in, and use the included worksheets to evaluate your options.

5

Work closely with your Financial Advisor/Professional

Partner with your Financial Advisor and other trusted professionals (e.g., accountant, lawyer, etc.) to develop a plan based on your preferences.

6

Be prepared for all scenarios

Acknowledge and understand that aging will have many health care implications and that you need to make plans now, not when an event has taken place that forces a decision.

7

Maintain complete records of your financial and estate planning documents, including your health care, power of attorney, will and other instructions

Review the location of these documents with your loved ones and beneficiaries. It is also a good idea to provide a copy to family members and beneficiaries who will handle your affairs upon death.

8

Visit Legg Mason

Visit us at www.leggmason.com/aging. Our website features more information, tools and additional resources.

GLOSSARY OF TERMS



The glossary is designed as a reference for the vocabulary of terms you may encounter as you navigate the transition to housing and health care for older adults.

55+ independent living community/ Age-restricted community

55+ independent living communities offer independent, relatively maintenance-free living, often with services and amenities specific to the needs of engaged, older adults. The “age restriction” or “age target” is typically age 55 or older, but may vary by community. These communities, which may include owner-occupied homes or high-end rental apartments, do not provide any medical care and offer appealing, well-constructed housing options for nearly every budget. Many communities have a vacation/resort environment, offering residents social and cultural activities. Amenities may include golf, tennis, marinas, equestrian clubs, fitness centers, hiking/biking trails, dining and many other types of clubs and social activities.

Accessory apartment/Accessory dwelling unit (ADU)

Independent apartment either attached or separate from the main structure, with own entrance, sleeping area, bathroom and kitchen; see also Granny annex or in-law suite.

Activities of daily living (ADL)

Basic ADLs consist of self-care tasks, including functional mobility (often referred to as transferring or moving from one place to another while performing activities), bathing and showering, dressing, self-feeding (not including cooking or chewing and swallowing), personal hygiene and grooming (including brushing/ combing/styling hair) and toilet hygiene (getting to the toilet, cleaning oneself and getting back up).

Adaptation (of residence)

Permanent fixtures or alterations to a home to help someone get about or manage better (distinguished from “aids” or “equipment,” which are more portable). Also referred to as home modifications, adaptations may include lowering a door threshold, widening a door to accommodate a wheelchair, adding a first-floor powder room or replacing a bath tub with a walk-in shower.

Adapted housing

Home or apartment in which alterations have been made to accommodate older adults in wheelchairs, walkers, or with other supportive needs.

Adult day care/services

Adult day programs typically provide socialization, reminiscing, recreational exercise, counseling, support groups, information, nutritious meals and snacks, health monitoring and art/music therapy. Some day centers also offer nursing, occupational therapy, physical therapy and personal care.

Age-targeted community

Community appeals to older adults, but does not exclude younger residents who want to live there.

Aging in community

General term for efforts to support older people aging in their current neighborhood.

Aging in place

Aging in place refers to the decision to live at the home of your choice as you age. Aging in place recognizes that physical functions decline with age and certain tasks — such as climbing stairs, bending and lifting — become more challenging. Aging in place calls for ensuring the home is a safe and convenient place, and may entail making modifications to accommodate needs as circumstances change.

Assisted living facility/assisted care living facility

Assisted living facilities are designed for individuals who want to be as independent as possible but may need help with some activities of daily living (ADLs). Assisted living facilities provide social and community interaction and will monitor residents’ activities to ensure health, safety and well-being. They do not provide 24-hour medical or skilled care. Instead, assistance with the activities of daily living (ADLs) is provided primarily by health aides and nurse’s aides. Some assisted living facilities offer specialized round-the clock supervision and therapeutic activities for residents suffering from dementia or cognitive impairment.

Assistive device

Any device or equipment (assistive technology) that enables an individual who requires assistance to perform the daily activities essential to maintain health and autonomy and to live as full a life as possible. Such devices or equipment may include monitoring devices, adapted utensils, enlarged telephones and clocks, motorized scooters, walkers, walking sticks, grab rails or tilt-and-lift chairs.

