RHODE ISLAND

Aging in Community

Final Report
June 2016

Subcommitee of the Long Term Care Coordinating Council

Maureen Maigret, Chair

The following persons are gratefully acknowledged for participating in the Subcommittee's work

Christine Amedeo Heather Amaral Linda A'Vant-Deishinni
Kirsten Bryan Deb Burton Susan Bouchard
Bernie Boudreau Councilwoman Barbara Capalbo Marie Carpenter
Senator Carol Cool Rumsey John Dooley Rachel Filinson Bill Flynn
Jim Dealy John DiTamasso Joyce Dolbec Craig Dwyer Cathy Gorman
Linda Katz Kathleen Langford Skye Leedahl Erin McAndrew
Kathy McKeon Paula McFarland Maureen Maigret Karen Mensel
Connie Milbourne Mary Lou Moran Jessica Mowry Manny Murray
Paula Parker Susan Pomfret Esther Price Susan Saccoccio-Olson
Janet Spinelli Marianne Raimondo Corinne Russo
Karen Ryan Karen Testa Kali Thomas
Meg Underwood Mike Walker

Daniel J. McKee, ***Lieutenant Governor***
Chair, Long Term Care Coordinating Council

Funding to support the focus groups was partially provided by the Rhode Island Division of Elderly Affairs, with funds from the Older Americans Act, to assist in the development of Rhode Island's State Plan on Aging and in part by a grant from the Tufts Health Plan Foundation.

TABLE OF CONTENTS

INTRODUCTION

WHY THIS REPORT?

This report responds to passage of the Aging in Community Act of 2014 (RIGL 42-66.11) sponsored by Senator Maryellen Goodwin and Representative Christopher Blazejewski. The Act directed the chair of the state Long Term Care Coordinating Council to create an Aging in Community Subcommittee with the following purpose:

> ***"to develop a plan to provide the needed infrastructure and program improvements in support services, housing and transportation that will enable the state's growing elder population to safely remain living at home and in community settings. The aging in community plan shall include an inventory of available services, identification of service and program gaps and resource needs. In addition to members of the long-term care coordinating council, the subcommittee shall include those members of the state's academic community with expertise in aging services and community-based long-term supports and services as the council deems appropriate."***

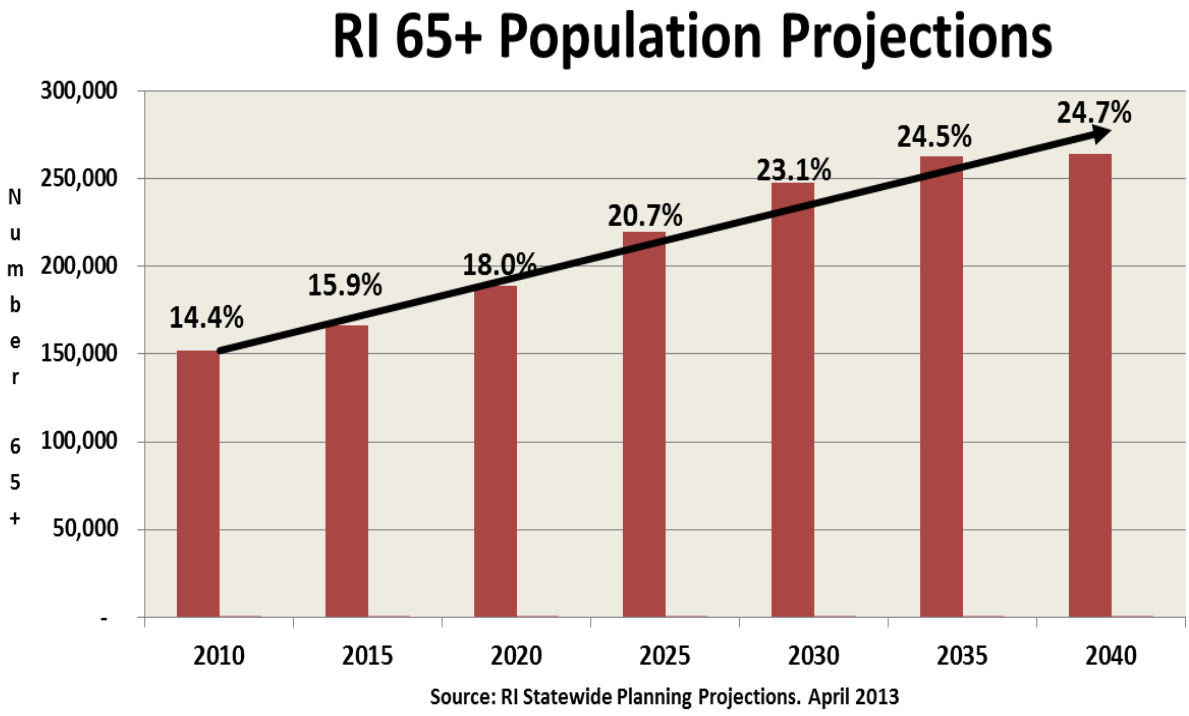
Former Lieutenant Governor Elizabeth Roberts organized the Subcommittee in the fall of 2014 appointing Maureen Maigret as Chair. This report presents the work of the Subcommittee conducted over the past year and a half. It provides information on current services and service gaps in nine different issue areas or domains. The issue areas were selected based on a review of published indicators (cf. MetLife Mature Market Institute, 2013; World Health Organization, 2007). Plan recommendations for strategies to promote Aging in Community in Rhode Island are based on the service information gathered from state agencies, the input of Rhode Island seniors gathered from ten focus groups of older Rhode Islanders, survey work, key informant interviews with providers and advocates, a focus group of case managers in Community Action Agencies under contract with the Division of Elderly Affairs and Neighborhood Health Plan of Rhode Island and research on best practices.

Much Subcommittee work was done by members on a volunteer basis. In January 2016, the Tufts Health Plan Foundation awarded the Rhode Island College Foundation a modest grant to build on the work of the Subcommittee and to work towards building an "Age-Friendly" Rhode Island. Rhode Island College faculty member Marianne Raimondo serves as principal investigator for the grant and Rachel Filinson and Connie Milbourne are co-investigators. Maureen Maigret serves as a consultant. In addition to the Tufts Health Plan Foundation grant award, the Foundation is funding research by faculty at the Gerontology Institute of the John W. McCormack Graduate School of Policy and Global Studies at the University of Massachusetts to create a Rhode Island Healthy Aging Data Report similar to ones done for Massachusetts in 2014 and 2015. The Rhode Island Healthy Aging report (scheduled for fall 2016 release) will provide data on each of Rhode Island's 39 communities on 121 metrics relating to individual and community health and allow for comparisons with the rest of the state. The Subcommittee views this Aging in Community report as an initial step. We identified several areas as high priority with strategies to be implemented early on due to critical needs as expressed by our findings and seniors themselves. As a follow up to this report, with the funding from the Tufts Health Plan Foundation, the Subcommittee will reinvent itself into a broad-based Age-Friendly Rhode Island Coalition working to implement the recommendations in this report and to develop a Strategic

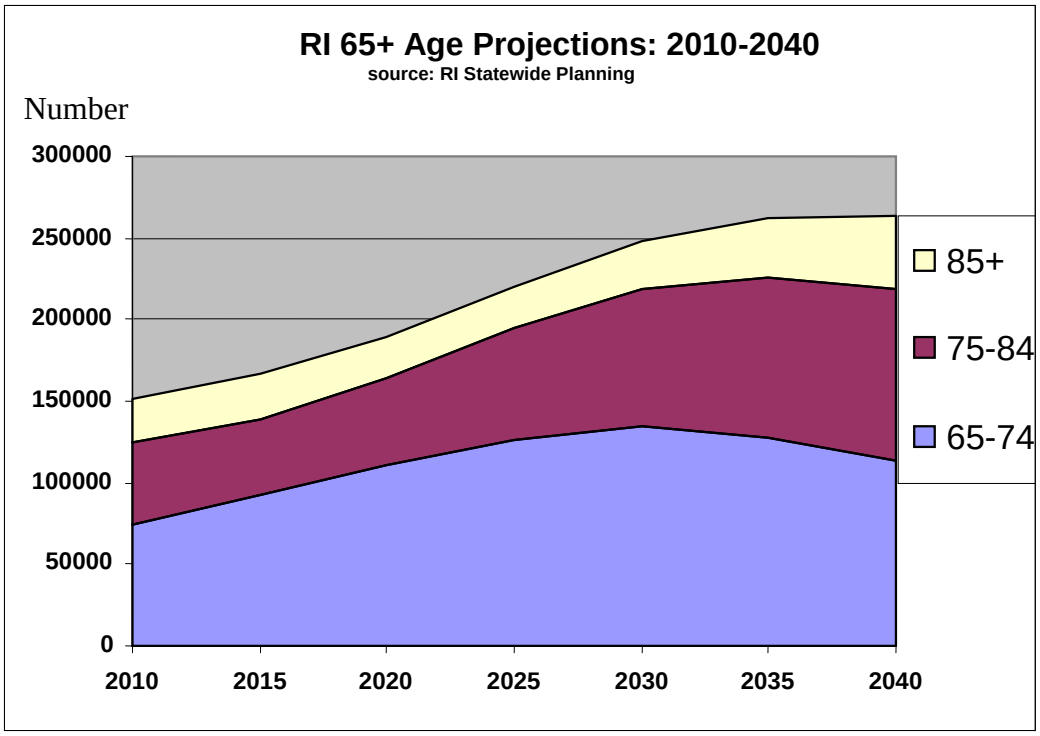
Plan to build an Age-Friendly Rhode Island. The results of the Rhode Island Healthy Aging Data Report, showing individual community-level data, will provide local public officials, advocates, private entities, social service agencies and healthcare organizations with additional information to plan strategies responsive to community-level areas of special concern. Appendix A contains a schedule of Subcommittee meetings and a list of persons who participated in the work of the Subcommittee.

WHY IS THIS REPORT IMPORANT?

In 2010, an estimated 14.4% of the state population was age 65 and over and 2.5% age 85 and over. By 2014, an estimated 15.8 percent were age 65 and over and 2.7% age 85 and over (Administration for Community Living, 2013a). Appendix D contains a state map showing percentages of the older population by census tract. According to Rhode Island Statewide Planning Office projections, by 2030 there will be almost 100,000 more persons age 65 and over than there were in 2010 and they will make up 23% of the state population (State of Rhode Island Division of Planning, 2013 @ http://www.planning.ri.gov/geodeminfo/data/popprojections.php).



By 2040, the number of persons ages 74 to 84 will increase by 100% and those 85 and over will increase by 72%.



This growth in the state's older population has important social and economic implications. Rhode Island policy leaders need to recognize that the state's older population is a growing one and adopt policies and strategies to help the state's seniors remain healthy, active and engaged and to support efforts to allow them to "Age in Community." Enabling Rhode Island seniors to age in community will lead to a better quality of life, enhanced well being and reduce overall health system costs.

Helping seniors to remain active and engaged is smart public policy as older Rhode Islanders, as noted below, contribute substantially to the state's economy through Social Security payments, labor force participation, volunteerism and serving as family caregivers.

- Social Security economic value to Rhode Island (AARP, 2013)
  - Total 2012 Social Security benefits: $2.9 billion
  - Provides $4.98 billion in economic output
  - $1.37 billion in employee compensation
  - Generated $281 million in state and federal taxes
  - 33,750 jobs across all sectors

- Older Rhode Islanders in the Workforce (2013) (RI Department of Labor and Training, 2015)
  - 69.2 % of persons ages 55-64 are in labor force
  - 18.3 % of persons age 65 and over are in labor force
  - From 1st Qtr 2002 & 1st Qtr 2015, private sector employment by persons 55+ increased 48.8%

- Older Rhode Islanders as caregivers
    - An estimated 134,000 Rhode Islanders are unpaid caregivers (AARP Public Policy Institute, 2015)
    - Total estimated value of $1.78 billion
    - RI AARP survey found 70% of RI caregivers age 55+ (AARP Research, 2015)
- Older Rhode Islanders as Volunteers (Corporation for National and Community Service, 2015b)
    - 18.9% of Rhode Islanders age 65+ volunteer (between 2012 & 2014)
    - 65,000 volunteers age 55 and older in Rhode Island
    - $149 million of service contributed

PART 1: ABOUT OLDER RHODE ISLANDERS

Older Rhode Islander Demographic Profile

The Rhode Island older population is not as diverse as those under age 65. Close to 92% of those age 65 and over are white, compared to 81.3% for those under age 65. Slightly over half of seniors are married (52.2%), 26.3% are widowed and 13.5% divorced. Close to six out of ten Rhode Island seniors are women (57.6%) and 31.6% of older householders live alone. Eighty-six percent are native born, and 9.4% report speaking English less than well. More than one-third report having some type of disability, with ambulation being the most frequent (23.5%). Only 7.3% report having difficulty with self-care (Administration for Community Living, 2013a).

Rhode Island population age 65 and over

White	91.9%	Married	52.2%
Female	57.6%	Widowed	26.3%
Householders Live Alone	31.6%	Divorced	13.5%
Native born	86%	With Disability	35.2%
Speak English less than well	9.4%	Ambulation Difficulty	23.5%
Income below Poverty	9.7%	Self care difficulty	7.3%

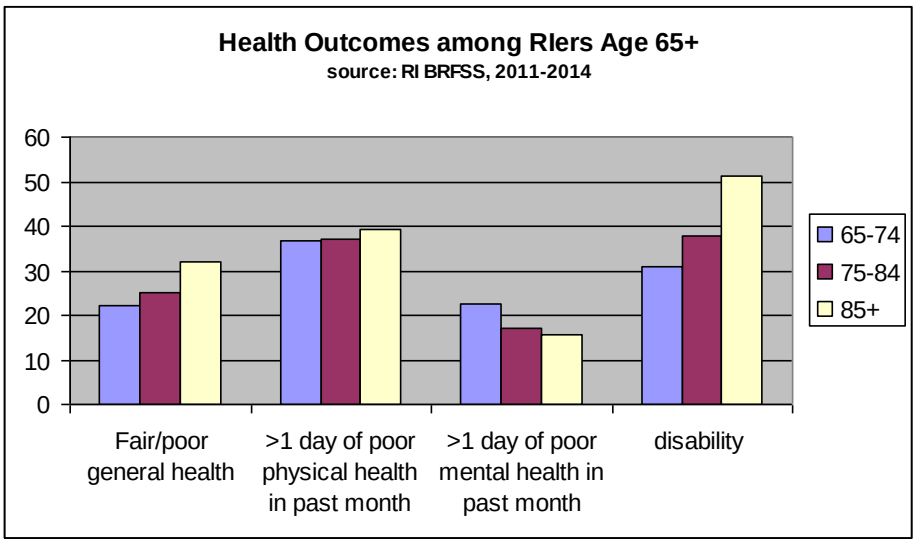
Source: American Community Survey 2014, Table S0103

Health and Social Profile of Older Rhode Islanders

With the highest proportion of older adults aged 85 or older in the U.S., Rhode Island faces the challenge of a substantial minority of its population being at risk of serious health conditions that would impair their ability to age in place. For the 10% of Rhode Island residents aged 60 and older who are minority (Administration for Community Living, 2013b), the over 7% of this demographic who live in poverty (Administration for Community Living, 2013b), and the nearly 20% (Administration for Community Living, 2013a) of elders who have not completed a high school education, the obstacles to healthy aging can be expected to be even greater, given the correlations of these factors with poorer health and inferior healthcare. To ascertain the current

health status of the older population and identify the areas of greatest need to be addressed we examine physical, behavioral, and social health measures; indicators of healthcare utilization; and implications of the findings for engendering age-friendly community.

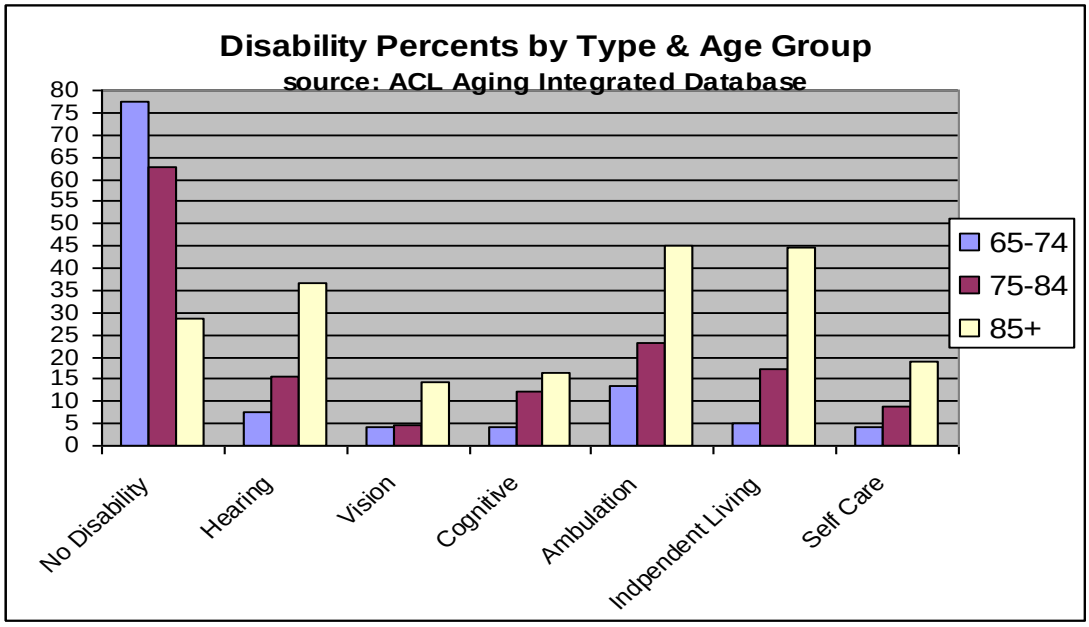
Physical health According to survey data from the Behavioral Risk Factor Surveillance System, made available by the Rhode Island Department of Health, 90% of Rhode Island seniors have at least one chronic disease, the majority have two or more chronic diseases and 50% of those over age 85 have some sort of physical limitation. The table below details the percentages reporting poor or fair health, at least one day of poor physical health in the past month, at least one day of poor mental health in the past month, and prevalence of disability, distinguishing between the young-old, old, and oldest-old subgroups of the senior population.



