The AdvantAge Assessment: Using Data to Design Elder Friendly Initiatives

Interview with Mia Oberlink

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ACCESS Health United States

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Our vision is that all people, no matter where they live, no matter what their age, have a right to access high quality and affordable healthcare.

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Introduction

Innovative programs that enable the elderly population to maintain a connection to their communities and remain in their homes are gaining attention as the population ages. Ensuring that older adults have access to local supports and services, volunteer or employment opportunities, and civic connection are factors that promote community engagement and connection. An age friendly built environment includes walkable sidewalks, streets that are safe to cross, accessible transportation, close proximity of shops and grocery stores, age friendly housing, and community leisure facilities like parks and senior centers.

“The AdvantAge Initiative survey is a tool for hearing the voices of older adults and understanding the level of age friendliness of an apartment complex, neighborhood, town, or county.”

The AdvantAge Initiative consumer survey was developed over four years, 1999 to 2003, by the Center for Home Care Policy and Research division of the Visiting Nurse Service Of New York. The AdvantAge Initiative led the age friendly or elderly friendly movement that has become a strong force globally. The AdvantAge Initiative survey is a tool for hearing the voices of older adults and understanding the level of age friendliness of an apartment complex, neighborhood, town, or county.

The survey collects qualitative and quantitative data in a defined community and measures thirty three indicators of age friendliness. The indicators were developed after fourteen focus groups were conducted with older adults and younger people in four cities in four regions of the United States. The socioeconomically and ethnically diverse residents and community leaders were asked to name the characteristics that make a community age friendly. Common themes were identified that later became the indicators.

The AdvantAge Initiative framework is divided into four domains: Addressing Basic Needs, Promoting Social and Civic Engagement, Optimizing Health and Well Being, and Maximizing Independence for the Frail and Disabled. See Appendix B for further details within each category.
The AdvantAge Initiative survey is conducted either as a randomized telephone survey or as an online survey. The relatively recent addition of the online option has made the survey component of the initiative more affordable to smaller, community based organizations and expands the range of organizations and communities that can use the model to build community specific, data driven, age friendly communities.

The AdvantAge Initiative survey has been used in over fifty communities. The AdvantAge survey tool is employed when an organization hires the Center for Home Care Policy and Research to conduct the survey and report the findings using the thirty three indicators of age or elder friendliness. The survey reveals areas that are working well in the community and those that need to be addressed to create a more age friendly environment. The data are analyzed by the Center for Home Care Policy and Research and a customized action plan is designed with the participation of community stakeholders.

In this interview, Mia Oberlink, senior research associate for the Center for Home Care Policy and Research, discusses how the AdvantAge Initiative collects data directly from community residents. She also describes how the data inform strategic planning that prioritizes the findings that need the most attention. Several of her projects are with naturally occurring retirement communities (NORCs). These communities are places where people moved when they were young, raised their families, and then stayed in their housing as they aged. Eventually, their communities began to look like retirement communities but were not specifically built for retired older adults. There are naturally occurring retirement communities all over the country. In some areas, particularly in New York City, the city and the state governments have funded supportive services programs to help older residents age in place.
About Mia Oberlink

Mia Oberlink is a senior research associate at the Center for Home Care Policy and Research. She joined the center in June 1999. Ms. Oberlink currently manages the AdvantAge Initiative, a data driven community development project that helps communities measure their elder friendliness. The initiative also helps communities to develop strategies that sustain older residents’ independence and allow these residents to age in place and community.

Ms. Oberlink also directs the Center for Home Care Policy and Research portion of the Health Indicators in Naturally Occurring Retirement Communities (NORCs) Programs Initiative, a collaborative project with the United Hospital Fund. The initiative helps supportive services programs in naturally occurring retirement communities (NORC-SSPs) identify health needs in their communities, develop health interventions targeted to identified needs, measure the impact of these interventions for residents over time, and generate a body of evidence regarding the efficacy of program services to advance healthy aging in place. She is also coeditor of the book Life in an Older America.4

Prior to her current role at the Center for Home Care Policy and Research, Ms. Oberlink worked on elder and long term care issues at the Robert Wood Johnson Foundation, Mount Sinai Medical Center, and the International Longevity Center. She received both an undergraduate and several graduate degrees from New York University.
Interview

Jean Galiana (JG): Please describe the activities of the Center for Home Care Policy and Research.