Assistive technology

An umbrella term for any device or system that allows individuals to perform tasks they would otherwise be unable to do, or that increases the ease and safety with which tasks can be performed. New technologies have enabled technologies that support communication and engagement, health support and medication management; and home safety and security.

Baby boomers

The generation of persons born between the years 1946 and 1964.

Beneficiary

A person or entity named in a will, trust, insurance policy, retirement plan or other financial contract who is entitled to receive the benefits or proceeds. Persons who are covered by Medicare are also called beneficiaries.

Benefit period

The length of time, in years, during which a benefit will be paid by an insurance policy. Buyers usually have a choice when deciding on a benefit period from many long-term care insurance policies.

Benefit trigger

An event or events that must occur before an insured person can receive benefits under a long-term care insurance policy.

Buy-in/entrance fee

The one-time cost that you pay up front when you become a resident at a housing community, such as a CCRC or retirement community. It is typically the cost of buying the unit, and in some CCRCs it also includes a portion of the health care services. These fees vary by community and depend on the size of the unit, the location of the community and any services included. Full or partial refunds of these fees are available in some communities when the resident moves out.

Care coordination

The goal of care coordination is to ensure that patients' needs and preferences are achieved and that care is efficient and of high quality. Care coordination involves information-sharing across providers, patients, types and levels of service, sites and time frames. Care coordination is most needed by persons who have multiple needs that cannot be met by a single clinician or by a single clinical organization, and which are ongoing, with their mix and intensity subject to change over time.

Care-dependent

Persons with chronic illnesses and/or impairments that lead to long-lasting disabilities in functioning and reliance on care (personal care, domestic life, mobility, self-direction).

Care need

Some state of deficiency that is decreasing quality of life and triggering a demand for certain goods and services. For the older population, lowered functional and mental abilities are decisive factors that lead to the need for external help.

Catered living

A senior housing community that offers full independent living and assisted living. It also can provide memory care. It sometimes is also called "assisted living."

Chronic condition/disease/illness

A disease that has one or more of the following characteristics: is permanent, leaves residual disability, is caused by non-reversible pathological alternation, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation or care.

Cluster housing

A subdivision technique in which detached dwelling units are grouped relatively close together, leaving open spaces as common areas.

Cognitive impairment

Cognitive impairment is when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. Cognitive impairment ranges from mild to severe. With mild impairment, people may begin to notice changes in cognitive functions, but still be able to do their everyday activities. Severe levels of impairment can lead to losing the ability to understand the meaning or importance of something and the ability to talk or write, resulting in the inability to live independently. Source: Centers for Disease Control (www.cdc.gov).

Co-housing/cooperative housing

A form of planned community in which older adults live together, each with his or her own dwelling or living space, but there are also some common areas, and joint activities may be arranged.

Communal care

Assistance provided free of charge or at reduced rates to members of a group or society. Other members of the group or society generally provide care on a voluntary basis.

Community-based care/community-based services

The blend of health and social services provided to an individual or family in his/her place of residence for the purpose of promoting, maintaining or restoring health or minimizing the effects of illness and disability. These services are usually designed to help older adults remain independent and in their own homes. They can include senior centers, transportation, delivered meals or shared (congregate) meal sites, visiting nurses or home health aides, adult day care and homemaker services.

Co-morbid condition

Conditions that exist at the same time as the primary condition in the same patient (e.g., hypertension is a co-morbidity of many conditions, such as diabetes, ischemic heart disease, end-stage renal disease, etc.). Two or more conditions may interact in such a way as to prolong a stay in a hospital or hinder successful rehabilitation.

Congregate housing

Individual apartments in which residents may receive some services, such as a daily meal with other tenants. Buildings usually have some communal areas, such as a dining room or lounge, as well as additional safety measures, such as an emergency call system.