Considering the chronic diseases that are the major causes of death among older adults (heart disease, stroke, chronic lower respiratory disease, stroke and Alzheimer's disease), two trends are notable. First, cancer rates continue to be higher in Rhode Island among all age groups, including those aged 65 and over compared to the average for the country, with a rate of 2142.5 (per 100,000) among older adults in Rhode Island vs. a rate of 2033.8 for the United States. (National Cancer Institute and Centers for Disease Control, 2012). Second, while the expected growth in new cases of Alzheimer's disease over the next ten years is moderate in Rhode Island (slightly over 20%) compared to the rest of the country (Alzheimer's Association, 2015), Rhode Island's baseline of Alzheimer's disease prevalence starts at a relatively higher level. This is due to the greater incidence of the disease among the very old, who constitute a larger segment of the Rhode Island older population relative to other states.

According to the findings of the Centers for Disease Control's (2013) comparative report card for states on healthy aging in 2013, Rhode Island older adults rank in the healthier half of the U.S. in terms of average number of physical unhealthy days in a month (5), the number of days of mental distress (7.2), the percentage of teeth retained (57.6%), and the prevalence of disability (36%). It is, however, in the second quartile in terms of incidence of falls with injury during the past year (36%)—that is, it exceeds all but 25% of states in its incidence of falls.

The chart below shows various types of disability or functional limitations derived from the American Community Survey and provided by the Administration for Community Living (2013a). As noted, significant increases in disabilities occur as advance from young-old to old to old-old.



How do Rhode Island Seniors Compare to Seniors in Other States

The America's Senior Health Report calculated by United Health Foundation (2015) provides data on 35 health-related metrics. The 2015 report ranked Rhode Island 14th nationally, up from 26th in the prior report. Rhode Island ranked #1 (best rating) for:

Percent of seniors with a dedicated healthcare provider
Health Screenings (mammography and colo-rectal cancer screening ages 65-74)

Rhode Island was in the Top Ten for: (with number one being the best)

Low percent of smokers age 65+	Underweight seniors
Seniors having a dental visit	Percent of persons age 60+ in poverty on SNAP
Prescription drug coverage	Low incidence of suicide for age 65+
Hospice enrollment	Geriatrician shortfall

***Rhode Island was in the Bottom Ten for:* (*poorer rating*)**

chronic drinking	recommended hospital care
volunteerism	low-care nursing home residents
multiple chronic diseases	community support (dollars spent/65+ persons in poverty)

CDC's (2013) comparative report card on healthy aging corresponds with these high health screening ratings. It ranked Rhode Island in the top quartile for:

- Flu vaccination in the past year (70.3%)
- Ever having pneumonia vaccination (71.7%)
- Mammogram in past two years (88.4%)
- Colorectal cancer screening (78.1%)
- Being up to date on selective preventative services for women (53.4%)
- Being up to date on selective preventative services for men (51.9%)

The CDC additionally found that Rhode Island seniors compared favorably in regard to diet, being in the top quartile in consumption of at least two fruits a day (45.3%) and in the top half of states in consumption of at last three vegetables a day (31.9%). The proportion of smokers (8.5%) was among the lower (healthier) half for the country but the prevalence of obesity was in the top (unhealthier) half (22.9%) as was the proportion not engaged in physical activity (34.8%).

Social health. A number of indicators suggest that older Rhode Islanders are disadvantaged in terms of social engagement. Among those 60 and over, the American Community survey (2013a) found the percentage living alone (26%) in Rhode Island was higher than the national average (25%). For those aged 65 and older, the percentage grows to over 30% (United States Census Bureau, 2010). Although living alone in a household doesn't automatically translate to loneliness or social isolation, it is likely to raise the prospects of their occurrence. Moreover, it could partially explain the levels of inactivity among a considerable minority of seniors. For instance, the "America's Health Ranking" report showed that the older population in the state was characterized by low rates of volunteerism (United Health Foundation, 2015). The CDC (2013) documented the relatively higher percentage of older adults in Rhode Island who stated they had no leisure time and did not participate in physical activity.

A lack of economic resources could exacerbate the limited social resources. Rhode Island ranks 15th in the proportion of those aged 65 and older below the poverty level (9.7%) (United States Census Bureau, 2010). Among Rhode Islanders age 65 and older, nearly 20% live at 150% below the federal poverty level; the median income for seniors, reported in 2015, was $38,391 with 34% of senior households having an income of less than $25,000 (Senior Agenda Coalition, 2014). Minority status could also impact social health. An illustration of its effects on social health would be the finding that minorities are underrepresented (in Rhode Island) among those involved in Title III programs of the Older Americans Act, with only 5.9% of participants being minority (Administration for Community Living, 2013b).

Healthcare utilization. Findings under behavioral health demonstrated the favorable utilization of preventative health services by older Rhode Islanders. In other areas of healthcare, utilization is less than optimal for Rhode Island seniors. The primary issues concern inappropriate healthcare utilization. In a National Healthcare Quality and Disparities report (Agency for Healthcare Research and Quality, n.d.), Rhode Island misses it benchmarks for quality on a number of targets focused on avoidable hospitalizations for diagnoses amenable to non-hospital care among Medicare patients. Mirroring the over-hospitalization of older adults in the state, America's Health Rankings pointed to the high percent of low-care patients in nursing homes as one of the state's weaknesses (United Health Foundation, 2015).

In regards to cost, less than 1% of older Rhode Islanders do not have health insurance, with the vast majority being Medicare or Medicaid beneficiaries (United States Census Bureau, 2010). According to 2014 data from the Centers for Medicare and Medicaid services (2014), the costs of health in Rhode Island are at or below the national average apart from ambulance standardized costs which are 79% above the national average. Nevertheless, in light of the level of poverty in Rhode Island, the use of more expensive forms of care, and the heightened need for care among the oldest population, these findings may mask the true burden of costs on seniors in the state.

Implications for building age friendly community. The findings on physical health confirm the pervasiveness of chronic disease and disability among the older population in Rhode Island and the difficulties they pose for self-sufficiency. Consequently, they suggest that older adults are in need of 1) information and education about prevention measures that can reduce risks of developing these conditions (such as heart disease and cancer), 2) increased awareness of and access to self-care programs that foster successful management of disease (such as diabetes and high blood pressure) and 3) expanded home and community based care programs that enable older adults to age in place when they are no longer able to do so independently (including support for caregivers of those with cognitive or physical deficits). The findings on behavioral health further corroborate the importance of behavioral modification strategies for seniors to maintain a healthy weight, engage in more physical and leisure activity, and avoid falls, thereby reducing the probability of disease and injury (or at least delay their onset). These recommendations dovetail with the age-friendly spheres of health/community and communication/information but additionally demand tailoring interventions to the underserved populations of poor, minority, and less educated older adults to reach a wider audience and enhance their implementation. The evidence on social health demonstrates that the domains of social participation and civic engagement within the age-friendly model also have to be fostered in order to counteract the isolation and inactivity seniors may experience. Efforts that expand the daily social interactions of elders who live alone and provide opportunities to participate in activities outside of the home would help address the social health inadequacies. Finally, an age friendly agenda that incorporates these goals and institutes best practice models to achieve them could play a role in reducing or delaying the recourse to institutionalization that inappropriately dominates health and long term supports and services utilization among older Rhode Islanders.

PART 2: VOICES OF OLDER RHODE ISLANDERS

With the assistance of a small grant from the Division of Elderly Affairs, and another source, ten focus groups were conducted across the state by Professors Marianne Raimondo and Connie Milbourne and Susan Bouchard, a graduate student. A total of 111 adults between the ages of 50 and 97 years old participated in the groups. There were 21% males and 79% were females. A list of focus group locations is found in Appendix B.

Highlights of findings from focus group participants and the specific strategies they offered to address areas of concerns are presented below. Many of the suggested strategies are encompassed within the strategies recommended by the Subcommittee.

Communication and Information

- Need for finding and difficulty in finding information about available services
- Participants were not aware of "THE POINT" or the services provided
- Participants, case workers and senior center employees consistently reported difficulties with accessing the Department of Human Services (phone calls not being answered, phone calls not being returned, inaccurate information being provided and a lack of customer service)
- Senior centers currently offer informational sessions; however, they are not accessible to older adults with no means of transportation
- Community Information Specialist at the senior centers helpful but not always available
- Some concerned about sharing personal and financial information with professionals at the senior center, fearing a breach of confidentiality
- Would like information on taxes (homestead freeze), legal services, reverse mortgages, financial planning, end-of-life planning (advance directives), etc. Website not always preferred source of information as many do not have computers
- Children and caregivers also need information about financial and end-of-life planning, recognizing private attorneys and accountants are unaffordable

Recommended Strategies

1. Work with local newspapers to create a dedicated column on information for older adults
2. Use traditional media (radio and television) to provide information to older adults
3. Develop an "Angie's List" like resource for older adults – hard copy and online
4. Cities and towns, businesses, and health service entities could sponsor programs that are open to the general public and cover topics important for seniors, such as Medicaid eligibility, financial planning, legal services, reverse mortgages, end-of-life, etc.
5. Create a statewide website just for older adults
6. Sponsor "Social Service Malls" where multiple social service agencies participate in a one-stop/one-day shopping event such as one done at the Edward King House in Newport

Transportation

- Older adults emphasized their need for transportation to physician offices, grocery stores, drug stores, the library, etc.
- Transportation was one of the most significant problems identified in all focus groups in all geographic regions of the state
- Respondents concerned over the expense of transportation, recognizing the increased fare for public transportation and the cost of the RIDE system ($4.00/one way)
- Many problems with the reliability and availability of the current LogistiCare system were identified including:
  - Buses/vans not picking up at senior housing complexes
  - Buses/vans arriving late for pick up, resulting in late or missed medical appointments
  - Buses/vans not picking up at convenient locations i.e. a long walk for older adults
  - Buses/vans being delayed in picking up riders after medical appointments; some spoke of being stranded at physician offices for two hours or more waiting for their ride
  - Modes of transportation being inconsistent so that older adults are confused as to who is picking them up. At times taxis are used, other times ambulances, and other times a van

- Ambulances are sometimes used for routine transportation which is embarrassing and uncomfortable for older adults.
- Drivers do not always assist older adults with physical limitations to get into vehicle
- Rural areas (Richmond, Hopkinton, Exeter, Charlestown) were especially vocal about their need for transportation.

- Older adults value their ability to shop for themselves, seek medical care, attend religious services and socialize. One of their greatest fears is to lose their independence and become isolated and trapped in their home

Recommended Strategies

1. Consider the utilization of school buses to transport older adults during the hours when they are not in use transporting school children
2. Provide an Uber system in the state that serves older adults
3. Find a way to fund a van/bus for all senior centers
4. Expand hours that senior center vans operate so that members can participate multiple activities (beyond meals)
5. Reinstitute free passes for older adults on public transportation

Economic Security

- Participants shared grave concerns about their ability to finance their own homes and pay for rent as they age
- Most desire to remain in their home but struggle to keep up with rising property taxes, home repair and maintenance, and the ability to afford mortgages when medical expenses increase
- Some participants interested in Assisted Living communities but rent may not be affordable

Recommended Strategies

1. Freeze city/town taxes for adults over 65 years of age, as some cities/towns currently do
2. Provide financial services (perhaps through senior centers, volunteers from the business community) to help seniors with financial planning, paying bills, and financial oversight
3. Create partnerships with schools, colleges, churches and community service groups so adolescents and young adults could provide services to seniors living in the community

Community and Social Engagement

- Participants were extremely positive about their senior center experiences and the many activities and benefits offering such comments as: senior centers "are my home away from home," "keep us alive," "the senior center was my therapy when my husband died."
- Many participants talked about loneliness or isolation as children and relatives lived out of state and they had no family nearby to provide support. Others shared the difficulty of living along after losing their spouse. This isolation can lead to depression, anxiety, and other mental health problems, which can be related to the progression of chronic diseases
- Participants expressed fear and worry about being alone in an emergency situation or as their health and functioning declines. Many commented "I don't know what to do if something

happened" "What will I do if I get sick?" "Who will be available to help me?" "What if I broke my leg? Who would help me?"

- The greatest fear expressed was the loss of independence. Young seniors said they were doing everything they could to stay healthy (e.g. exercise), however, older seniors with increasing health problems worried about their future and their ability to remain in their home

Recommended Strategies

1. Promote senior center offerings in the communities to increase awareness among older adults.
2. Expand and enhance senior center offerings to include more intergenerational programs, musical performances, dances, theater, painting, etc.
3. Create inter-generational programs with local colleges and universities (RIC, URI, CCRI, Brown University, JWU, Providence College) where students could engage in programs/activities with older adults or provide services to older adults, such as yard work, home maintenance, housekeeping, help with medication management, social activity and others.
4. Implement daily "check in" program using volunteers (perhaps through cities and towns) to assure older adults safety
5. Develop programs with schools, youth programs, churches, other community organizations where volunteers could provide services to assist seniors (yard work, house repair, etc.)
6. Encourage Assisted living communities to offer programs/activities for older adults who live in the community to engage them in social/cultural/recreational events

Volunteerism

- Older adults are interested in volunteer opportunities
- Many seniors volunteer at their senior centers and others shared that they are interested
- Older adults expressed a strong desire to share their life experience, knowledge, and skills with others and to work against "ageism" and being treated as unintelligent and incapable of contributing to their community

Recommended Strategies

1. Develop a program between senior centers and the court probation system where older adults oversee the community service hours of adolescents and young adults and provide mentoring
2. Increase participation of seniors in the Volunteer Ombudsman program
3. Provide opportunities for older adults to volunteer at local animal shelters, hospitals, tutoring school children especially for those for whom English is a second language. While older adults could help children with reading and writing, the children will be providing meaningful relationships and companionships for the seniors

Nutrition Assistance - Food Security

- There was mixed feedback about the quality of meals offered through the senior centers but all valued the socialization of eating meals with others
- At some senior centers, participants were very satisfied; however, at other centers, there was great dissatisfaction with food quality, food choices and food preparation
- Many shared had tried the Meals on Wheels program but were not satisfied with the food

Recommended Strategies

1. Improve the quality and desirability of food served at senior center meal sites
2. Improve the quality of the Meals on Wheels food
3. Increase communication among seniors about food pantries and provide transportation
4. Develop programs with local colleges/universities where students could assist in preparing meals for older adults (i.e. Johnson and Wales culinary program)

Housing

- Focus groups revealed many older adults are struggling to maintain their home as they age
- There is a need for homemaker services, home maintenance and repair, yard work/snow removal and companionship
- Problems were reported with current home-based services including unreliability of caregivers, inconsistencies and lack of competency of staff, and dissatisfaction with services provided
- Others said they cannot afford to pay for these services and do not qualify for the Co-Pay
- Concerns regarding the safety and security of those in elderly housing, as 24-hour on-site security/monitoring is not provided. Residents feared problems with theft, rowdy and noisy parties, and alcohol/drug use among younger residents. This was especially problematic in subsidized housing complexes, with mixed population of younger, disabled and older adults
- Sanitation problems in some housing complexes including roaches and bed bugs

Recommended Strategies

1. Consider subsidized housing exclusively for older adults. (advocate for policy and legislative change)
2. Provide on-site, staffed 24-hour security/surveillance in housing complexes where older adults reside
3. Encourage the development of more innovative models of housing in Rhode Island, for example the Village concept which is currently operational in Providence or the Greenhouse model developed by the St. Elizabeth community
4. Expand Medicaid support of Assisted Living for low income seniors

Healthcare Coverage and Access

- Participants in focus groups discussed an age-related bias prevalent among healthcare professionals and healthcare organizations. They described being treated as if they were ignorant and unintelligent patients in healthcare organizations which was perceived as

compromising the level of care they were receiving because the healthcare professionals were being dismissive
- Concerns about the cost of healthcare were raised. For example, some participants shared that they forego medication to pay for food or rent, others shared that they were putting off surgery because of their inability to pay for services

Recommended Strategies

1. Develop educational programs for health-care professionals in care that is specific to older adults

Open Spaces – Public Access/Buildings

- Participants voiced several concerns related to the mobility in their environment (e.g., cracked and crumbling sidewalks in Pawtucket prevented older adults from taking walks
- Residents in parts of Providence had concerns about lack of parks within walking distance where they felt safe and that sidewalks were not adequately cleaned after snowstorms
- A particular concern was raised by the residents of the St. Elizabeth Home in Providence. The local bus stop that they had been accustomed to was moved to a new location that was inconvenient and unsafe for older adults

Recommended Strategies

1. Move the bus stop closer to the St. Elizabeth residents in Providence
2. Engage cities and towns in repairing sidewalks and promoting safe streets
3. Create a map of parks and walking areas to identify space that would be appropriate for older adults walking, exercise, recreation and leisure

PART 3: KEY DOMAINS AND ISSUES

3.1. COMMUNICATIONS & INFORMATION

Why is this Important?