Mia Oberlink (MO): We are a research center that is an independent arm of the Visiting Nurse Service of New York (VNSNY). We are largely funded by grants and contracts. Many of our grants are government funded studies of our patient population and Medicare claims data. One recent study found that early and intensive home health nursing and a physician visit at the start of home care was more effective at reducing thirty day hospital readmissions than usual care.

JG: What is the focus of your work, personally?

“We began with the thought that although census and local health department data on older adults are available, one of the factors that is definitely missing is the input, experiences, and perceptions of the community residents themselves.”

MO: The work that I do is community focused. I started here in 1999. We were questioning whether communities could measure how elder friendly they are. Today people are more likely to say “age friendly,” but at that time it was more often referred to as “elder friendly” communities. We use those terms interchangeably now because, in my opinion, they have the same meaning. We developed the AdvantAge Initiative, which is a process and set of tools to help communities measure their elder friendliness. We began with the thought that although census and local health department data on older adults are available, one of the factors that is definitely missing is the input, experiences, and perceptions of the community residents themselves.

When talking about an elder friendly community, who is the end user? It is the older adult. That was our driving idea. That is why we came up with the AdvantAge Initiative. Do you see those books up there? Those are our original participants in the initiative. We had ten communities that pilot tested our questionnaire for older adults. In 2004, we did a national survey using the same questionnaire so that the participants could compare their survey findings to a
That work was done more than ten years ago, so the data are fairly outdated now.

**JG:** Will you aggregate all the data from all your programs?

**MO:** When we did the original surveys in our ten communities, one of the things that the participants wanted to do was to compare their survey results with those of the other communities. We did compare them. We provided averages of the ten and then the highest and the lowest percentages for each community. At the end of the day, we felt that it was not fair to compare the results of one community to another because there are so many variables. Communities are very different from one another.

The first ten projects were somewhat like a learning collaborative. We saw that it worked well. Then we opened the project up to anyone who wanted to contract with us for our elder friendly community research services. That is how it has been ever since.

**JG:** Did you use other tools along with the survey for your projects?

**MO:** Our original ten communities were taken through a process of understanding the data, working with community groups to identify priorities, and translating the data into action. We developed tools that the communities could use at each phase of the process. These were technical assistance tools that helped the participants do such things as conduct analyses of the community with input from the residents, set priorities, and figure out how to move from the data to action.

**JG:** What happens after you complete the survey portion?

**MO:** After we complete the survey, we do the data analysis and create several types of reports, depending on what the client needs. We work with the client to interpret the reports and the data and discuss the main findings. We look at areas that are the most alarming or most interesting to our client. We then use the data to inform an action plan for the community. For example, one group we are working with now is an East Harlem senior center. The center commissioned the survey. We received nearly five hundred responses from older adults in the community. We performed data analysis that gave us a lot of information. We reviewed the information together. There were three issues that jumped out. Falls was the most pronounced. Forty percent of the respondents said they fell in the
past year. That is an unusually big number. The other two issues were mental health and access to food.

JG: Some of the residents are food insecure?

MO: Yes. It is fortunate that this neighborhood does have a lot of resources to address issues like food insecurity. That part of it is good. The falls data were very alarming. Respondents said that they fell inside and outside. One of the top three neighborhood problems that the respondents experienced was sidewalks that are uneven and in bad shape. This detail got us seriously thinking that falls happen due to different causes, not just one thing. There are potentially a lot of contributing factors to falls. From the survey results, we did not really learn why the residents were falling. We do not know whether a specific characteristic of the outdoor environment contributed to the fall or not. There may be other causes for falling, such as residents’ chronic conditions or environmental factors in the home. From our East Harlem survey, we found that thirty nine percent of the people who fell, fell indoors, forty six percent fell outdoors, and fifteen percent fell indoors and outdoors.

JG: Will your next step be based on those findings?