Continuing care

The provision of one or more elements of care (nursing, medical, health-related services, protection or supervision or assistance with personal daily living activities) to an older adult for the rest of the resident's life.

Continuing care retirement communities (CCRCs)

A continuing care retirement community (CCRC), or life care community, offers maintenance-free housing and a multi-dimensional lifestyle along with a contract for care for health care services. A CCRC is distinct in three important ways from other types of retirement communities:

- CCRCs offer a combination of living accommodations and a "continuum of care" for the remainder of the resident's life.
 - The continuum of care encompasses different levels of service all at one location — from independent living to assisted living and skilled nursing. These services are either pre-funded or provided on a fee-for-service basis, for the remainder of the resident's lifetime.
 - CCRC residents sign a contract that involves the right to live in a specific place, and the intent to purchase services.
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Continuum of care

Full spectrum of care available through a long-term contract at continuing care retirement communities (CCRCs), which may include independent living, assisted living, nursing care, home health, home care, and home and community based services. Also see Continuing Care Retirement Community.

Cost of illness

The personal cost of acute or chronic disease. The cost to the patient may be an economic, social or psychological cost or loss to the patient or the patient's family or community. The cost of illness may be reflected in absenteeism, productivity, response to treatment, peace of mind or quality of life. It differs from health care costs in that this concept is restricted to the cost of providing services related to the delivery of health care, rather than the impact on the personal life of the patient.

Culture change

Global initiative focused on transforming care as we know it for older adults and individuals living with frailty and disability. It advocates for a shift from institutional care models to person-directed values and practices that put the person first.

Daily benefit

The daily dollar amount an individual chooses as the base benefit for his or her long-term care insurance. The daily benefit is computed based upon eligibility and is derived from one of the following methods: expense-incurred method, indemnity method or disability method.

Dementia

Dementia is an overall term that describes a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities. Alzheimer's disease accounts for 60 to 80 percent of cases. Vascular dementia, which occurs after a stroke, is the second most common dementia type. But there are many other conditions that can cause symptoms of dementia, including some that are reversible, such as thyroid problems and vitamin deficiencies. While symptoms of dementia can vary greatly, at least two of the following core mental functions must be significantly impaired to be considered dementia: memory, communication and language, ability to focus and pay attention, reasoning and judgment, and/or visual perception. People with dementia may have problems with short-term memory, keeping track of a purse or wallet, paying bills, planning and preparing meals, remembering appointments or traveling out of the neighborhood. Many dementias are progressive, meaning symptoms start out slowly and gradually get worse. (Source: Alzheimer's Association.)

Domiciliary care

Care provided in an individual's own home.

Dual-eligible

A person who qualifies for more than one type of insurance coverage, such as both Medicaid and Medicare.

Durable medical equipment

Refers to any medical equipment used in the home to aid in a better quality of living. It is a benefit included in most insurances and may include a hospital bed, wheelchair, monitors, and oxygen tanks.

Echo Boomers

Also called “Millenials” or “Generation Y,” there are approximately 80 million Echo Boomers between the birth dates 1982 to 1995.

The Eden Alternative

A movement to change the culture in institutional facilities (nursing homes) from a medical model to a person-centered approach, and involves creating a “human habitat” where life revolves around close and continuing contact with plants, animals and children.

Elimination period

A type of deductible; the length of time the individual must pay for covered services before the insurance company will begin to make payments.

Enriched housing

An adult care facility licensed to provide long-term residential care to five or more adults, for the most part 65 years or older, in community-type settings similar to independent housing units.

Entrance assessment (Health and financial)

Many senior housing communities use an entrance assessment to establish financial viability and to determine the level of care and services needs of the older adult.

Extended care facility (ECF)

A facility that offers subacute care, providing treatment services for people requiring inpatient care but whom do not currently require continuous acute care services, and admitting people who require convalescent or restorative service or rehabilitative services or people with terminal disease requiring maximal nursing care.