Getting timely, accurate information to help manage life, stay connected to the community and meet personal needs is essential for healthy aging. This is especially important for persons who are looking for support services or benefits for themselves or for persons they care for that would help them remain in the community and/or be more economically secure.

Current Services:

The Rhode Island Information/Referral and Counseling Program

In 2005, with the help of federal funding, the Department of Elderly Affairs (now a Division) started its Aging, Disability and Resource Center (ADRC) called THE POINT. Since March 2010, THE POINT has been hosted and managed by United Way 211. The program receives no state dollars for operations and dedicated federal funding has ceased. It has evolved from a single

call-in, walk-in site to a delivery system using a network of agencies that provide information, referral and counseling services to elders, caregivers and adults with disabilities. Services are provided by phone or in-person. Screening for program eligibility is done, but not the actual eligibility process. The state's Senior Health Insurance Program (SHIP), the Senior Medicare Patrol and the community Information Specialists are integrated into a POINT network that includes 25 entities. The United Way operates the primary POINT program. Other network participants include the Division's contracted case management agencies which serve as regional POINTS, regional POINT partners at senior centers and other service agencies, the Ocean State Independent Living program, and the long term care office of the Department of Human Services. Both the state and federal government promote Options Counseling as a way to promote home and community-based and person centered-care. To train staff to provide this service, the state conducted a four-month training program for its integrated POINT program and included staff from the Veterans Administration and the RI Parent Information Network. The POINT does not have its own website; however, the Division of Elderly Affairs reports that the goal is to have one constructed. In Federal Fiscal Year 2015, 55,000 contacts were made to the central POINT and 11,000 contacts to Regional POINTS.

Division of Elderly Affairs (DEA) Communications

To keep the public informed of pertinent issues and events related to the older population, in 2015 the Division started to distribute an e-newsletter and publishes frequent articles in a column called "Taking Charge," in the Providence Journal, Rhode Island's only statewide newspaper. For many years, the Division has also published a useful Pocket Manual of Elder Services. The Division does have a website but it has not been kept updated on a routine basis. The Division website is undergoing revision and the revised website should be available in the spring/summer of 2016.

Challenges – Service Gaps – Resource Needs

- Despite the fairly extensive network of POINT partners, focus group participants report confusion about where to obtain information about services. Also, the service delivery system is fragmented. For example, while POINT partners may help with filling out applications for various benefits such as Medicaid, eligibility determination is typically done by Department of Human Services. Further, key informant interviews and focus groups revealed major problems with customer service at DHS, including phone calls not being answered, inaccurate information being provided and uninformed and impolite staff. The state has attempted to bring a "One-Stop" philosophy or "No Wrong Door" to the system, but this goal has yet to be fully achieved.
- Community-based case managers experienced problems with THE POINT services, including inappropriate referrals and inadequate screening. Further, POINT staff do not have knowledge of what Community Action Programs provide.
- The vision of the ADRC serving as the One Stop/Statewide starting point for elders and adults with disabilities will require a greater investment of resources. The ADRC has the potential to be a major resource for discharge planners, case managers, community social workers and family caregivers. Case Management agencies carry large caseloads of Medicaid and Co-Pay eligible clients, often leaving little time for assessment and options counseling

for folks who do not meet eligibility for public programs. The staff of agencies partnering with THE POINT/ADRC have indicated a need for specific training to assist private pay clients. Training in this area needs to be ongoing.

- THE POINT network does not operate using a system-wide electronic database directory of services to provide information. The Division of Elderly Affairs does hold periodic Training Academies for THE POINT network staff to keep them updated on new services and program changes. This is not a substitute for a continuously updated electronically available directory for persons delivering information and referral services.
- THE POINT does not offer an online interactive consumer resource guide to services. As older adults become internet savvy, a web-based resource specific to Rhode Island with an easily used navigator function is essential.

Recommended Strategies

- **Create an interactive web site for THE POINT** as a "one-stop" link to consumer information about aging, disability and long term care support services to include a consumer/caregiver assessment guide and navigator to help persons determine what services may be helpful to them or a care recipient and a benefits screener to enable them to quickly find out what benefits they may be eligible for. This could be linked to the state Bridges system under development that will do online eligibility for Medicaid and other assistance programs. An excellent example of this type of website is the Minnesota InfoLink-Seniors (https://www.minnesotahelp.info/SpecialTopics/Seniors).
- **An assessment of ADRC** systems and services should be conducted to determine how screening and referral services could be improved.
- **Enact a specific ADRC enabling statute with a state appropriation** of $250,000 in General Revenue for administration and service expansion, including the capacity to do in-person Options Counseling and to add a chat-type internet-based service for consumers to get real-time information.
- **Co-locate staff from the Department of Human Services long term care eligibility offices in POINT programs** with the highest demand to assist in preparing Medicaid eligibility applications and to assist with the state mandated Options Counseling service. This will help decrease fragmentation experienced by consumers.
- **Provide Options Counseling staff with permissions to access to Medicaid client information** which will allow them to provide assistance in real time.

3.2 TRANSPORTATION

Why is this important?

The ability to get to where one needs or wants to go at a time when one needs to get there is a key factor for successful Aging in Community. When seniors can no longer manage to drive on their own or to maintain a car, they often turn to family and friends for transportation help but, for a number of reasons, that is not always a sustainable option. Research findings suggest that

after age 70 older women may spend 10 years dependent on others for transportation and older men seven years (Foley, Heimovitz, Guralnik, & Brock, 2002). By age 75 one-third of Rhode Islanders do not have drivers' licenses (Senior Agenda Rhode Island, 2008).

Having to stop driving is a huge fear of most seniors who have been lifelong drivers. Stopping driving raises serious issues of social isolation, a social determinant of health and longevity. It is a special concern for the many seniors no longer able to drive who have chronic conditions needing transportation to multiple healthcare appointments and those with ambulation, physical or cognitive difficulties who are not able to use the state's public fixed-route or paratransit systems. Transportation availability impacts most of the issues addressed in this report – healthcare access; community and social engagement; food security; and use of open spaces, parks and public venues. Rhode Island needs to develop and fund an affordable and accessible public transportation system. And, as the state's population ages, increasing transportation options for those with mobility needs must be a top priority to promote Aging in Community.

Current Transportation Options

Walking

Walking is the second most popular means of travel for seniors after travel by car (AARP Public Policy Institute, 2011). However, a national study found 14% of persons ages 65 to 74 had difficulty walking a quarter of a mile as did 28% of persons age 75 and over (Centers for Disease Control, 2014). Walking as a means to conduct errands or engage in social activities is not an option for the many seniors with ambulation difficulties, those who live in areas with poor walkability features (lack of sidewalks, poorly designed pedestrian crossings, etc), and during periods of inclement weather.

Walk Score (https://www.walkscore.com/cities-and-neighborhoods/) provides information on a geographic area's walkability and transit friendliness. A score above 69 means the city is very walkable; between 50 and 69, somewhat walkable; and lower than 50, mostly car dependent. The chart below shows four of the state's most populated cities as car dependent meaning most errands would require a car. Based on 2010 US Census data, there are close to 40,000 seniors residing in these four car dependent cities. The transit scores show how well a location is served by public transit. An area would need to score above 50 to be considered as "good" transit. For transit friendliness, Providence scored the highest at 48 but all others were found to have only some transit availability with Westerly having only minimal transit options. While several of these cities offer some level of senior transportation, Providence, which has the largest number of persons age 65 plus and the highest poverty rates for seniors, does not provide any city-supported transportation services for seniors.

Walkability and Transit Friendly Scores for Most Populated RI Cities

City	Zip Code	Walk Score	Transit Score	Bike Score	65+ Population
Central Falls	02863	78	36	--	1,684
Providence *(the largest city in Rhode Island)*	02909	76	48	67	15,504
Pawtucket	02860	65	38	--	8,992
Newport	02840	61	33	--	2,510
Woonsocket	02895	51	28	--	5,448
Cranston	02920	48	31	--	12,305
East Providence	02914	47	29	--	8,632
Westerly		34	4	--	4,241
Warwick	02886	30	26	--	14,144

Source: https://www.walkscore.com/cities-and-neighborhoods/

Rhode Island Public Transportation Authority

The Rhode Island Public Transportation Authority (RIPTA) provides fixed route transportation, a Flex Service and operates the state's Americans with Disabilities (ADA) paratransit program. The FY2016 budget of $106 million is supported by a combination of state gas tax, farebox revenue and federal funds with gas tax the largest revenue source. RIPTA operates 55 different fixed routes, a Downcity Loop and 10 Flex routes. It provides 3,000 daily trips. All fixed-route buses are wheelchair lift or ramp equipped. Flex Service operates Monday thru Friday and offers passengers the option of calling for a ride or picking up the Flex Vehicle at one of its regularly scheduled Flex Stops. The Flex Vehicle, typically a 16 passenger vehicle with space for two wheelchairs, travels within a geographically-limited zone known as a Flex Zone. Each Flex Zone represents a suburban or rural area that has little or no fixed-route bus service. The Flex Vehicle travels within the Flex Zone, picking up and dropping passengers off within the zone and connecting them to fixed-route bus service for travel outside the zone. One-way fares for both fixed route and Flex Service are $2.00 with multi-day and monthly passes available (http://www.ripta.com/).

Discounted RIPTA Fares

As required by federal law, seniors and persons with disabilities are eligible to pay half-fare ($1.00) on fixed and Flex routes during non-peak hours. RIPTA reports 436 seniors and 78 persons with disabilities with these designated passes. Low-income seniors and persons with disabilities can purchase a pass allowing them to ride fixed route and flex routes at no fare. RIPTA reports 6,980 seniors with no-fare passes and 17,760 persons with disabilities (personal communication, 2016d). The majority of the discounted trips are on the "R" Line traveling on Broad and North Main St. in Providence and the Cranston Street Routes (personal communication, 2015). State legislation enacted in 2015 permits RIPTA to eliminate the no-fare rides. RIPTA reported it had experienced a decline in revenues when LogistiCare (LGTC), a new transportation broker for Medicaid funded Non Emergency Medicaid Transportation (NEMT) and the Elderly Transportation Program (ETP), took over in May 2014 and RIPTA was no longer

the exclusive provider of services for these services (http://www.ripta.com/). The RIPTA board proposed instituting elimination of the no-fare program beginning in January 2016 and charging half fare ($1.00). At the urging of advocates the Governor directed the change put on hold until July, to set a $.50 fare and to try to identify funds to continue the no-fare program (Anderson, 2015). Legislation has been filed in the 2016 legislature to restore the no-fare program to its prior status (H7937 and (S2685).

ADA Paratransit

Under federal law, RIPTA must provide paratransit services (a flexible shared ride service not following fixed route or schedule) within three-quarters of a mile from a public fixed route (both pick-up and drop-off points). Persons must complete an application signed by a health professional to determine if they are eligible because a disability prevents them from using a regular fixed route. One-way fare is $4.00 and if a person uses a personal care assistant no fare is charged for the assistant (http://www.ripta.com/).

The Elderly Transportation Program (ETP)

The RI Department of Human Services administers the ETP which, since May 2014, has been managed under contract with LogistiCare (LGTC). The program was transitioned from the Department of Elderly Affairs in 2009 and RIPTA formerly served as both a broker and service provider for the program. The ETP provides trips to special medical appointments, general medical appointments, adult day programs, congregate meal sites and the In-Sight program for visually impaired elders. The program is subject to available funding and not an entitlement. Rider fee is $2.00 per one-way trip although not all providers ask for the fee which is kept by the provider and the fee is not charged for trips to adult day programs. LGTC data show the number of elders using the program increased from 1,319 unduplicated persons in July 2014 to 1,761 in January 2016. For the month of January 2016, a total of 13,240 trips were made. Dialysis trips accounted for 31%; adult daycare trips, 20.5%; medical specialists, 14% and meal sites, 13% (Personal communication, 2016b).

To offset the cost of the ETP and the discounted bus fares for seniors and persons with disabilities, in 1993 legislation was passed to dedicate 1-cent per gallon of gas tax revenue for these services. A Memorandum of Understanding between RIPTA and the Office of Health and Human Services directs the allocation of these gas tax monies. Estimated yield of the 1-cent in 2016 is $4,428,470. Of this, 21% (up to $929,980) is dedicated to the Department of Human Services for partial funding of the ETP under contract with LGTC and 79% (up to $3,498,498) to RIPTA to partially subsidize RIPTA's elderly/disabled reduced fare program, partially subsidize the ADA paratransit program and provide match for paratransit vehicle purchases and maintenance (Personal communication, 2016b).

Medicaid Non-Emergency Medical Transportation (NEMT)

Since May 2014, NEMT (formerly provided by RIPTA) has been provided by LGTC under a state contract. Medicaid enrollees able to walk a one-half mile and understand common directions and signage are expected to use regular bus routes if they live within one-half mile of a bus stop and the medical provider is within one-half mile of a bus stop. Rides generally must be booked 48 hours in advance and a 15 minute window before and after scheduled pick-up time

is the performance standard (https://memberinfo.LogistiCare.com/rimember/FAQ.aspx). LGTC uses a variety of providers including taxis, the RIPTA paratransit vans and ambulance companies. Transitioning from RIPTA being the exclusive paratransit provider using its fleet of wheelchair accessible vans to LGTC with a variety of vendors and vehicles had a problematic start, and problems continue. Complaints about late and no-show rides, insufficient providers, lack of sensitivity for dealing with an elder and disabled population and expectations for persons to use regular bus service was consistent. In response, the Alliance for Better Long Term Care instituted monthly open meetings with LGTC management and state oversight staff at which complaints and issues could be brought up by the public and care providers and remedies sought. In addition, the Alliance has organized and conducted a number of trainings for LGTC drivers to increase understanding of rider needs. LogistiCare has reported that the ratio of complaints to number of trips has decreased and the provider network has expanded; however focus groups and key informant interviews revealed that major problems exist with LogistiCare services throughout the state.

Accessible Private Taxi Service

With the assistance of federal funds, 13 wheelchair accessible taxis were purchased by local taxi companies and they serve 17 RI communities and TF Green Airport. Standard fares are charged and there are no discounts (http://www.ripta.com/).

Municipal Senior/Disabled Transit

A number of Rhode Island municipalities offer some transportation assistance to seniors and persons with disabilities. These local programs vary greatly in what types of trips are provided, frequency of operations, vehicle capacity and passenger fees. Most only provide service within the local area. (See Appendix C for list)

Volunteer Programs

Several community-based transportation programs using volunteer drivers also operate in Rhode Island. A sample list of these programs is found in Appendix C.

Challenges – Service Gaps – Resource Needs

- RIPTA's routes are predominantly designed to serve commuters. They bring commuters into the Providence metro area from the suburbs. To reach shopping and other venues in their own town by bus non-commuters often must take a circuitous trip into Providence on one line and back to their town on another. For example North Kingstown residents, including many living in senior housing, can only reach a local Walmart that is less than three miles away by taking a half-hour bus trip to downtown Providence and transferring to a return trip on a different commuter line that stops at Walmart. There are countless examples of this experience.
- Elderly Mobility Study Outdated. RIPTA in collaboration with the Department of Human Services conducted a Human Service Transportation Study in 2010; however, the data was from state FY2009, and it has not been updated since then (RIPTA, 2010). The need for transportation alternatives for seniors no longer able to drive will grow as the state's older population increases. Additional public and private resources will be needed to meet the demand. The state lacks a coordinated approach to data collection to determine current use of

the various public, volunteer and private transportation services available for persons age 65 and over, the cost per type of service and geographic areas of greatest need.

- RIPTA is considering eliminating no-fare bus rides for low income seniors and persons with disabilities which will present financial hardship for many who either do not drive or can not afford to maintain a vehicle and depend on the public bus system for their transportation.
- Complaints regarding dissatisfaction with LogistiCare service continue to be voiced. LogistiCare has not conducted Rhode Island specific consumer surveys nor organized a formal consumer advisory board. Both of these requirements appear to be part of the contract with LGTC, but have not been implemented. .
- Several municipalities and volunteer programs provide some transportation assistance for seniors but they may limit service to certain geographic areas or not have the resources to meet demand. For a number of years, state community service grants were awarded to several senior volunteer programs which offered transportation assistance. However, since FY2007 these grants have decreased. For example, in FY2006 Seniors Helping Others (now known as Southern RI Volunteers), which provides some volunteer transportation, received $30,375. In FY2016 their grant amount is $10,389.