MO: Yes. We hope to get support to develop a comprehensive approach to fall prevention. That would include addressing the physical environment, medical factors, and preventive measures. The environmental factors could be in the home or outside the home. The medical factors have to do with people’s health status. Do they have a condition like orthostatic hypotension, which causes someone to feel dizzy when they first stand up or when their blood pressure is low. Do they need glasses? Do they use an assistive device that may or may not be appropriate for them? The preventive factors include what people do, or don’t do, for exercise. Do they walk around and use their bodies actively for daily living or do they limit their movement because of fear of falling? One measure, such as implementing an evidence based fall prevention program, such as Matter of Balance, may address only certain risk factors for falls. There may be other risk factors at play that require other types of interventions. We want to know what those risk factors are and what specific interventions will address them.

JG: Who contracts your services?

MO: It is different in each case. We have contracted with foundations, particularly those that have never funded aging related programs before;
community based organizations, like senior centers and naturally occurring retirement communities; city and county governments; human services organizations; and others.

We did a survey of older adults in the Chelsea and Clinton neighborhoods in Manhattan for the Actors Fund Senior Care Program. The Actors Fund is a social service agency for people in the entertainment industry. The Actors Fund has a senior program, among its many other programs. The Actors Fund hired us to survey people aged sixty and older in these neighborhoods. Many theater people live in those neighborhoods because they are close to the theater district. These neighborhoods used to be accessible to lower income individuals but have become popular and expensive in the last decade. Developments like Hudson Yards, the Chelsea art scene, new office towers, and the High Line park have changed the culture and affordability of the neighborhood. These changes have also made the sidewalks crowded and streets less accessible to frail older adults.

The Actors Fund chose to focus on the Clinton neighborhood, partly because it contains Manhattan Plaza, which opened in 1977 and reserved seventy percent of the units for performing arts professionals and thirty percent for seniors. Manhattan Plaza houses 2,600 residents. As of 2012, forty six percent of the residents were sixty years old and older.

JG: What was your process with the Actors Fund project?

MO: We began by recommending that the Actors Fund build a well rounded advisory committee. Optimally, the committee would include members like local seniors, private foundations, faith based organizations, unions, and cultural organizations. We also invited the public sector, including city and state agencies, and social service and health organizations. We were lucky with this project because the actor Angela Landsbury agreed to be the spokesperson for the project. Ms. Landsbury is a resident in the Chelsea neighborhood and a former resident of Manhattan Plaza. We named the project the Seniors Community Survey Project.

JG: Did Angela Landsbury’s involvement get many people to participate in the survey?

MO: I think so. Her image was on a postcard announcing the survey that was sent to many people in the area. We also had promotional assistance through the advisory board. The unions that people in the theater arts belong to were
especially helpful. We received over twelve hundred responses, which was really nice. We did an extensive comparative analysis of people who are in the entertainment industry versus residents who are not. One of the most interesting outcomes of this survey was that people in the performing arts are highly educated but have very low incomes. Usually, the correlation between education and income is positive. It is not that way at all for this group.

Because the residents are so educated and many use computers, half of the people did our survey online and the other half did it on paper. We included some open ended qualitative questions. Many of the people who did the survey online wrote very lengthy answers to the open ended questions. We were completely surprised by how much they wrote. We had pages and pages of comments from people that offered incredibly informative insights into their daily lives.

**JG:** What did you learn from analyzing that data?

**MO:** One of the main things that people commented on was the traffic in the neighborhood that made crossing the street treacherous, particularly for older adults and those with disabilities. Manhattan Plaza is a huge complex near the entrance to the Lincoln Tunnel. The traffic patterns around that area were frightening to the residents, the older adults especially. There were bicycles going in all directions and a lot of traffic turning into the approach to the Lincoln Tunnel. There were even a couple of fatalities there. An issue that we did not know about or understand became clearer to us because the survey participants wrote so much in such detail and explained clearly. The community board encompassing these neighborhoods took action to resolve some of these traffic issues.

**JG:** What were the other findings from the survey?

**MO:** We found that the percentage of those over sixty who live alone was substantially higher in these communities than the national average. Nationally, about twenty eight percent of older adults live alone. We found that in the two communities we surveyed, sixty nine percent of the respondents live alone.