Extra care sheltered housing

Housing where there is additional support (such as the provision of meals and extra communal facilities) on top of that usually found in sheltered housing.

Foster care homes

Private residences licensed to provide care to five or fewer residents. They offer room and board and personal care from a caregiver in the home 24 hours a day. Planned activities and medication management are available, and some provide transportation services, private rooms or nursing services. The type of care provided in an adult foster home varies greatly, depending on the consumer’s needs and the skills, abilities, and training of the provider. They are licensed, monitored and inspected by the state or local area agencies on aging. Medicaid may cover the cost for some older adults.

Functional status

The extent to which an individual is able to perform activities associated with the routines of daily living.

Geriatric care manager

Geriatric care managers are specifically trained to conduct an assessment of an individual’s current health and status to determine appropriate solutions for care. Geriatric care managers typically have a minimum of a bachelor’s degree or substantial equivalent training in gerontology, social work, nursing or counseling. They are best described as “liaisons” or “consultants” who can provide valuable input and guidance at a time when you may not be able to research all of the local options on your own. They can also conduct thorough due diligence on service providers.

Geriatrician

A physician who is trained to evaluate and manage the unique health care needs and treatment preferences of older people. Most geriatricians become certified in internal or family medicine and pursue additional training in treating the special health needs of older patients in order to become board certified in geriatric medicine.

Granny flat/annex

See accessory apartment/accessory dwelling unit (ADU); in-law suite.

The Green House Model

Part of the movement for de-institutionalization, or moving people from institutional (nursing homes) facilities to community-based living arrangements. It is an effort designed to restore individuals to a home in the community by combining small homes with the full range of personal care and clinical services expected in high-quality nursing homes.

Guaranteed renewable

When a policy cannot be canceled and must be renewed when it expires, unless the benefits have been exhausted. The company cannot change the coverage or refuse to renew the coverage for anything other than non-payment of premiums.

Homebound/housebound

Refers to a person who is unable to leave the house due to a chronic illness or acute illness. A person can be homebound for a short or long time.

Home care agency

A home care agency, also known as non-medical senior care or in-home care, provides services that do not require a licensed professional or a physician’s prescription. A home care worker can provide companionship to an older adult who is aging in place, as well as help with activities such as medication reminders, preparing meals, transferring from chair, toilet or bed, bathing, getting dressed, light housekeeping, or transportation to and from doctor appointments.

Home health aide

A home health aide can provide more hands-on care and will typically assist with basic health-related tasks such as getting out of bed, bathing, dressing and feeding. These individuals typically have state-approved advanced training and would help to monitor someone in their home and report any/all more serious medical concerns to a physician. In some cases, a home health aide may receive more advanced or complex training and could provide even further care.

Home health care agency

A home health care agency provides services that require a licensed professional — such as a registered nurse, or physical, respiratory, speech or occupational therapist — and a physician's prescription. These medical services are provided in the person's home, and they can involve care for chronic health conditions, or temporary care, as in the case of someone recovering from surgery or an injury.

Home help

A person or a service providing practical help in the home, such as household chores, to support an older adult with disabilities to remain living in his/her own home.

Home improvement agency

An organization offering advice and practical assistance to older adults who need to repair, improve or adapt to their homes.

Homemaker service

A home help service for meal preparation, shopping, light housekeeping, money management, personal hygiene and grooming, and laundry.

Home medical equipment

Equipment, such as hospital beds, wheelchairs and prosthetics, provided by an agency and used at home. Also known as durable medical equipment.

Home visits

Professional visits in the home.

Hospice care

Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so.

Housing association

Non-profit organization providing rental housing.

Independence

The ability to perform an activity with no or little help from others, including having control over any assistance required rather than the physical capacity to do everything oneself.

Inflation protection

A policy option that provides for increases in benefit levels to help pay for expected increases in the costs of long-term care services.

Informal assistance/caregiving

Help or supervision (usually unpaid) that is provided to persons with one or more disabilities by family, friends or neighbors (who may or may not be living with them in a household).