Recommended Strategies

- **Conduct a comprehensive senior transportation/mobility needs study including review of options such as Uber for seniors and use of school buses when not in use.** Potential sources for the study include federal funds and foundation grants. The study would examine the mobility needs of the state's elderly population, identify best practices for more responsive senior transit, estimate needed resources to help meet the projected demand and design a coordinated transportation data system. In its 2010 report, *Funding the public transportation needs of an aging population* (Koffman, Weiner, Pfeiffer, and Chapman, 2010), the American Public Transportation Association projected the demand needs for mobility services for the nation's growing older population no longer able to drive and the costs needed to meet the demand. This study could serve as a model for Rhode Island. The Statewide Planning Office has commenced the process for rewriting the State Transportation Plan. This presents an ideal opportunity for using federal funds to conduct an Elderly Mobility Study and should be a priority.
- **Retain free bus fare program for low-income seniors or alternate way to provide no-cost rides through vouchers or other means.** Persons using this program tend to have very little discretionary income and public transportation may be their only available option for personal trips such as grocery shopping, getting to work and going to support groups such as AA. Information from RIPTA shows the vast majority of the trips are made on routes in or near Providence areas with high percentages of persons living in poverty.
- **Require Consumer Input for LogistiCare Performance**. The state should require LGTC to create an independent Consumer Advisory Committee to receive consumer input regarding program performance and to review complaint investigation. Customer satisfaction surveys by an external entity to identify areas needing service improvement should be conducted periodically.

- **Promote Volunteer Transportation Services.** Volunteer programs operate successfully in several parts of the state including southern Rhode Island. Program managers are interested in expanding to other areas. State community service grants to expand volunteer transportation programs into areas not adequately served by municipal transportation programs should be appropriated in the state budget. Funds could be used to support stipends for mileage, for purchasing trip scheduling software and for program administration. Volunteers could also serve as escorts for seniors who need assistance navigating to and from a vehicle and at their destination location. Central coordination and administration of these programs should also be explored. To address any concerns about legal issues potential volunteers may have, the state "Good Samaritan" law should be reviewed.
- **Create Transportation Locator website**. To assist seniors and persons with disabilities to locate appropriate public and volunteer transportation services, the state should create an interactive Transportation Locator website. This could be part of a revamped DEA website.

3.3. ECONOMIC SECURITY

Why is this important?

Having sufficient income in one's older years to pay for necessary food, housing, health, transportation and other basic needs is essential for a senior's well being and quality of life. One national study found that more than half of fully-retired Rhode Island elder-only households were economically insecure based on a basic elder standard of living index. The study found that with a median income of $18,034, a single retired woman had an income gap of $7,412 to meet estimated living expenses of $25,176 (Wider Opportunities for Women, 2013). Low income seniors struggle with rising housing and healthcare bills, inadequate nutrition, lack of access to transportation and diminished savings. For many who are economically secure today, one major adverse life event such as the need for prolonged long term care assets saved for "old age" are quickly depleted.

Rhode Island 65+ Household Income (N=98,061)

# Hshlds			# Hshlds			# Hshlds		
Less than $10,000	7,951	8%	$40,000 to $49,000	8,379	8.5%	$100,000 to $124,999	5,267	5%
$10, 000 to $19,000	18,804	19%	$50,000 to $60,000	6,446	6.6%	$150,000 to $199,999	3,212	3%
$20,000 to $29,000	14,917	15%	$60,000 to $75,000	8,045	8%	$200,000 or more	2,977	3%
$30,000 to $39,000	10,209	10%	$75,000 to $99,999	8,748	9%			

Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates

According to the 2014 American Community Survey, close to one in ten (9.7%) of older Rhode Islanders had income below the federal poverty level (FPL). But the FPL does not give a complete picture of how many elderly Rhode Islanders lack sufficient resources to meet basic needs. The following chart shows what it costs for seniors to pay their basic bills.

RHODE ISLAND ELDER INDEX

	Single Woman			Couple		
	Owner w/o Mortgage	Owner w Mortgage	Renter	Owner w/o Mortgage	Owner w Mortgage	Renter
Housing	$653	$1,556	$906	$653	$1,556	$906
Food	252	252	252	463	463	463
Transportation	267	267	267	413	413	413
Health Care	398	398	398	796	796	796
Miscellaneous	314	314	314	465	465	465
Monthly	$1,884	$2,787	$2,137	$2,790	$3,693	$3,043
Annual	**$22,608**	**$33,444**	**$ 25,644**	**$33,480**	**$ 44,316**	**$36,516**
2016 FPL 100%	$11,880	$11,880	$ 11,880	$16,020	$16,020	$16,020
2016 FPL 200%	$23,760	$23,760	$23,760	$32,040	$32,040	$32,040
2016 FPL 300%	$35,640	$35,640	$35,640	$48,060	$48,060	$48,060

Source: Wider Opportunities for Women. Elder Index @ http://www.basiceconomicsecurity.org/EI/location.aspx. retrieved April 20, 2016

As the above chart shows, single persons and couples who are renters or homeowners without a mortgage need near or above twice the federal poverty level just to meet basic needs. Couples and singles still paying a mortgage need close to three times the federal poverty level for basic expenses. In 2014, about one in three (34%) of seniors had income below twice the poverty level.

Social security is the most important source of income for many seniors. About one in three state retirees rely solely on Social Security income for their support and 22% rely on Social Security income for more than 90% of family income (AARP, 2014). Yet the average yearly Social Security benefit in 2014 of $18,432 for men and $14,340 for women was significantly below twice the poverty level - the level that the Standard of Need suggests seniors need to meet basic needs (150% FPL for men; 120% FPL for women) (Social Security Administration, 2015).

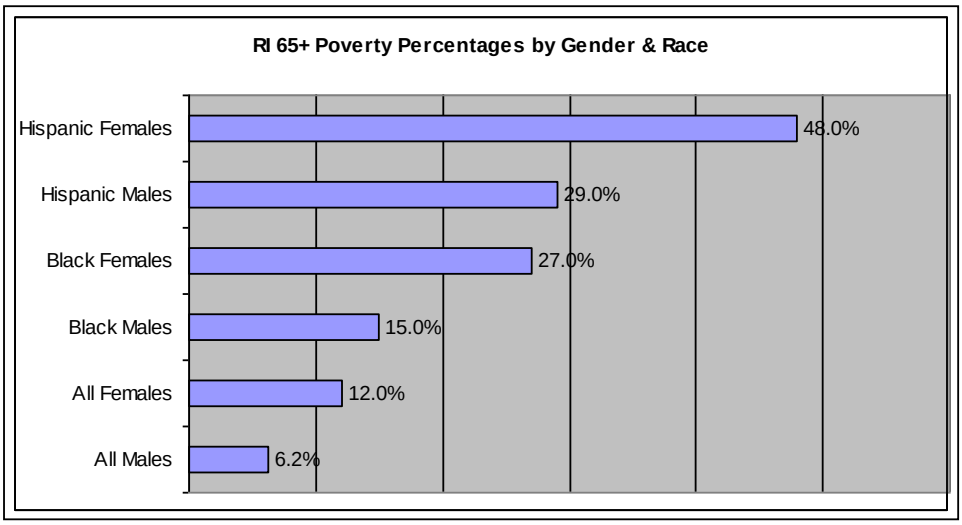
In 2014, 37% of older Rhode Island households had earnings (mean earnings: $58,813) and 49% had retirement income other than Social Security (mean: $24,530). The fact that slightly over half reported no retirement income (non-Social Security) has consequences for Rhode Island seniors' long term economic security.

Income disparities in the older Rhode Island population exist for age, geography, gender, and minority status. US Census data shows 24% of persons age 65 to 74 years in the state and 34% for persons age 75 and over have income below 200% of the FPL(U.S.Census Bureau, 2015).

Older Poverty Levels by RI County

RI COUNTY	Persons 65+	% below 100% FPL	% above 150% FPL
State Total	158,672	9.3	79.8
Providence	86,715	18	71.8
Kent	27,291	8.8	84.7
Washington	20,872	9.4	85.9
Newport	14,982	8.5	85.8
Bristol	8,812	7.1	85.5

Source: U.S Census Bureau, 2014c Table S0103. 5-yr estimates 2010-2014



Source: U.S. Census Bureau (2014a)

Challenges – Service Gaps – Resource Needs

- Many older Rhode Islanders may not be aware of the benefits to help them pay for basic needs for which they may be eligible. For example, a single senior with income of $14,500 and assets below $7,000 would be eligible for the Medicare Premium Savings Plan and SNAP benefits of $194/month. This amounts to $3,587 in "savings" to meet their other needs.
- Medicaid Financial Eligibility varies for different populations and between those living in the community versus those needing long term services and supports. The rules can be confusing for consumers and raise issues of fairness.
- Required Medicare Part B premiums of $104.90/month can be a financial hardship for low-income persons leaving them with inadequate income to meet other basic needs, such as food, transportation and housing.

- About 34,000 Rhode Island seniors and adults with disabilities rely on Supplemental Security Program (SSI) benefits for their survival. The federal payment is $721/month for an individual in 2016. States are authorized to supplement the federal payment and Rhode Island does so. The current state payment is $40.00 for an individual, bringing total income to $761 (23% below the poverty level). The federal benefit is indexed to inflation as was the state benefit until it was frozen at $40 a number of years ago due to budget constraints. This means that each year these very poor Rhode Islanders fall further behind since only a portion of the benefit is indexed to inflation.
- In Rhode Island, slightly less than half of seniors were estimated to have retirement income in 2014. Social Security alone is not enough to depend on. Yet Social Security is the only source of income for one in three Rhode Islanders age 65 and over. Fifty-five million Americans – 189,000 Rhode Islanders – are unable to save for retirement at work. Employees that are able to save for retirement out of regular paychecks are 15 times more likely to save.
- Rhode Island lacks detailed data to project the long term economic vulnerability of its seniors.

Recommended Strategies

- **Improve outreach for benefits counseling.** Provide adequate resources to the state's senior centers, POINT network and Community Action agencies for providing outreach, counseling and enrollment assistance for available benefit programs that help to meet basic living expenses. In July 2016, enrollment in all Medicaid programs, SNAP and a number of other programs will be accessed on-line through the new state Bridges system. Increased training and funding for agencies that serve seniors will better help older adults enroll in healthcare assistance programs and SNAP. A consumer-friendly website showing available benefits assistance programs with eligibility guidelines and on-line applications for seniors should be available on the Divisions of Elderly Affairs website.
- **Expand Medicare Premium Savings Program.** The Medicare Premium Savings program (funded by both the state and federal governments) pays for the Medicare Part B premium, and in some cases, required co-payments and deductibles. Current income eligibility in Rhode Island is capped at $16,038 for one-person and $21,627 for a couple. In addition, persons can not have more than $7,289 (individual) and $10,930 (married couple) in resources. Federal law allows states to set higher income levels for the program and eliminate or increase the resource limits; a number of states have done so. Rhode Island should expand financial eligibility for the program to assist low-income seniors to meet healthcare costs. Legislation has been introduced in the last several years, and again this year, to accomplish this, but has not passed (2016 S2151, H7123).
- **Standardize Medicaid Income Eligibility.** Persons age 65 and over who are not receiving long term care services must generally have income less than 100% of the FPL and resources not exceeding $4,000 (single person) or $6,000 (couple) - one car, a small burial amount and home are excluded as resources - to be eligible for Medicaid. The new Medicaid expansion program for persons under age 65 sets income eligibility at 133% of the FPL and there is no resource limit. This difference in income and resource eligibility is viewed as unfair by senior advocates and can create problems when a person under age 65 on Medicaid turns 65 and loses Medicaid eligibility. The state should standardize income criteria for Medicaid to

the 133% level and consider increasing the resource limit for older persons especially those living in their own homes to give them a cushion for dealing with home repair and maintenance issues. At a minimum, the state should increase the Medically Needy income limit to 100% FPL so that elders with limited income and resources, who have income above the poverty level, are able to qualify for Medicaid through the "flex test," if they "spend down" their income on medical bills. Under the current policy, seniors need to "spend down" their income to below poverty levels (80% FPL) to qualify for medical assistance.

- **Index the SSI benefits.** The state should resume indexing the state supplement to inflation.
- **Support New Research on Income Security.** Researchers at the Heller School for Social Policy and Management at Brandeis University (Meschede, Sullivan & Shapiro, 2009) developed a Senior Financial Stability Index to project long term economic stability during retirement years. When applied to Massachusetts' seniors, the researchers found 68% would face clear economic vulnerabilities with single seniors and minorities being in a much more precarious situation. High housing costs, home equity and inadequate assets were significant factors in projecting economic vulnerability. With its current high percent of older adults and projected growth in the older population, the state should work with its academic institutions to conduct similar research for Rhode Island.
- **Promote Financial Planning and Services Programs and Retirement savings accounts.** The AARP is supporting state level "Work and Save" legislation to help Rhode Islanders gain access to save for retirement at work via a state facilitated automatic IRA (Martin, 2016). The legislation, H7219, has been filed and should be carefully considered as a way to promote individual savings to help ensure economic security during retirement years.

3.4. COMMUNITY AND SOCIAL ENGAGEMENT

Why is the Important?

Senior Center participation, volunteering and employment are some of the basic ways that seniors remain connected to and contributing to the community. A large body of evidence exists demonstrating the value of community engagement in promoting health in one's older years and combating loneliness and isolation. Meaningful interpersonal relations are repeatedly cited by older adults as important to health and well-being. Volunteering is associated with better health, fewer functional limitations, lower utilization of health services and lowered mortality risk. Contributory activities can bring a sense of purpose and meaning to life as one grows older (Scharlach & Lehning, 2015).

Senior Centers

Research shows that activities and services offered at senior centers promote physical well-being, facilitate self-sufficiency, and the quality of life of seniors. Programs offered at senior centers may slow or prevent functional deterioration, help prevent fall injuries and contribute to long-term national economic and societal benefits. The meaningful social networks fostered at senior centers can help reduce the risk of depression and engagement in mental activities may help maintain cognitive health (Jacobson, O'Hanlon, and Bennett & McCloskey).

Rhode Island's 46 senior centers are a major source of social integration for seniors in the state. They serve as hubs of social and human services offering a variety of health and wellness, physical, educational, nutritional, and recreational programming as well as volunteer opportunities. Some of the programs include tai chi, yoga, aerobics, cooking classes, support groups, and art and language classes. Senior centers also provide opportunities for day trips and travel for shopping, sightseeing, sports events and performances. They respond to their diverse needs of older adults in their communities, providing information on healthy aging, resource referrals, and support for caregivers. Senior centers vary in size and program offerings and may be a part of municipal government or operated by a non-profit agency. Thirty-two senior centers serve as congregate meal sites. Many serve as shelters and warming centers in emergencies. Transportation may be provided by senior centers. Some of the larger communities provide the most comprehensive transportation services, while smaller centers only provide transportation for special trips. Funding sources vary and may include municipal support, state community service grants through the Division of Elderly Affairs, federal Older Americans' Act funds, Community Development Block grants, member fees and private funds. Senior centers are at the center of the delivery system of information and assistance for older adults to age in the community with fifteen serving as POINT community partners.

State Funding

Some funding for Rhode Island's senior centers is provided from the Division of Elderly Affairs based on allocations for Community Service grants directed by the state legislature in the annual state budget. Funding is based on historical amounts supported by local legislators. As of 2015, nine communities did not receive funds for senior center programming. From FY2006 to FY2015, the aggregate amount of the community senior center state grants decreased from $860,786 to $358,494. Some senior centers also receive small grants directly from the state legislature in the form of legislative grants. In 2013, 2014 and 2015, legislation was introduced to distribute the community services grants for community senior services based on a formula using US Census data for the number of persons age 65 and over in a community. The legislation has not passed the general assembly. In her proposed state budget for FY2017, Governor Raimondo included an additional $600,000 in additional support for the state's senior centers.

Related State Rankings: The America's Health Senior report ranked Rhode Island 39th in social support for seniors and 44th in expenditures captured by Administration on Aging divided by number of persons 65+ living in poverty. It ranked the state 47th in volunteerism (18.5%), 42nd in chronic drinking (4.9%), 40th in multiple chronic conditions (40.2%), 36th in physical inactivity (34.9%) and 35th in depression (16.3%) (United Health Foundation, 2015).

Challenges – Service Gaps – Resource Needs

- Results of a 2015 survey of the state's senior centers conducted by the Aging in Community Subcommittee showed the almost universal response to challenges faced by the centers were inadequate funding with tightening of government budgets, inability to increase staff to expand services and meet demand for social services and the ability to respond to a new generation of baby boomers coming of age. Results suggested a need to change the name from Senior Center to Community Resource Center or Center for Health Aging to make programs more appealing. Some centers have changed names accordingly.

- Accurate counts of unduplicated senior center users, or the types of services used, is not available. While DEA does collect some data for centers receiving government funds, not all centers receive state or federal funds so accurate reports are not available.