Additionally, we found more of the residents who are arts professionals are still in the workforce. Five five percent of arts professionals are still working in some capacity – working periodically, part time, or full time – as compared to twenty two percent of the non arts professionals. This difference could be because people
in the arts had not made enough money to have sufficient retirement savings or that they wanted to continue to practice their craft, as many creative people do.

According to the National Endowment for the Arts, the annual median income for arts professionals is 23,400 US dollars. The median income for the general workforce in the US is 30,100 dollars. A mere fifteen percent of arts professionals have full time employment, as compared to seventy percent of the general workforce. As you might imagine, this affects their health benefits and social security savings. These community specific data offer clarity to inform initiatives in those areas.

**JG:** Did you ask about the residents’ civic and social engagement?

> “Community connection and involvement is an important factor in a person’s health and well being.”

**MO:** We always include questions of that nature because we know that community connection and involvement is an important factor in a person’s health and well being. We found that about thirty nine percent of the respondents said that they would like to engage in more social activities than they are currently doing. Many of their comments were about their desire to stay involved in community life.

We learned much more than what I have mentioned, but it gives you a good idea of the information we collect and how it is used to create initiatives to meet the individualized needs of the communities we serve.

We have many other past projects like the one just described.

**JG:** What is your next project?

**MO:** We are currently working with three New York City naturally occurring retirement community programs, the Spring Creek naturally occurring retirement community in Brooklyn, and with a housing provider and United Way in Plainfield, New Jersey. We have customized the AdvantAge Initiative survey for each of these organizations. All of them will use the findings for planning purposes.
**JG:** What are your future plans for the AdvantAge Initiative?

**MO:** Right now our plate is more than full. We hope to work with additional communities locally and nationally in the near future.

**JG:** Thank you for this interesting discussion.

**MO:** Thank you, Jean.
Appendix A. Indicators List: Essential Elements of an Elder Friendly Community

*Percentage of People Age Sixty Five and Older Who Report Their Community is a Good Place to Live*

*Addresses Basic Needs*

**Affordable housing is available to community residents**

Percentage of people age sixty five and older who spend more than or less than thirty percent of their income on housing

Percentage of people age sixty five and older who want to remain in their current residence and are confident they will be able to afford to do so

**Housing is modified to accommodate mobility and safety**

Percentage of householders age sixty five and older in housing units with home modification needs

**The neighborhood is livable and safe**

Percentage of people age sixty five and older who feel safe or unsafe in their neighborhood

Percentage of people age sixty five and older who report few or multiple problems in the neighborhood

Percentage of people age sixty five and older who are satisfied with the neighborhood as a place to live

**People have enough to eat**

Percentage of people age sixty five and older who report cutting the size of or skipping meals due to lack of money

**Assistance services are available and residents know how to access them**

Percentage of people age sixty five and older who do not know whom to call if they need information about services in their community
Percentage of people age sixty five and older who are aware or unaware of selected services in their community

Percentage of people age sixty five and older with adequate assistance in activities of daily living and/or instrumental activities of daily living activities

**Optimizes Physical and Mental Health and Well Being**

**Community promotes and provides access to necessary and preventive health services**

Rates of screening and vaccination for various conditions among people sixty five and older

Percentage of people age sixty five and older who thought they needed the help of a healthcare professional because they felt depressed or anxious and have not seen one (for those symptoms)

Percentage of people age sixty five and older whose physical or mental health interfered with their activities in the past month

Percentage of people age sixty five and older who report being in good to excellent health

**Opportunities for physical activity are available and used**

Percentage of people age sixty five and older who participate in regular physical exercise

**Obstacles to use of necessary medical care are minimized**

Percentage of people age sixty five and older with a usual source of care

Percentage of people age sixty five and older who failed to obtain needed medical care

Percentage of people age sixty five and older who had problems paying for medical care

Percentage of people age sixty five and older who had problems paying for prescription drugs
Percentage of people age sixty five and older who had problems paying for dental care or eyeglasses

**Palliative care services are available and advertised**

Percentage of people age sixty five and older who know whether palliative care services are available

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**Maximizes Independence for the Frail and Disabled**