In-law suite

See accessory apartment/accessory dwelling unit (ADU); Granny flat/annex.

Instrumental activities of daily living (IADL)

Activities with aspects of cognitive and social functioning, including shopping, cooking, doing housework, managing money and using the telephone.

Level of care

The level of care in senior housing refers to independent, assisted living or skilled nursing, and is based upon the amount of care provided for activities of daily living and for medical care.

Life care community

See definition for Continuing Care Retirement Communities (CCRCs).

Lifetime home

Housing built to be adaptable to people's changing needs, thus avoiding the need for expensive and disruptive adaptations.

Live/work flex house

A house or apartment that includes both living and working spaces for the residents.

Long-term care (LTC)/long-term aged care

A range of health care, personal care and social services provided to individuals who, due to frailty or level of physical or intellectual disability, are no longer able to live independently. Services may be for varying periods of time and may be provided in a person's home, in the community or in residential facilities (e.g., nursing homes or assisted living facilities). Individuals have relatively stable medical conditions and are unlikely to greatly improve their level of functioning through medical intervention.

Long-term care insurance

Insurance coverage that provides at least 24 months of coverage on an expense incurred, indemnity, prepaid or other basis; for one or more functionally necessary or medically necessary services, including but not limited to nursing, diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital.

Medicaid

The federally supported, state-operated public assistance program that pays for health care services to people with a low income and minimal assets. Medicaid pays for nursing home care, limited home health services and may pay for some assisted living services, depending on the state.

Medicare

A federally administered system of health insurance available to persons aged 65 and over. It pays for some rehabilitation services, but otherwise does not pay for long-term care. The four parts (A, B, C and D) are described below:

- **Medicare Part A:** hospital insurance that helps pay for inpatient care in a hospital or nursing home (limited-time rehabilitation care following a hospital stay only), some home health care and hospice care.
 - **Medicare Part B:** This helps pay for doctors' services and many other medical services, outpatient rehabilitative services and home care, as well as some supplies that are not covered by hospital insurance. It does not pay for long-term care.
 - **Medicare Part C:** People with Medicare Parts A and B can choose to receive all of their health care services through one of these provider organizations under Part C plans.
 - **Medicare Part D:** Prescription drug coverage that helps pay for medications doctors prescribe for treatment.
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Naturally occurring retirement communities (NORC)

Geographic areas or multi-unit buildings that are not restricted to persons over a specified age, but which have evolved over time to include a significant number (typically, over 50%) of adults who are aged 60 and over.

Nursing homes/skilled nursing/nursing facility

Skilled nursing facilities are medical facilities that offer full-time, on-site nurses and nurse practitioners, social workers and dietitians. These facilities, also known as nursing homes, provide the highest level of medical care, with 24-hour nursing care for residents with serious medical conditions and/or advanced dementia or cognitive impairment. Medically qualified adults are admitted when they need skilled care above and beyond the ADLs. Skilled nursing may be appropriate for short- or long-term care up to the final stage of life.

Nurse practitioner

A nurse practitioner (NP) is a registered nurse (RN) who has completed advanced education (a minimum of a master's degree) and training in the diagnosis and management of common medical conditions, including chronic illnesses. Nurse practitioners provide a broad range of health care services and can serve as a patient's regular health care provider.

Occupational therapist

An occupational therapist works with clients to help them achieve a fulfilled and satisfied state of life through the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and which develop, improve, sustain or restore the highest possible level of independence.

Palliative care

Palliative care is care for adults and children with serious illness and which focuses on relieving suffering and improving quality of life for patients and their families, but it is not intended to cure the disease itself. It provides patients of any age or disease stage with relief from symptoms, pain and stress, and it should be provided along with curative treatment. Palliative care is also called "supportive care." It's aimed at relieving suffering and improving quality of life. It's designed to help people live as well as they can for as long as they can, even though they have a serious illness.