Recommended Strategies

- **Restore Senior Center Funding to FY2006 levels.** Advocate for inclusion of $600,000 in additional state funding as proposed by the Governor in the FY2017 budget to restore funds to senior centers that were cut in FY2006.
- **Create formula-based funding program for local senior services based on population of older persons**. This will ensure all communities receive state funds based on the population age 65 and over living in their community.
- **Encourage senior centers that receive state grants to offer, or to coordinate with the Health Department to offer, health promotion activities that focus on evidence-based fall prevention programs and increasing physical activity.**
- **Identify ways for more persons without transportation to access senior center services and to engage in community and social events and activities.**
- **Promote Inter-generational programming at senior centers and community recreational programs** for student volunteers to engage in activities with older generation and to offer services to seniors needing assistance (e.g., yard work, snow shoveling).
- **Use community-level data to plan programs and senior services.** As more detailed data by individual community on senior health and social indicators are made available, senior centers should plan programs in response to these findings. For example, senior centers might expand offerings to include dances, concerts, choral groups, bands and theater.

Volunteerism

Volunteering has significant positive impacts on the community and beneficial health effects on volunteers themselves. Volunteering among older adults age 65 and older has a positive effect on mental health due to the personal sense of accomplishment that an individual gains from their volunteer activities. Older volunteers can be found in any number of non-profit, for-profit and government entities. They deliver Meals on Wheels, serve meals at senior centers, transport elders and the disabled to appointments, tutor school children, visit nursing home residents and engage in myriad other activities.

There are three formal volunteer programs for Rhode Island seniors supported by the Corporation for National and Community Service's Senior Corps program: Foster Grandparents, RSVP and Senior Companions. In 2014-15 there were 3,574 Rhode Island seniors participating in these programs. These included ten local RSVP programs providing a wide variety of services to local agencies, three Foster grandparent programs providing tutoring to 2,100 young persons, and one statewide Senior Companion program serving 590 homebound seniors (Corporation for National and Community Service, 2015a).

Challenges – Service Gaps – Resource Needs

- While there are about 65,000 volunteers age 55 and over in Rhode Island, when compared to neighboring states, Rhode Island falls short in percent of older adults who volunteer. Nationally, the state ranks 48th among all states in its volunteer rate of 18.5%, vs. the US rate of 23%, among the 65 and older age group. Serve RI (http://serverhodeisland.org/) estimates that Rhode Island is about 24,000 short of older volunteers, when compared to other New England states. The annual dollar value of these missing contributions to the Rhode Island economy is estimated by Serve RI to be $29 million.

Recommended Strategies

- **Provide support for implementation of the Plan to Increase Volunteering among older Rhode Islanders.** To increase the number of older volunteers in the state, Serve RI has partnered with the Division of Elderly Affairs and the Senior Agenda Coalition in a planning process to: a) create a three-year plan for improving senior volunteerism and b) engage more nonprofit and government leaders and volunteers in a renewed campaign to engage more older Rhode Islanders into volunteer service. The report of this planning process is expected to be available by the end of the fall of 2016.

Employment

Service, Employment and Redevelopment (SER) focuses on the training and employment needs of the mature worker. SER is funded by the U.S. Department of Labor to operate the Senior Community Service Employment Program (SCSEP) in Rhode Island (Rhode Island Department of Labor and Training). SCSEP participants are low income persons age 55 and over. They work about 20 hours/week and are paid the state minimum wage. Priority is given to veterans, those over 65, those who have a disability, persons with low English skills and at risk of homelessness. Participants come from all walks of life, have diverse work experiences, and possess various levels of education. SER partners with local host agencies to provide participants with training opportunities to update their skills, if necessary, and works to place workers into permanent, unsubsidized and productive employment.

Challenges – Service Gaps – Resource Needs

- There may be older adults who are interested in employment, but do not have the knowledge and opportunities that may be available or how to pursue them.

Recommended Strategies

- The state Department of Labor and Training should engage senior centers as a resource for employment for older adults. For example, senior centers could serve as a clearing house for businesses interested in hiring older adults. Additionally, senior centers could offer workshops for employment-seeking older adults.
- Develop education for businesses interested in hiring older adults.

3.5. FOOD SECURITY – NUTRITION ASSISTANCE

Why is this important?

The USDA defines food insecurity as "the state of being without reliable access to a sufficient quantity of affordable, nutritious food" (Stuckhouser, Wright & Donley, 2015, p. 2). There are four key terms in that definition: access, sufficient, quantity, affordable and nutritious. Affordability has received the most attention.

In 2014, 9% of households with seniors age 65 and older in the US experienced food insecurity. The number of food insecure seniors is projected to increase by 50% when the youngest of the baby boom generation reaches age 60 in 2025. Food insecurity impacts seniors' health and healthy aging. Food insecure seniors are:

- 60% more likely to experience depression
- 53% more likely to report a heart attack
- 52% more likely to develop asthma
- 2.33 times more likely to report fair/poor health status and had higher nutritional risk. (Feeding America)

Protecting seniors from food insecurity and hunger is more difficult than for the general population. For example, food insecure seniors sometimes have enough money to purchase food but may not be able to obtain or prepare food due to lack of transportation or health problems.

Poverty and Food Insecurity

The cost of food is significant for seniors with low incomes. A single female aged 51-70 years with income at the 2016 FPL of $990/month would need to spend $256 for food (26% of income). An older couple with income at the 2016 FPL of $1,335/month would need to spend $595 for food (44.5% of income) (USDA, 2016). This can be problematic for seniors who need to pay rent/mortgages, healthcare premiums/copays, medications, etc.

State and Federal Nutrition Assistance

SNAP, the Supplemental Nutrition Assistance Program, helps seniors make ends meet and buy the food they need to stay healthy. It is the key anti-hunger federal program. Nationally, about 3.37 million older adults age 60 and over are enrolled in SNAP, an estimated 39% of the eligible older adult population. Currently in Rhode Island, there are 29,470 elder SNAP recipients which is similar to the previous year (Personal communication, 2016c). Eligibility is based on income with deductions taken for medical expenses and certain household expenses. Seniors with incomes below $1,814 (single) and $2,455 (couple) do not have to meet any resource limit guidelines to be eligible and applications can be made in person or over the phone. American Community Survey data show that an estimated 13.1% of Rhode Islanders age 65 and over had SNAP benefits in 2014. The state Department of Human Services reports that over 70% of Rhode Island Seniors receive more than the minimum SNAP benefit of $16.00 per month.

Congregate Dining, *The Rhode Island Café Program*

In 2016, the Rhode Island Division of Elderly Affairs reports that there are 54 Café Senior Nutrition Program meal sites located in cities and towns throughout Rhode Island. Select IHOP and Newport Creamery restaurants have collaborated with Meals on Wheels of RI and East Bay Community Action Program to provide vouchers to individuals who prefer dining in a restaurant setting for use at some of their locations. Ethnic meals are served at Progresso Latino, the Center for South East Asians, Temple Am David and the Jewish Community Center. A new café program to serve the LBGT community has also been started. The Café program is open to persons age 60 and over and persons under age 60 through a state-funded handicapped meals program. A voluntary contribution of $3.00 per meal is suggested but no one is turned away. A voluntary contribution of $5.00 is suggested for each Senior Nutrition Program restaurant voucher.

Six vendors prepare meals for the Café program. It is funded by a number of resources, including federal Title IIIC funding; state Community Services grants; Nutrition Supplemental Incentive Program (NSIP) allocations; participant donations; and other resources. Estimated total cost for the congregate meals program in 2016 calendar year is $3,597,197. Trend data for the past few years shows that there is a decrease in the number of meals served in the congregate meals program. From federal fiscal year 2011 to 2015, the number of meals served decreased about 12% -- from 359,221 meals to 316,513 (Personal communication, 2016f).

Home Delivered Meals: Meals on Wheels (MOW)

MOW provides a mid-day meal five days a week to frail persons age 60 and over and qualified persons with disabilities. The person must be unable to shop, cook or drive and have no one to assist them. Donations are accepted but not mandatory. In addition to the nutritional benefit offered by MOW, the person benefits from the social contact provided and "eyes on" observation of the meal deliverer. Research shows that funding MOW in Rhode Island can contribute to a delay in nursing home placement for persons with low care needs (Brown University, 2015). In state FY2015, MOW delivered 304,655 meals. Funding comes from a number of sources including the Older Americans Act, Medicaid, state community service grants and client contributions. Total program costs in state FY2015 were $2,073,848 of which about half were federal Older Americans Act funds (Personal communication, 2016e).

Other nutrition-related programs to assist seniors with nutritional needs/food security include: The Federal Commodities program, Farmer's Market Vouchers (through the Department of Environmental Management) and the Farm to Senior Program.

Challenges – Service Gaps – Resource Needs

The majority of funding for senior nutrition programs comes from the federal Older Americans Act which has essentially been level-funded for the past decade.

- Many eligible seniors may be missing out on SNAP benefits for a number of reasons. They may perceive a stigma related to "welfare" programs, they may not be aware they are eligible or know how to apply, or they believe they are only eligible for $15 in benefits.
- A reduction in state community service grant funds to MOW from $530,000 in FY2006 to $181,260 in FY2015 led to waiting list for service as high as 124 persons (July 2013). Senior

advocates called on Governor Raimondo and the legislature to restore MOW state grant funding to the FY2006 level. The Governor proposed, and the legislature approved, an additional $330,000 for MOW in the state FY2016 budget. This allowed MOW to add a Saturday meal program and to effectively eliminate any wait list.

- Persons on home and community waiver services are eligible to receive MOW and the state receives federal match for the meals. MOW reports that Medicaid payment of $4.50 does not cover the $6.50 cost.
- Lack of transportation to meal sites can serve as a barrier for many seniors. The elderly transportation program provides limited transportation to meal sites but funds are inadequate to meet any new demand. Seniors also may not be able or willing to pay the required $2/trip in addition to donating $3 for the cost of the meal.
- Older Rhode Islanders may not be aware they are eligible for the SNAP program and that under a certain income there are no asset restrictions. Also they may not be aware that the application has been streamlined and can be done by telephone.
- The decrease in participation in meal sites may be due to client dissatisfaction with food quality, choices and preparation.

Recommended Strategies

- **Target SNAP outreach.** Review communities level data and continue to target SNAP outreach efforts to lower income elders to encourage and assist them to apply for SNAP.
- **Analyze the capacity and demand for transporting more seniors to the state's meal sites.** This should be done as part of a larger study of Transportation needs of Rhode Island seniors and include impact of $2 fee required by Elderly Transportation Program.
- **Continue efforts to bring more fresh foods to homebound seniors through mobile food vans and for seniors to access food pantries.**
- **Continue to improve participant satisfaction with food served in nutrition programs.** This could be done by secret shopping at meal sites.

3.6. HOUSING

Why is this important?

Adequate housing is essential to one's safety and well-being and there is a strong link between appropriate housing and access to community and support services for the older population. Time and time again the analysis of Rhode Island's housing situation informs policy makers that resources must be redirected to offer both affordable housing and sufficient home and community-based services. This effort becomes even more critical as the population of Rhode Islander's over 65 continues to increase. Without affordable housing and effective home and community-based services long-term care expenditures escalate while consumer choice to remain living in the community diminishes.

Almost seven out of ten Rhode Island seniors live in owner-occupied housing units and 30% are renters. The state has 19,580 subsidized elderly housing units available for low-income seniors. Providence, Warwick, East Providence, Pawtucket, Cranston and Woonsocket each have more than 1,000 of the subsidized units. Rent is generally based on 30% of income (Housing Works RI, 2015).

Older Rhode Islanders Housing & Living Arrangements

Number of 65+ Households	102,237
Family households (2 or more related persons)	50.5%
Married-couple family	39.7%
Female – no husband present	8.8%
Nonfamily households	49.5%
Householder living alone	47.1%
65+ Occupied Housing Units	102,237
Owner-occupied	69.7%
Renter-occupied	30.3%
Average Household size Owner-occupied	1.95
Average Household size Renter-occupied	1.42
Owner Cost 30% or more of Household Income	32.7%
Gross Rent 30% or more of Household Income	51.7%

Source: US Census Bureau (2014c) Table S0103 RI

Challenges – Service Gaps - Resource Needs

- In a recent report commissioned by Rhode Island Housing and produced by Housing Works Rhode Island (2016), the population of Rhode Islander's age 65 and older is the fastest growing age-group in the state. While home ownership is the second highest among those 70+ (69%), they have the least earning power and the second lowest average income ($18,136).
- Housing costs burdens for seniors who are renters have risen dramatically. In 2000, 38% of senior renter households were cost burdened. This increased to 49% in 2013. And of those who were cost-burdened, one out of four was severely cost-burdened (rent is more than 50% of income (Housing Works Rhode Island, 2015). A higher incidence of housing cost burden has consequences that impact health and well-being. This is especially true for older adults and often results in unnecessary institutionalization, as basic needs go unmet.
- In addition to the cost burden, older adults who own their homes may find that their home is not well suited to meet their physical needs. Many homes have multiple levels, no first floor bathrooms and entryways with stairs. The cost of home modifications to increase accessibility may be steep and beyond home owner's resources. Home and yard maintenance may become unmanageable as people age. And procuring these services in addition to any homemaker and personal care may be unaffordable and leave one unable to age in their community safely and comfortably.
- According to Rhode Island Housing, the state has 19,580 subsidized elderly apartment units. Wait lists for tenancy varies by apartment complex and can be several years. For those apartment complexes in which both those age 62 and over and younger disabled persons

reside, there are numerous reports from seniors of being bullied by younger tenants and/or their guests leaving seniors anxious and fearful of retaliation if they complain to management.

Recommended Strategies

- **Improve access to affordable housing opportunities through centralized housing locator.** Increase coordination and streamlining of the process to access available subsidized housing opportunities by the adoption of a centralized access point for housing that includes a centralized wait list for public housing and other subsidized opportunities. Consider pursuing preference for persons wishing to transition from nursing home/institutional care through the Housing Choice Voucher Program or Low Income Housing Tax Credits that target older adults.
- **Increase awareness of available municipal property tax credits for seniors, veterans and persons with disabilities and the state Property Tax Relief Circuit Breaker** program which provides state-funded tax credit to low-income senior and disabled homeowners and renters whose property taxes exceed between 3% and 6% of their household income. For renters, property tax is calculated at 20% of annual rent. The maximum credit is $300.
- **Develop innovative models of community care and supportive housing that fit the needs of aging adults** by promoting and incentivizing partnerships among nursing home, assisted living and home care providers and housing entities. The Vermont SASH program is one such model that has had positive outcomes.
- **Provide funding and training to support the role of resident services coordinators** in providing support services and in dealing with tenant to tenant issues in mixed population housing programs.
- **Encourage universal design in housing and development of alternative housing options such co-housing** for seniors who wish to share a small housing unit and accessory apartments so seniors can live close to family members who can provide support but still remain independent in their own dwelling.
- **Promote "Village" type community programs** that offer members a menu of support services (transportation, home maintenance, homemakers, etc) to help them remain living at home. One of the first programs of this type is the very successful Beacon Village in Boston. At Home in Little Compton is an example of a Village-type model and The Providence Village has been under development in Rhode Island for several years.
- **Create or identify funds (e.g., Community Development Block Grants) to offer low-interest loans or tax credits for costs of home modifications** that allow seniors to remain living in their own homes.
- **Require 24-hour security/surveillance staff in elderly housing.**
- **Consider policy change to allow subsidized housing just for older adults.**
- **Explore how other states optimize federal funds for housing** and whether there are opportunities in Rhode Island for maximizing federal subsidies.

3.7. SUPPORTS TO REMAIN AT HOME

Why is this important?

As persons age they may experience difficulties in carrying out everyday activities due to loss of function. These activities include household tasks (e.g., laundry, housekeeping, grocery shopping, food preparation and money management and personal care (bathing, grooming and hygiene) and medication management. Getting assistance with these tasks can mean the difference between remaining in one's home or seeking care in a residential setting (assisted living or nursing home). Surveys consistently show that the vast majority of older persons say they would prefer to remain in their own home and community when they may need assistance with everyday activities. State policy also supports providing long term care and services in the least restrictive setting. Studies show that unpaid caregivers provide the vast majority of long term care services for all ages. In Rhode Island there are an estimated 134,000 unpaid caregivers providing 124 million hours of care at an estimated value of $1.78 billion. Many juggle work and other family responsibilities in addition to their caregiving tasks (AARP Research, 2015). Caregiver burdens can lead to stress that impact caregivers physically and emotionally. Policies that support caregivers are important in helping seniors to remain living at home.

Behavioral health issues among elders may significantly increase the difficulties and burdens of caregiving. Addictions to alcohol, drugs (whether prescribed or legal), depression, hoarding and other conditions, sometimes combining with Alzheimer's or dementia, often decrease elders' home and self-care ability, contribute to victimization, medical and psychiatric issues and frequently make them less able to seek services outside the home.