**Transportation is accessible and affordable**

Percentage of people age sixty five and older who have access to public transportation

**The community service system enables people to live comfortably and safely at home**

Percentage of people age sixty five and older with adequate assistance in activities of daily living

Percentage of people age sixty five and older with adequate assistance in instrumental activities of daily living

**Caregivers are mobilized to complement the formal service system**

Percentage of people age sixty five and older who provide help to the frail or disabled

Percentage of people age sixty five and older who get respite or relief from their caregiving activity

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**Promotes Social and Civic Engagement**

**Residents maintain connections with friends and neighbors**

Percentage of people age sixty five and older who socialized with friends or neighbors in the past week

**Civic, cultural, religious, and recreational activities include older residents**

Percentage of people age sixty five and older who attended church, temple, or other in the past week
Percentage of people age sixty five and older who attended movies, sports events, clubs, or group events in the past week

Percentage of people age sixty five and older who engaged in at least one social, religious, or cultural activity in the past week

**Opportunities for volunteer work are readily available**

Percentage of people age sixty five and older who participate in volunteer work

**Community residents help and trust each other**

Percentage of people age sixty five and older who live in “helping communities”

**Appropriate work is available to those who want it**

Percentage of people age sixty five and older who would like to be working for pay
Appendix B.

An Elder Friendly Community

**Addresses Basic Needs**
- Provides appropriate and affordable housing
- Promotes safety at home and in the neighborhood
- Assures no one goes hungry
- Provides useful information about available services

**Optimizes Physical and Mental Health and Well Being**
- Promotes healthy behaviors
- Supports community activities that enhance well being
- Provides ready access to preventive health services
- Provides access to medical, social, and palliative services

**Promotes Social and Civic Engagement**
- Fosters meaningful connections with family, neighbors, and friends
- Promotes active engagement in community life
- Provides opportunities for meaningful paid and voluntary work
- Makes aging issues a community wide priority

**Maximizes Independence for Frail and Disabled**
- Mobilizes resources to facilitate “living at home”
- Provides accessible transportation
- Supports family and other caregivers

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Appendix C.

The AdvantAge Initiative survey was conducted in the following locations:

**National Survey**

**States**

Indiana

**Counties**

Contra Costa and Santa Clarita Counties, CA
El Paso County, TX
Elkhart, Kosciusko, LaPorte, Marshall, and St. Joseph Counties, IN
Maricopa County, AZ
Newaygo County, MI
Orange County, FL

**Cities, Towns, and Neighborhoods**

Six neighborhoods of Chicago, IL
Grand Rapids, MI
Indianapolis, IN
Jacksonville, FL
Parsippany, NJ
Puyallup, WA
Upper West Side and Yonkers, NY

**Naturally Occurring Retirement Communities (NORCs)**

Gary Midtown, Huntington, Martindale/Brightwood (Indianapolis),
Linton, and LaSalle Park (South Bend), IN
Brownsville, Chinatown, Harlem, and Lincoln Square, NY
Appendix A
Appendix B
Appendix C

ACCESS Health International works to help provide high quality, affordable care for the elderly and the chronically ill. Our method is to identify, analyze, and document best practices in managing the elderly and chronically ill patients and to consult with public and private providers to help implement new and better cost effective ways to care for this population. We also encourage entrepreneurs to create new businesses to serve the needs of this rapidly expanding population. At present, ACCESS Health works on these issues in high income countries, including Singapore, Sweden, and the United States. ACCESS Health is working to expand this work to low and middle income countries, including India and China.

According to estimates from the US Department of Health and Human Services, people aged sixty five and older will represent nineteen percent of the population by 2030, up from just over twelve percent in 2000. And a 2013 survey by the Pew Research Center found that seventy five percent of adults in this age group are living with a chronic condition, such as high blood pressure, diabetes, or heart disease. With four in ten Americans currently tasked with the care of their elderly and chronically ill relatives, the US healthcare system urgently needs to adjust to meet the rapidly growing demand for high quality and affordable elder and long term care. ACCESS Health United States helps practitioners and policymakers locate, learn from, and scale up pockets of excellence in elder and long term care.

Learn more at www.accessh.org.