Plan of care

The plan of care outlines the strategies designed to guide health care professionals and other individuals involved with patient or resident care. Such plans are patient-specific and are meant to address the total status of the patient. It sets out what support the person should receive, why, when, and the details of who should provide it.

Resident

The recipient of care in a residential care facility.

Resident contribution

A contribution paid by residents toward the cost of their accommodation and care in a facility.

Residential care

Provides accommodation and other care, such as domestic services (laundry, cleaning), help with performing daily tasks (moving around, dressing, personal hygiene, eating) and medical care (various levels of nursing care and therapy services). Residential care is for older adults with physical, medical, psychological or social care needs that cannot be met in the community.

Residential care services

Accommodation and support for people who can no longer live at home.

Retirement community

Retirement communities offer the privacy and freedom of home combined with the convenience and security of on-call assistance and a maintenance-free environment. Residents live on their own and care for themselves in a community where household services and recreational and social outings are available to them. Housing options include private homes, townhouses, villas and apartments.

Reverse mortgage

A reverse mortgage is designed for homeowners 62 years of age and older. It provides access to a home's equity, freeing up money that may be used to meet other expenses.

Revocable living trust

A revocable living trust allows transfer of property to a separate entity called a trust. The trust is managed according to the rules established in the trust document for the benefit of the beneficiaries named in the trust.

Senior apartment

Age-restricted multi-unit housing with self-contained living units for older adults who are able to care for themselves. Usually no additional services, such as meals or transportation, are provided. The age of eligibility varies and is often waived for the spouse of a resident.

Senior move managers

Specialize in helping older adults and their families with the task of downsizing and moving to a new residence.

Shared housing/Subsidized housing

Government supported accommodation for people with low to moderate incomes.

Skilled care

"Higher level" of care (such as injections, catheterization and dressing changes) provided by trained health professionals, including nurses, doctors and therapists.

Skilled nursing care

Skilled nursing facilities are medical facilities that offer full-time, on-site nurses and nurse practitioners, social workers and dietitians. These facilities, also known as "nursing homes," provide the highest level of medical care, with 24-hour nursing care for residents with serious medical conditions and/or advanced dementia or cognitive impairment. Medically qualified adults are admitted when they need skilled care above and beyond the ADLs. Skilled nursing may be appropriate for short- or long-term care up to the final stage of life.

Skilled nursing facility (SNF)

Nursing homes that are certified to provide a fairly intensive level of care, including skilled nursing care.

Speech therapist

Speech-language pathologists (sometimes called speech therapists) assess, diagnose, treat, and help to prevent communication and swallowing disorders in patients. Speech, language, and swallowing disorders result from a variety of causes, such as a stroke, brain injury, hearing loss, developmental delay, a cleft palate, cerebral palsy, or emotional problems.

Spend down

A requirement that an individual use up most of his or her income and assets to meet Medicaid eligibility requirements.

Supported housing

Accommodation where there is a degree of daily living support for its residents to enable them to live independently.

Transitional care

A type of short-term care provided by some long-term care facilities and hospitals, which may include rehabilitation services, specialized care for certain conditions (such as stroke and diabetes), post-surgical care, and other services associated with the transition between hospital and home.

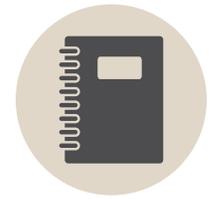
Universal Design

Design philosophy emphasizing products and buildings that are usable by people of all abilities without additional accessories or adaptations.

Village concept

Not-for-profit organizations that coordinate the delivery of services to members who live within the village's service area; services and membership fees vary. The "village" refers to a designated geographic area in a targeted neighborhood.

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Allaboutlongtermcare.com. Glossary of terms
www.allaboutlongtermcare.com/glossary.html

Assistedlivingfacilities.org. Senior care glossary of terms
www.assistedlivingfacilities.org/glossary

Eden Alternative
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Ecumen. An innovative leader of senior housing and services, with the mission of empowering individuals to live richer and fuller lives. www.ecumen.org

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