Current Services

Home and Community-based Services (HCBS)

Rhode Island has 55 licensed home nursing care providers and 16 licensed home care providers (Rhode Island Department of Health) to help seniors with daily activities and care needs that help them to remain living at home. The state also has 27 licensed adult day programs that offer assistance, nursing oversight, socialization and a range of activities during the day. It also has one PACE (Program of All-Inclusive Care) that provides medical and home and community care under one payment and service delivery system organized around an adult day program. Paying privately for these services can be costly for seniors with modest incomes. For example, 20 hours of home health aide services per week would cost $500/week ($26,000/year) and five days of adult day services would cost $335/week ($17,420) (Genworth, 2015).

To help lower-income seniors pay for these services and allow them to remain living at home, the state obtained Medicaid waivers to allow Medicaid-eligible persons at risk of nursing home placement to receive Home and Community Based Services (HCBS). The Department of Elderly Affairs Home and Community Care Program offers HCBS to seniors eligible for Medicaid and the Co-Pay program, for low-income persons who do not meet the strict income and resource criteria for Medicaid.

Community Supports for Medicaid-eligible Seniors

Medicaid eligible seniors may receive home and community-based services (homemaker/home aides, adult day services, assisted living, case management, emergency response equipment) if they meet both financial and clinical eligibility for long term care. They access these services from either the Division of Elderly Affairs (DEA) or the Department of Human Services (DHS). In November of 2013 the state offered elders eligible for both Medicaid and Medicare, and those with Medicaid only, the option of receiving Medicaid long term services through a managed care plan, Neighborhood Health Plan of RI (NHPRI). The state calls the program Rhody Health Options (RHO). As of March 31, 2016, there were 1,257 persons age 65 and over with both Medicare and Medicaid enrolled in RHO receiving long term supports and services in home and community settings including assisted living (NHPRI, 2016).

In FY 2015, a total of 6,504 persons age 65 and over received Medicaid-funded HCBS at a cost of $56,578,178 (not including persons in the NHPRI program). This was an 82% increase in the number of persons age 65 and over receiving Medicaid HCBS since FY2011. A slight decrease in persons age 65 and over on Medicaid and in nursing homes occurred during this time period (Rhode Island Executive Office of Health and Human Services, 2016).

Community Supports for non-Medicaid Eligible Seniors

The DEA Co-Pay program provides up to 20 hours per week of homemaker/home health aide services, adult day services and case management. Clients pay a portion of the cost based on income. Originally, only state funds and the client cost-share supported the program. It was subject to an annual appropriation and had "wait" lists on occasions when demand exceeded the budget allocation. In 2009, the state received approval from the federal government to allow the state to get federal matching funds for the Co-Pay program. The support of federal funds which typically matches 50% of the cost has helped to maintain the program.

To be eligible for the Co-Pay program, persons must be age 65 or over, homebound, need assistance with activities of daily living, and meet the income criteria set by regulation. The state received federal authority to increase the income limit from 200% of the FPL to 250% of FPL, and to allow persons with dementia ages 19 to 64 years to be eligible if they meet other criteria. Regulations for these expansions were to be implemented in June 2016 subject to authorization by the legislature. According to the Division of Elderly Affairs, in FY2015 1,596 persons participated in the Co-Pay program at a cost of $5,478,301.

Caregiver Supports

DEA provides federal funds ($113,427 in FFY2014) from the Older Americans Act to the state Alzheimer's Association to provide support for caregivers of persons with Alzheimer's and related dementias. The funds are used to provide educational programs for caregivers, support a helpline service, conduct caregiver consultations and to support an annual Caregivers' Conference.

The Carebreaks Respite Program

Carebreaks (http://11097.sites.ecatholic.com/carebreaks-program) is administered by the Diocese of Providence under contract to DEA. It offers short-term relief to a primary caregiver who cares for a care recipient age 60 or over who can not be safely left alone. Respite services can take

place in the home, in an adult day program or a residential facility. The majority of respite services are provided in a home setting. The care recipient and Carebreaks share in the cost of care with the recipient's income and type of service determining share amounts. Cost share is based on four income levels and range from $0 for those with very low incomes to half cost for those with higher incomes. The Division of Elderly Affairs reported that in FFY2014, $274,000 in Older Americans Act funds and $136,680 in state funds supported the program which served 320 caregivers with 14,574 hours of respite. It should be noted that state support for elder respite services was cut from $399,650 in FY2006 to its current level in FY2012 and has yet to be restored despite senior advocacy efforts. The average expenditure per family has been $1,120. Sixty-nine percent of the caregivers were age 60 and over. From time to time there are waiting lists when projected demand exceeds government allocations. In January 2015 there was a wait list of 38 families In FY2016, DEA allocated an additional one-time additional grant of $50,000 in federal funds for respite and as of March 2016 there is no wait list. However, the program does no marketing and public awareness of the program is minimal. As a way to address increased demand, DEA worked with Rhode Island College and University of Rhode Island to create a program in which upper level nursing students provide respite services for all ages. In its first semester, five families were served -- three placements where the caregivers were caring for children, and two placements where the caregivers were caring for older adults (Personal communication, 2016g).

Powerful Tools for Caregivers Training

In 2014, using funds from the federal Older American's Act, the Diocese of Providence trained persons to be class leaders to teach Powerful Tools for Caregivers. This evidence-based program operates in over 40 states and provides a free, six week class for caregivers focusing on building and strengthening communication skills, reducing stress, maintaining personal health while caregiving. The one and one-half hour program has been offered as a noon-time program in the work place, an evening program in Assisted Living, day programs in senior centers and weekend programs at a home care agency. The Diocese is training a second group of class leaders in May 2016 with the hopes of expanding sessions throughout the State.

Caregiver Support Policies

Over the last several years, Rhode Island has enacted several laws to support caregivers.

- 2013 – Requires a caregiver assessment be done for persons applying for Medicaid home and community-based services and the plan of care involves a caregiver.
- 2013 - Enactment of "Temporary Caregiver Insurance Act" to provide up to four weeks of paid leave (up to two-thirds of pay) to care for ailing family member or to bond with newborn and newly adopted child.
- 2015 – CARE (Caregiver Advise, Record and Enable) Act provides that upon discharge from a hospital a person designated by the patient be provided with instructions on after-care tasks they will be called on to provide.

The state (Rhode Island Executive Office of Health and Human Services, 2014) also developed a Caregiver's Guide (available in print and online).

Numerous support groups are offered throughout the state and a fledging Rhode Island Family Caregiver Alliance is being rejuvenated as an activity of the state's Lifespan Respite award. The Alliance sponsors an annual State House "Kick Off" in November, National Family Caregiver Recognition Month. With modest funding from DEA the Alliance is in the process of incorporating as a 501 C 3 in Rhode Island.

Challenges – Service Gaps – Resource Needs

- **Co-Pay limitations.** While the DEA Co-Pay program effectively keeps many frail seniors from accessing Medicaid and transitioning to nursing homes. Public awareness of the program is limited and allowed service amounts may be insufficient to maintain a person at home.
- **Workforce capacity.** Home care provider rates for state services have not been increased in seven years and providers report difficulties in attracting and maintaining certified nursing assistants as they can generally earn higher wages in nursing homes, hospitals or other types of employment. This presents significant challenges in providing continuity of care for clients and the situation may be especially problematic in the more rural parts of the state. Home care providers are not typically trained to recognize or respond to mental illness or addiction, nor are home care provider agencies necessarily prepared to support staff in dealing with challenging behavior or in connecting clients with appropriate behavioral health services.
- **Eligibility Delays.** The eligibility process for Medicaid funded home care can take many weeks to complete leaving frail seniors without needed care. And family members desperate to ensure the health and safety of their loved ones may resort to nursing home placement.. For several years advocates have pushed the state to put an expedited eligibility system in place to help frail seniors and persons with disabilities get timely home care and avoid unnecessary nursing home placements. For persons in the state's managed care program for long term services, this is not a problem as the managed care plan is required to put services in place quickly when a person is assessed as needing them.
- **Fragmented case management services.** Three different entities are responsible for case management for state-funded home care – DHS (for Medicaid fee-for-service clients), DEA contracted regional case management agencies (for CoPay and some Medicaid fee-for-service and NHPRI clients) and NHPRI (for some persons enrolled in Rhody Health Options). A focus group conducted with case managers from agencies under contract with DEA and NHPRI reported challenges involved from required use of different assessment tools, different timeframes for reassessments and different software systems. This fragmentation has caused duplication and an increased workload for staff. Turnover in case managers is high and caseloads are high.
- **Lack of in-home medical care.** It is often difficult to transport frail seniors and persons with disabilities to primary care practices when urgent needs arise. They may not have family who can provide rides or meet the required 48 hour notice for the LogistiCare program. Few Rhode Island physicians or medical practitioners (e.g., nurse practitioners, podiatrist) offer house calls. Often, rescue services take persons to hospital emergency departments for issues that could be taken care of with a home visit by a physician or nurse practitioner. Neighborhood Health Plan of RI initiated an in-home clinical program using nurse

practitioners that has shown positive results. A federal demonstration under Medicare (Project Independence) showed significant improvements in patient care while reducing expenditures for chronically ill complex elder homebound patients. In-home behavioral healthcare is available to very few individuals in the state. In addition to the mobility issues associated with age, elders' behavioral health problems tend to make them reluctant to seek treatment., which makes the need for in-home behavioral health services particularly acute for this age group.

- **Dramatic cuts in the state subsidized elder respite program.** State funding cuts for respite since FY2006 have resulted in putting families on wait lists for the service at times. The maximum grant of $3,000 in service with the family paying a share, may not be enough to keep the care recipient at home especially when the caregiver is at an advanced age or has medical issue themselves. Moreover, many caregivers are not aware of the program that can give them needed breaks to take care of their own needs or to do errands and help postpone residential placement for their loved one.
- **Families just above income for publicly subsidized programs have difficulty finding affordable care**. While one-time assessments and options counseling are offered through the DEA-funded networks, families often report being advised that "You are not eligible for assistance." There is a need for education of network workers to provide meaningful guidance for families who will face long term care in the private pay arena.
- **Emergency respite services are not always available**. A caregiver may face urgent or emergency care needs and require residential placement of the care recipient. This is may be difficult to arrange.
- **Elder Abuse and Self Neglect were issues brought before the Subcommittee as special challenges**. The issue of financial exploitation seems to be on the rise and persons suspected of self-neglect may refuse to accept services to promote their health and safety. Hoarding can be a problem for some and few clinicians in the state are experienced in dealing with the issue. Efforts are underway to train more clinicians in this area. A work group is being formed to explore the issue of financial exploitation and abuse.

Case Managers Focus Group

A focus group of case managers from five Community Action agencies that have contracts with DEA to provide case management services to clients in the DEA Co-Pay, DEA Medicaid home and community-based waiver services (HCBS), and DEA protective services programs and to NHPRI clients in Phase 1 of the Integrated Care Initiative (Rhody Health Options) was held in April 2016. Below is a summery of problems experienced by older persons that were identified by the case managers.

- **Economic Security.** A gap in services exists for middle income older adults. While these individuals do not qualify for Medicaid, they are unable to afford the services that enable them to remain in their home. Home based services including housekeeping, personal care, yard work, home repair/maintenance, errands/shopping would help support these seniors. Many are too proud to seek help and others spend their savings paying out of pocket for such

services. As the health of older adults declines, their ability to maintain their home becomes even more difficult.

- **Community based support.** There is a crisis in home care in Rhode Island due to a significant shortage of home care staff, in particular CNA's. This problem is especially problematic in certain areas of the state including the East Bay and South County areas. Case managers are often unable to locate staff that can provide in home services for older adults who need assistance. They also cited a shortage of male CNAs, and Spanish speaking CNA's in homecare. There is a high turnover of home case workers due to the low pay which is not commensurate with the requirements of a demanding job.
- **Food insecurity** is another problem for older adults who cannot get out to shop and who have no local family to provide assistance. Again, affordable community based services that would include shopping and errands is needed.
- **Housing.** Older adults are sometimes evicted from senior housing complexes because of hoarding problems, or their inability to keep a clean apartment. Again, home based services that would include housekeeping would enable these older adults to remain independent in their own apartment.
- **THE POINT and DHS.** The case managers affirmed problems with DHS and THE POINT services stating that staff are often uninformed, provide inaccurate information, make inappropriate referrals for services and are not knowledgeable of services provided by CAP agencies.

Recommended Strategies

- **Increase home care provider rates.** In order to maintain an adequate home care workforce and work toward the state goal of rebalancing long term care so fewer low-care persons receive care in nursing homes, adequate provider rates are needed.
- **Expand Co-Pay program hours or days of adult day service**. This is needed to meet client increased needs when a person may be recovering from an acute care issue or when a senior's function declines. Adding other services such as medication management in selected cases may also be helpful as would authorizing nurse delegation of some certain nursing tasks to home health aides.
- **Expedite eligibility for home and community-based services.** This is important for persons in regular fee-for-service Medicaid.
- **Streamline and unify case management services.** Leadership from the three agencies involved in home care case management (Human Services, DEA and NHPRI) should review the assessment processes used in each program and work toward implementing a more streamlined and uniform process and establish caseloads consistent with good practice.
- **Explore ways to offer affordable homemaker and home maintenance/repair services.**
- **Promote telephone reassurance services for seniors, especially those who are frail or living alone.**

- **Work with the medical community to promote in-home medical visits for frail elders with complex needs.**
- **Promote Telehealth technology.** This has the potential to add increased support for frail elders living at home. Insurers including Medicare, Medicaid and commercial carriers should support increased use of telehealth technology through appropriate reimbursement for "telehealth" visits.
- **Increase state funding for elder respite.** Appropriate $265,000 in general revenue to restore state funding for elder respite services to FY2007 levels as a start. The state should also pursue federal Medicaid match for these services and other grant opportunities in order to expand the program service levels and to market the program so more caregivers can be helped.
- **Develop and offer a hands-on training program for caregivers** to include a component on dealing with basic behavioral health difficulties.
- **Expand Temporary Caregiver Insurance law from four to six weeks.** The bill 2016-S2723 provides for this expansion.

3.8. HEALTH CARE COVERAGE AND ACCESS

Why is this Important?

Access to affordable, quality medical care including preventive care, rehabilitative care, palliative care and hospice is important to maintaining optimal health in our older years and in ensuring death with dignity. Medicare is the primary source of health coverage for persons age 65 and over. In RI, 99.4% of seniors have Medicare (United States Census Bureau, 2014b) with 35% enrolled in a Medicare Advantage Plans (Kaiser Family Foundation). All but 14% of Rhode Island Medicare enrollees have Prescription Drug coverage through Medicare Part D stand alone plans or through their Medicare Advantage Plans. In 2011, 13% of Rhode Island seniors were on Medicaid (Kaiser Family Foundation).

Despite this almost universal coverage, seniors may have considerable out-of-pocket costs for deductibles, co-payments and items or services not covered by Medicare such as dental care, hearing aids, eyeglasses and most long term care. Fidelity Investments (Hamilton, 2013) estimated that in 2013 a 65-year old couple would need $240,000 to cover future health costs not including long term care. Medicare (https://www.medicare.gov/) estimates a Rhode Island senior would have out-of-pocket costs between $4,000 and $5,000 per year depending on the Medicare Plan. A Kaiser Foundation study (Cubanski, Swoope, Damico & Newman, 2014) of Medicare 2010 beneficiaries found average out-of pocket costs were $4,734 with premiums a large share of the costs (42%). Long-term facilities were the largest component of service costs. Out-of-pocket costs rose with age and persons age 85 and over spent three times as much as those ages 65 to 74. Women had higher costs primarily due to age, as did those with poorer health.

In 2015 the Rhode Island Department of Health (2015) released the first Statewide Health Inventory of Utilization and Capacity report as mandated by law. The report concluded that Rhode Island has an approximate 10% shortage of full-time primary care physicians working in

outpatient settings. Geographic mapping of primary care practice locations show certain areas where access could be problematic. Glocester, West Greenwich, Exeter and Richmond had no full-time primary care practices (PCP), and a number of communities had high population per primary care providers (Burrillville, Central Falls, Foster, Little Compton, and Scituate). Medicare was the source of payment for 20% of patients in the primary care practices and 17% for Medicaid. Nurse case managers were employed by 44.4% of the primary care practices, 41% of the primary care practices had received patient-centered medical home recognition and about one in three employed a behavioral health type staff member with clinical social workers the largest type. Thirty-four percent of primary care practices were not accepting new adult patients and 55% were not accepting new Medicaid patients. Wait lists were maintained by 28% of the primary care practices.

The survey of outpatient specialists found more than 80% of endocrinologists, rheumatologists and women's health practices had waiting lists and 63% of neurologists had waiting lists. Medicare patients comprised 25% of these practices and Medicaid 8%. The survey did not include geriatrics as a specialty so data was not available for these physician specialists. The American Geriatrics Society recommends one geriatrician for every 700 persons age 65 and over. This would equate to about 24 geriatricians for Rhode Island. The America's Senior Health Rankings report (United Health Foundation, 2015) estimates Rhode Island had a 53% deficit in meeting the geriatrician requirement ranking it number 10 in the nation. Most seniors, however, receive medical care from internists and family practitioners who may or may not have had training in geriatrics-competent care. In Rhode Island, 97.5% of persons age 65 and over reported they had a personal doctor or healthcare provider ranking first in the country (United Health Foundation, 2015). A new Dartmouth Atlas report (Bynum, Meara, Chang & Rhoads, 2016) found 24% of Rhode Island Medicare beneficiaries received an annual wellness visit as provided under Medicare by the Affordable Care Act, ranking it third highest in the nation. This same report showed Rhode Island doing better than the US average in percent of diabetic persons ages 65 to 75 receiving recommended tests (61.7% RI vs. 53.2% US average) and percent of Medicare enrollees filling high risk medications (18.5% RI vs. 24.9% US average).

The Statewide Health Inventory survey asked about the use of various forms of information technology. Other than secure email used by 43% of practices, few used electronic technology such as text messaging (29%), remote monitoring devices (14%), video conferencing (6%) and audio visits (7%).

Behavioral Health

The inventory identified 48 behavioral health clinics. Geographically, most were in Providence County and only four of them were located in western areas of the state. Only 9.3% had Medicare as their principle source of health insurance while 45.1% had Medicaid as their principle insurance coverage. All were accepting new patients. Only modest integration with primary care was found, with only 18% reporting a Primary Care Medical Home delivery model, although 92% did report coordinating with primary practices. The survey of psychiatrists showed an average of 3.9% of patients on Medicare and 5.2% on Medicaid. New patients were accepted by 84% but only 16% accepted new Medicaid patients. Very modest integration with primary care practices was found. The survey of psychologists showed an average of 5.1% of patients on Medicare and 5.3% on Medicaid with 86% accepting new patients. Physicians who do not

operate within an integrated practice may lack the time or training to identify many behavioral health difficulties. The behavioral health system's capacity to effectively treat older adults with behavioral health difficulties has diminished. At one time, each of the Community Mental Health Organizations had at least one geriatric specialist who was able to do such critical tasks as conduct face-to-face assessments with seniors in crisis and advise other CMHO staff on best practices with older clients. Dedicated funding for these positions has ended, and most CMHOs have not been able to maintain them.

To promote greater integration of behavioral health into primary care practices, in January 2016 the Rhode Island Foundation awarded a grant to the Care Transformation Collaborative of Rhode Island (CTC) to fund a pilot program to place a behavioral health clinician into the primary care teams of 16 CTC practices throughout the state. Through this effort, CTC will work to identify more patients with behavioral health and substance-use disorders, increasing services to patients with moderate depression, anxiety, substance-use disorders and co-occurring chronic conditions; and reducing emergency room visits by providing care coordination and intervention for high-risk patients. (Rhode Island Health & Fitness magazine, January 11, 2016)

Nursing Facilities

All 90 licensed nursing homes responded to the survey. Thirty-seven reported having wait lists with an average number of 37 persons waiting. Wait times ranged between two weeks and 26.5 weeks. Sixty percent of nursing homes reported having no dementia units. Almost all were accepting new Medicaid patients. Nursing facilities without access to clinical psychiatric and addictions personnel may be unable to provide effective behavioral health treatment, and may be faced with caring for patients whose symptoms are difficult to manage in the facility.

Assisted Living

Of the 62 licensed assisted living residences in RI, 59 responded to the survey. There were 4,089 persons residing in these residences. Although all responded they were accepting new residents, 51% indicated new Medicaid residents would not be accepted. Waiting lists were reported by 36% of the residences with wait times ranging from 24 to 30 weeks. Facilities without access to clinical behavioral health and case management staff often report great difficulty getting services for residents with behavioral health issues and managing challenging behaviors.

Oral Health

The America's Senior Health Rankings report (United Health Foundation, 2015) shows Rhode Island ranking eighth in the country for seniors having visited a dental professional in last year (72%) and sixth in country for percent of persons age 65 and over who have had all teeth extracted due to gum disease or tooth decay (12.5%). However, for those seniors on Medicaid, accessing dental care can be difficult as many dentists to not accept Medicaid due to extremely low state reimbursement. Many of the state's Federally Qualified Health Centers offer dental services to Medicaid beneficiaries and low-income persons. And the Community College of Rhode Island offers a dental clinic as part of its dental hygienist program. To assist those in nursing facilities with oral health needs, Carelink RI offers nursing homes participation in the Wisdom Tooth program which provides oral evaluations and dental services via a mobile van. The program accepts Medicaid. Well One Community Health Center also provides dental services to nursing home residents at nursing homes.

Challenges – Service Gaps – Resource Needs

- The findings on primary care provider shortfalls may have an impact on access to care for Rhode Island seniors particularly those on Medicaid, those living in less populated areas where transportation may be problematic, and for non-drivers or where public transportation is not available/reliable.
- The state's primary care providers provide the majority of routine medical care for seniors. Yet, they may not have been trained in the care needs of an older population or be knowledgeable about the community supports that are so vital to maintaining good health for seniors. Efforts are underway to promote geriatric competent care through the Geriatrics Workforce Enhancement Program (GWEP) grant awarded to the University of Rhode Island and the Geriatrics Advocacy project underway through the Senior Agenda Coalition of Rhode Island funded by Community Catalyst.
- Although slightly more than 16% of Rhode Island seniors have been told they have a depressive disorder (United Health Foundation, 2015), a low percent of Medicare patients are reported to be in the practices of the state's psychiatrists and psychologists.
- The Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) has not had a formal plan to address the behavioral health needs of the state's older population and state funds previously available to community mental health agencies specifically to work with this population are no longer available. There are a limited number of behavioral health professionals who specialize in geriatric practice.
- The Rhode Island Elder Mental Health and Addiction Coalition and the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) Elder Behavioral Health Workgroup have identified the following areas relating to elders mental health that need to be addressed:
    - development of state data collection & reporting of older adults & behavioral health
    - crisis intervention services and resource websites for "at risk" older adults
    - wraparound behavioral health case management and clinical services for "at risk" older adults not currently meet eligibility criteria for specialized services such as ACT
    - development of geriatric behavioral health workforce capacity
    - opioid abuse prevention program targeted for seniors to include pharmacy misuse and polypharmacy

Recommended Strategies

- **Promote continuing education for primary care practitioners in geriatric-competent care** and community social supports and caregiver supports that assist frail elders to remain at home. At least one state (California) has required evidence of geriatric focused continuing education as part of physician relicensing. Rhode Island should consider such a requirement.
- Support development of a state strategic plan for elder behavioral health underway by the BHDDH's Elder Behavioral Health Workgroup work group in collaboration with the

Division of Elderly Affairs and the Rhode Island Elder Mental Health and Addictions Coalition.

- Develop plan to better address oral health needs of low-income older population.
- Explore the integration of community health workers with a specialization in geriatric care in the delivery of healthcare.

3.9. OPEN SPACES – PUBLIC ACCESS/BUILDINGS

Why is this important?

Outdoor spaces and buildings have a significant impact on mobility and the quality of life of older people, often affecting their independence and choices of where to live. Age-friendly features of outdoor spaces and buildings include: safe and accessible streets for pedestrians; the safety and accessibility of public buildings; a clean environment; access to green spaces with places to sit and walk, and accessible parks and recreational facilities. The state and its municipalities play a major role in promoting these features as part of their planning activities.

Accessibility of Rhode Island Public Buildings

RIGL 37-8-15. Access for people with disabilities requires that "all public buildings to be constructed, leased, or rented by the state or any municipality of the state must be in compliance with all the standards promulgated by the Rhode Island State Building Code, chapter 27.3 of title 23, which make buildings and facilities accessible to and usable by people with disabilities." Prior to a governmental body or public agency leasing or renting any facility, or renewing a lease, the governor's Commission on Disabilities must certify that the lessee agency's program accessibility plan is in compliance with state standards.

Accessibility of Rhode Island Parks and Beaches

The state has many publicly supported parks and beaches. Accessibility is automatically included in all new design and construction and the Division of Parks and Recreation in the Department of Environmental Management has an ongoing program to renovate facilities to make them accessible to persons with physical disabilities (http://www.riparks.com/Accessibility.html). In addition to designated wider parking spaces, restroom accommodations and ramped building entrances, the state park and beach system offers accessible picnic tables and sites at all major day use parks, boat ramps for handicapped use at two state parks and assisted surf chairs at a number of state beaches. State law provides that no fee will be charged to any person with a disability regardless of age, or to automobiles transporting a non-driver disabled persons. Proper identification showing person is on SSDI, SSI or 100% veteran's disability is needed to obtain a disability pass.

The Access RI website (http://www.access-ri.org/explore/arts/) provides a comprehensive listing of beaches and park and recreation sites in the state including guidance on their accessibility provisions including availability of wheelchairs wheelchair maneuverability and bathroom accommodations.

Complete Streets Promote Aging in Community

"Complete Streets are streets for everyone**.** They are designed and operated to enable safe access for all users, including pedestrians, bicyclists, motorists and transit riders of all ages and abilities. Complete Streets make it easy to cross the street, walk to shops, and bicycle to work. They allow buses to run on time and make it safe for people to walk to and from train stations. Adopting a Complete Streets policy means states and communities direct their transportation planners and engineers to routinely design and operate the entire right of way to enable safe access for all users, regardless of age, ability, or mode of transportation" (Smart Growth America).

In June 2012, with the advocacy of RI AARP, the Rhode Island general assembly passed the Complete Streets law (RIGL 24-16) to integrate multiple transit options into the design and construction of the state's transportation system. Following passage of the state Complete Streets law, the Rhode Island Department of Transportation (RIDOT) issued a policy directive on Complete Streets design to require that all consultants working on RIDOT transportation improvement projects consider people of all ages and abilities, and all appropriate forms of transportation. A Rhode Island Department of Transportation (2015) report showed Complete Streets progress to date included: 50 safety audits conducted, 30+ complete street intersection improvements, 10+ road diets (also called lane reductions or road rechannelizations) implemented, and 5+ miles of new bike lanes.

Challenges – Service Gaps – Resource Needs

- Many Rhode Island seniors live in suburban and rural areas with poor walkability features (such as a lack of sidewalks and poor street lighting) and in some urban areas, sidewalks may be in disrepair or too narrow to accommodate wheelchairs making it unsafe. Removal of snow pile up on sidewalks may also be an issue. These conditions make walking as a form of exercise difficult.
- In both urban and suburban areas, poor pedestrian crosswalk design may make it unsafe for seniors to safely cross streets.
- While the state has many parks, beaches and open space areas with accessibility features, non-driving seniors do not usually get to enjoy them unless family or friends provide transportation.
- While public buildings are required to be accessible, commercial buildings may lack accessible features and adequately marked public restrooms. Large medical complexes may also present access problems if valet parking and escort services are not available to assist with parking and navigating multiple floors and offices.
- Rhode Island municipalities vary in their age-friendliness relating to open spaces and public buildings due to many factors. Age-friendly audits can provide local officials with satisfaction levels of their residents. One survey constructed for the Age-friendly Chicago project (Johnson, Eisenstein & Boyken) measured community resident satisfaction in 13 indicators related to Open Spaces and Buildings (indicators shown below). This type of survey could be used by Rhode Island municipalities to gauge where improvements can be made to make them more age-friendly.

Outdoor Spaces and Buildings Items Indicator

1. Community buildings, including senior centers, libraries, post offices, and park districts, are accessible (have elevators or ramps, grab bars, are clear from ice and snow)
2. It is easy to use wheelchairs, walkers, and scooters on the sidewalks
3. Road conditions are safe for pedestrians
4. There is adequate time to cross the street
5. Businesses and organizations in my neighborhood, including grocery stores, religious centers, and shops, are accessible (have elevators or ramps, grab bars, are clear from ice and snow)
6. Restrooms are readily available and accessible in public and community buildings
7. Parks and green spaces are within easy walking distance from my home
8. Dog parks are within walking distance from my home
9. There are benches and resting areas in public spaces
10. Bicycling conditions are safe for pedestrians
11. Conditions for walking (presence of sidewalks, cracks, bumps, debris on the sidewalks, snow removal)
12. The ease of access to public and community buildings
13. The safety of your physical neighborhood environment (where feeling safe means being able to walk or exercise outside without worrying about crime)

The Chicago instrument described above was piloted by adapting its outdoor spaces and building indicators checklist to audit four urban census tracts in Providence County: Block group 2, Census Tract 9 (Federal Hill); Block group 1, Census Tract 11 (Federal Hill), Block group 5, Census Tract 24 (Mt. Pleasant); Block group 3, Census Tract 8 (Downtown Providence). An undergraduate student completed the checklist for each tract by walking through each tract, recording observations, and photographing illustrative examples of its character. The most favorable findings were that in each tract, seniors were a strong presence, being seen on the streets, interacting with others, and at work. Moreover, all tracts featured commercial establishments, bus stops, curb cuts for wheelchair access (though not necessarily on every street) and handicapped parking. The majority of tracts had parks/green spaces, benches, health resources, and faith based organizations. On the other hand, one half lacked crosswalk signs, water fountains, recreation centers, community art, and aids for non-English languages. Three quarters had no bike lines, no parking garage, and no senior center while being characterized by high traffic volume and noise pollution. All of the tracts were noted to have litter, graffiti, debris, at least some sidewalks in poor condition, and no grocery stores. In sum, the tracts observed were food deserts, had aesthetically displeasing elements, and could be difficult to navigate due to the traffic, the condition of the sidewalks, and the inconsistent presence of crosswalk signs.

Recommended Strategies

- **Continue implementation of Complete Streets by RIDOT.**
- **Encourage municipalities to create local Age-friendly volunteer committees.** These groups would conduct municipal Age-friendly audits to assess open-space and public building features and recommend local actions based on residents' assessments. These audits should consider the handicapped accessibility of buildings, the availability of restrooms, the length of time pedestrians are given to traverse the streets, and other measures of safety.

- **Encourage municipal Land Trusts and Conservation Commissions to create maps of places appropriate for older adults to walk, exercise and enjoy recreation and leisure.**

CONCLUSION AND NEXT STEPS

This report contains some of the most comprehensive data available on our state's older population, what challenges they face and where we have gaps in services and/or resources. The Subcommittee is hopeful the report's recommended strategies in the many areas researched important for successful aging in community will serve as a useful guide to proactively direct state aging policy responsive to the needs and challenges of our state's growing older population.

The next phase of this work will be to build an Age-friendly Rhode Island Coalition to make the state a better place to live for people of all ages, and to also recognize the special needs of the state's growing population. It will involve a multi-year effort requiring a robust coalition committed to a common vision to include representatives of all sectors including consumers, government leaders, the business community and community organization. With support from a Tufts Health Plan Foundation grant, the following steps will be pursued.

- Developing a strategic implementation plan with goals and objectives to achieve the Subcommittee's recommended strategies

- Engaging leaders from all sectors to join the coalition and become "age-Friendly" champions

- Promoting local "Age-Friendly" initiatives responsive to resident input and community data

The Subcommittee encourages readers of this report to join the coalition and work to make Rhode Island and its communities "Age-Friendly."

References

AARP (2014). *Social Security 2014 Rhode Island Quick Facts*. Retrieved May 4, 2016 from http://www.aarp.org/content/dam/aarp/research/surveys_statistics/general/2014/ssqf/Social-Security-2014-Rhode-Island-Quick-Facts-AARP-res-gen.pdf

AARP Public Policy Institute. (2013, October). *Social Security's Impact on the National Economy*. Prepared by C. Koenig & A. Myles. Retrieved May 4, 2016 from http://www.aarp.org/content/dam/aarp/research/public_policy_institute/econ_sec/2013/social-security-impact-national-economy-AARP-ppi-econ-sec.pdf.

AARP Public Policy Institute. (2015, July). *Valuing the Invaluable, 2015 Update*. Prepared by S.C. Reinhard, L.F. Feinberg, R. Choula, & A. Houser. Retrieved May 4, 2016 from http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf

AARP Public Policy Institute (2011, April). *How the Travel Patterns of Older Adults are Changing: Highlights from the 2009 National Household Travel Survey*. Fact Sheet 218. Prepared by J. Lynott & C. Figueiredo. Retrieved May 4, 2016 from http://assets.aarp.org/rgcenter/ppi/liv-com/fs218-transportation.pdf

AARP Research (2015, July). *2015 AARP Survey of Rhode Island Registered Voters Age 45 and Older on Caregiving*. Prepared by C. Burton. Retrieved May 4, 2016 from http://www.aarp.org/research/topics/care/info-2015/2015-Rhode-Island-Caregiving-Survey.html

Administration for Community Living. (2013a). *Aging Integrated Database of Administration for Community Living (data at a glance)*. Available at http://www.agid.acl.gov/DataGlance/ACS/.

Administration for Community Living. (2013b). *Aging Integrated Database of Administration for Community Living* (state profiles). Available at http://www.agid.acl.gov/StateProfiles/Profile/Pre/?id=42&topic=0&years=2013

Agency for Healthcare Research and Quality. *National Healthcare Quality and Disparities Reports: Rhode Island*. Retrieved May 4, 2016 from http://nhqrnet.ahrq.gov/inhqrdr/Rhode%20Island/benchmark/table/All_Measures/All_Topics#far.

Alzheimer's Association (2015). *2015 Alzheimer's Disease Facts and Figures*. Retrieved May 4, 2016 from http://www.alz.org/facts/downloads/facts_figures_2015.pdf

Anderson, P. (2015). Mattiello: "Retaining free RIPTA passes a 'difficult challenge. *Providence Journal*, December 29, 2015. Retrieved May 4, 2016 from http://www.providencejournal.com/article/20151229/NEWS/151229372

Brown University. (2015). Meal deliveries benefit seniors, report says. *News from Brown, May 2*. Retrieved May 5, 2016 from https://news.brown.edu/articles/2015/03/meals .

Bynum, J.P.W., Meara, E., Chang, C-H & Rhoads, J.M. (2016, February). *Our Parents, Ourselves: Health Care for an Aging Population*. Dartmouth Atlas Project,The Dartmouth Institute for Health Policy and Clinical Practice. Retrieved May 5, 2016 from http://www.dartmouthatlas.org/downloads/reports/Our_Parents_Ourselves_021716.pdf .

Center for Medicare and Medicaid Services. (2014). *Geographic variation in standardized Medicare spending*. Retrieved May 4, 2016 from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/GeoVar-State/GeoVar_State.html.

Centers for Disease Control (2014). Summary Health Statistics: National Health Interview

Survey 2014, Table A 10-a. Retrieved May 4, 2016 from http://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2014_SHS_Table_A-10.pdf

Centers for Disease Control. (2013). *The State of Aging & Health in America, 2013.* Retrieved May 4, 2016 from http://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf.

Corporation for National and Community Service. (2015a). *National Service in Rhode Island.* Retrieved May 4, 2016 from http://www.nationalservice.gov/sites/default/files/upload/state_profiles/pdf_2015/RI%20State%20Profile.pdf

Corporation for National and Community Service. (2015b). *Volunteering and Civic Engagement in Rhode Island*. Retrieved May 4, 2016 from https://www.volunteeringinamerica.gov/RI/

Cubanski, J., Swoope, C., Damico, A. & Newman, T. (2014) *How Much is Enough? Out-0f-pocket Spending among Medicare Beneficiaries: A Chartbook*. Kaiser Family Foundation. Retrieved May 5, 2016 from http://kff.org/medicare/report/how-much-is-enough-out-of-pocket-spending-among-medicare-beneficiaries-a-chartbook/.

Feeding America. . *Senior Hunger Facts. Senior Hunger Fact Sheet*. Retrieved May 5, 2016 from http://www.feedingamerica.org/hunger-in-america/impact-of-hunger/senior-hunger/senior-hunger-fact-sheet.html

Foley, D.J., Heimovitz, H.K., Guralnik, J.M. & Brock, D.B. (2002). Driving life expectancy of persons aged 70 Years and older in the United States. *American Journal of Public Health, 92*, 8, (August), 1284-1289. doi: 10.2105/AJPH.92.8.1284

Genworth. (2015). *Genworth 2015 Cost of Care Survey Rhode Island*. Retrieved May 5, 2016 from https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/cost-of-care/118928RI_040115_gnw.pdf .

Hamilton, M.M. (2013, January/February). *What health care will cost you*. AARP Medicare & Medicaid. Retrieved May 5, 2016 from http://www.aarp.org/health/medicare-insurance/info-12-2012/health-care-costs.html ,

Housing Works Rhode Island (at Roger Williams University). (2016, April). *Projecting Future Housing Needs Report*. Retrieved May 5, 2016 from http://www.rhodeislandhousing.org/filelibrary/HWRI-Projecting-Future-Housing-Needs-Report-04-06-16.pdf

Housing Works Rhode Island. (2015). *Seniors and Housing in Rhode Island*. Presented to the Aging in Community Subcommittee, November.

Jacobson, E., O'Hanlon, J., Bennett, C. & McCloskey, S. . *The Impact of Senior Centers and Geriatric Healthcare Policy*. Fact Sheet 1. University of Delaware Institute for Public Administration College of Human Services, Education & Public Policy. Retrieved May 4, 2016 from http://www.ipa.udel.edu/healthpolicy/srcenters/FactSheet1.pdf .

Johnson, R., Eisenstein, A. & Boyken, L. Age-Friendly Chicago: Findings from a Community-Wide Baseline Assessment. Retrieved May 5, 2016 from http://www.cityofchicago.org/content/dam/city/depts/fss/supp_info/AgeFriendly/FinalAgeFriendlyReport021815.pdf.

Kaiser Family Foundation. . State Health Facts (Rhode Island: Categories and Indicators). Retrieved May 5, 2016 from http://kff.org/statedata/?state=ri .

Koffman, D., Weiner, R., Pfeiffer, A., and Chapman, S. (2010). Funding the transportation needs of an aging population. Retrieved May 4, 2016 from http://www.aarp.org/content/dam/aarp/livable-communities/act/transportation/funding-the-public-transportation-needs-of-an-aging-population-2010-aarp.pdf

Martin, J. (2016). *Rhode Island. It's time to work and save*. Retrieved May 4, 2016 from http://states.aarp.org/rhode-island-its-time-for-work-save/ .

Meschede, T., Sullivan, L., & Shapiro, T. (2009). Living Longer on Less in Massachusetts: The New Economic (In)Security of Seniors. The Institute on Assets and Social Policy at Brandeis. Retrieved May 4, 2016 from http://iasp.brandeis.edu/pdfs/2009/LLOLMA.pdf

MetLife Mature Market Institute (with Stanford Center on Longevity). (2013). *Livable Community Indicators for Sustainable Aging in Place*. Retrieved May 4, 2016 from https://www.metlife.com/assets/cao/mmi/publications/studies/2013/mmi-livable-communities-study.pdf.

National Cancer Institute and Centers for Disease Control (2012). *State cancer profile: Rhode Island*. Retrieved May 4, 2016 from http://statecancerprofiles.cancer.gov/quick-profiles/index.php?statename=rhodeisland

Neighborhood Health Plan of Rhode Island (2016). Presentation to Voices for Better Health Steering Committee, April 15, Providence, Rhode Island.

Personal communication (2016a). Email to Maureen Maigret from Robin Etchingham, (Assistant Administrator, Department of Human Services, Rhode Island), Feb 8, 2016

Personal communication (2016b). Emails to Maureen Maigret from George Sousa (General Manager, RI operations at LogistiCare), March 2, 2016

Personal communication (2016c). Email to Corinne Russo from Kimberly Nikolaidis (RI Department of Human Services) dated March 28, 2016.

Personal communication (2016d). Email to Maureen Maigret from Barbara Polichetti (Director of Public Affairs, Rhode Island Public Transit Authority), April 13, 20166.

Personal communication (2016e). Email to Corinne Russo from Heather Amaral (Executive Director of Meals on Wheels), dated April 15, 2016.

Personal communication (2016f). Email to Corinne Russo from Althea Dickerson (Program Manager, RI Division of Elderly Affairs) Dated April 19, 2016.

Personal communication (2016g). Email to Maureen Maigret from Rhonda Schwartz (Chief Program Developer, RI Division of Elderly Affairs) dated May 3, 2016.

Personal communication (2015). Letter to William Flynn from Amy Pettine (Executive Director, RIPTA) dated September 14, 2015.

Rhode Island Department of Health. (2015). *Rhode Island Department Statewide Health Inventory Utilization and Capacity Study*. Retrieved May 5, 2016 from http://www.dartmouthatlas.org/downloads/reports/Our_Parents_Ourselves_021716.pdf .

Rhode Island Department of Health. *Home health agencies*. Retrieved May 5, 2016 from http://www.health.ri.gov/healthcare/providers/homehealthagencies/ .

Rhode Island Department of Labor and Training. (2015, January). *Rhode Island's Older Workforce*. Retrieved May 4, 2016 from http://www.dlt.ri.gov/lmi/pdf/olderwf.pdf.

Rhode Island Department of Labor and Training. *Senior Community Service Employment Program*. Retrieved May 5, 2016 from http://www.dlt.ri.gov/wio/pdfs/SCSCEPStatePlan.pdf

Rhode Island Department of Transportation (RIDOT). (2015, February). *Rhode Island's Complete Streets Action Plan*. Retrieved May 5, 2016 from http://www.dot.ri.gov/documents/community/safety/Complete_Streets.pdf

Rhode Island Executive Office of Health and Human Services. (2016, April). *State Annual Progress Report on Long-Term care System Reform and Rebalancing*. Retrieved May 5, 2016 from http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/LTSS_Reform_Rebalancing_April2016.pdf .

Rhode Island Executive Office of Health and Human Services. (2014, May). *Guide for Caregivers*. Retrieved May 5, 2016 from www.dea.ri.gov/New%20DEA%20Publications/RI%20OHHS%20CaregiverGuide_508_Compliant-pamphlet.pdf .

Rhode Island Public Transportation Authority. (2010). *Rhode Island Human Service Transportation Study*. Retrieved May 5, 2016 from http://www.ripta.com/stuff/contentmgr/files/0/6680f65d09fe6cdeacdd5dc158928a22/files/hst_study_executive_summary.pdf

Scharlach, A & Lehning, A. (2015) *Creating aging-friendly communities*. Oxford University Press.

Senior Agenda Rhode Island. (2014). *Older Rhode Islander Fast Facts* (based on American Community Survey 2014)

Senior Agenda Rhode Island (2008). *Senior Agenda Factbook 2007-2008*, p. 48. Retrieved May 4, 2016 from http://www.senioragendari.org/publications/factbook/2007-2008Factbook.pdf

Smart Growth America, Making Neighborhoods Great Together. (n.d.) Retrieved May 5, 2016 from http://www.smartgrowthamerica.org/complete-streets/complete-streets-fundamentals/complete-streets-faq.

Social Security Administration (2015). *Social Security Annual Statistical Report 2015*. Table 5.J3. Retrieved May 4, 2016 from https://www.ssa.gov/policy/docs/statcomps/supplement/2015/5j.html#table5.j3.

State of Rhode Island Division of Planning (2013). Rhode Island Population Projections 2010-2040, Technical Paper 162. Retrieved May 4, 2016 from http://www.planning.ri.gov/documents/census/tp162.pdf.

Stuckhouser, S., Wright, J.D. & Donley, A.M. (2015). *Food insecurity among older adults. 2015 update*. AARP Foundation. Retrieved May 5, 2016 from http://www.aarp.org/content/dam/aarp/aarp_foundation/2015-PDFs/AF-Food-Insecurity-2015Update-Final-Report.pdf

United Health Foundation (2015). *America's Health Rankings*. Retrieved May 4, 2016 http://www.americashealthrankings.org/Senior/RI.

United States Census Bureau (2015). *American Fact Finder* (2010-2014 American Community

Survey 5-Year Estimates. Table B17024: Age by ratio of income to poverty level in the past 12 months). Retrieved May 4, 2016 from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

United States Census Bureau. (2014a.) *American Fact Finder*. (2010-2014 American Community Survey 1-year estimates, Tables B01001, C17001, C17001B, C170011). Retrieved May 6, 2016 from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid= ACS_14_1YR_B17001&prodType=table

United States Census Bureau. (2014b). American Fact Finder. (2010-2014 American Community Survey 1-year estimates, Table C27001: Health insurance coverage status by sex and age). Retrieved May 5, 2016 from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_C27001&prodType=table .

United States Census Bureau. (2014c). *American Fact Finder* (2010-2014 American Community Survey 1-year estimates), Table S0103, Population 65 Years and older in the United States. Retrieved May 5, 2016 from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.

United States Census Bureau (2010). *American Fact Finder*. Retrieved May 4, 2016 from http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

United State Department of Agriculture (2016). *Official USDA Food Plan: Cost of Food at Home at Four Levels, U.S. Average, January, 2016*. Retrieved May 5, 2016 from http://www.cnpp.usda.gov/sites/default/files/CostofFoodJan2016_0.pdf

World Health Organization (2007). *Global Age-Friendly Cities: A Guide*. Retrieved May 4, 2016 from http://apps.who.int/iris/bitstream/10665/43755/1/9789241547307_eng.pdf.

Wider Opportunities for Women. (2013, September). Living Below the Line, Economic Insecurity and Older Americans. WOW No.1 State Rankings. Retrieved May 4, 2016 from http://www.wowonline.org/wp-content/uploads/2013/09/Living-Below-the-Line-Economic-Insecurity-and-Older-Americans-State-Rankings-Sept-2013.pdf)

Appendix A

AGING IN COMMUNITY SUBCOMMITTEE MEETINGS

The Aging in Community Subcommittee met on the Following dates. Minutes of the meetings are located on the RI Secretary of State website at: http://sos.ri.gov/openmeetings/

October 27, 2014
November 12, 2014
December 17, 2014
January 22, 2015
March 11, 2015
April 29, 2015
June 24, 2015
November 10, 2015
January 20, 2016
May 9, 2016

Appendix B

FOCUS GROUP INFORMATION

To understand the concerns and needs of seniors living in Rhode Island, ten focus groups from distinct geographic locations were conducted. These locations include:

1. Pilgrim Senior Center, Warwick, RI (May 11, 2015)
2. East Providence Senior Center, East Providence, RI (May 12, 2015)
3. Leon Mathieu Center, Pawtucket, RI (May 14, 2015)
4. Landmark Hospital (May Breakfast), Woonsocket, RI (May 15, 2015)
5. Richmond, RI (May 26, 2015)
6. St. Elizabeth Place, Providence, RI (June 17, 2015)
7. Edward King House Senior Center, Newport, RI (June 25, 2015)
8. Salvatore Mancini Resource and Activity Center, North Providence, RI (Feb. 29, 2016)
9. St Martin De Porres Senior Center, Providence, RI (March 7, 2016)
10. South Kingstown Senior Center, Wakefield, RI (March 28, 2016)

A total of 111 adults between the ages of 50 and 97 years old participated in the groups. There were 21% males and 79% were females.

Appendix C

MUNICIPAL SENIOR TRANSPORTATION SURVEY
SAMPLE OF VOLUNTEER TRANSPORTATION PROGRAMS

Information obtained from telephone interviews or email requests conducted in April 2016 by Karen Mensel and Maureen Maigret

City/Town	Description of Transportation Services for Seniors
Barrington	Town has two 12 passenger WC accessible vans. Mon-Fri trips to senior center and shopping trips to Shaws exclusively. 12-15 trips made per week. No medical trips provided; about 50 -60 people use services; (source: Michele Geremia, Senior Center Director)
Bristol (Benjamin Church Senior Center)	Senior Center van provides transportation 5 days a week to the Center for the meals program or other center activities. Transportation also provided for monthly health clinics and other appointments in Bristol & Warren (Shopping - Lunch Program – Banking - Post Office). No fee, but reservations required. (source: Elizabeth Langello @ Benjamin Church Senior Center)
Burrillville	Has one (1) 12 passenger van and one 4-door Ford Fusion. Do medical appointments (will go outside of area to Providence), shopping in Pascoag. Pick up passengers at home on first come, first serve basis.
Central Falls	No response
Charlestown	None provided by Town. Seniors may use Logisticare to attend meals program at Senior Center and for medical trips and also Southern RI Volunteers provides some medical transportation
Coventry	Vans operate M-F. Funded by the RI Department of Behavioral Health Care. Used primarily for transporting clients participating in the state licensed day service program for adults with developmental disabilities. On a weekly basis shopping trips to WalMart are made for Elders and person with Disabilities.
Cranston	Cranston Transvan provides rides to Cranston residents age 55+ and persons with disabilities for personal appointment including medical visits to anywhere in the City M-F. Monthly passes are $25. Approximately 200 persons use the service weekly. (source: David Quiroa, Center Director)
Cumberland	16 passenger WC enabled van and provides free daily transportation to Cumberland Seniors 55+ years old and the permanently disabled. It provides transportation for Cumberland's five elderly complexes and also provides transportation to grocery stores, the malls, and the Senior Center for its activities and meal site. (source: Michael Crawley, Senior Center Director)
East Greenwich	One van provides trips within East Greenwich to senior center, medical and dental providers, library, retail and grocery shopping, nursing home visits, special trips. Fee of $2/trip or $10 monthly pass.
East Providence	Two buses provide door-to-door transport to Senior Center
Exeter	None provided by Town. RIPTA does not provide "reliable" transportation to Town. (source: Christine Skaggs, Exeter Public Welfare Director)

Foster	None provided by Town. Human Services Director may attempt to find a volunteer for medical appointments for seniors. (source: Carol Mauro, Human Services Director)
Glocester	10 passenger van (rarely if ever carrying 10 people) does not have a wheelchair lift. Will transport people to RI Hospital but try to restrict medical trips to Glocester side of the bridge; currently shopping trips done sporadically as very few people were using this service; only about 5 people regularly use the transportation service; (source: Human Services Director)
Hopkinton	None provided by Town
Jamestown	Town just approved a PT bus driver and transportation for shopping, appointments, trips in town will be available (source: Ellen Vietri, Senior Center Director)
Johnston	3 "school type" buses provide transportation for special trips only
Lincoln	(1) 17 passenger van providing trips to Senior Center for meals, activities & shopping
Little Compton	Town purchased a 14 passenger WC lift van a year ago, Town, which pays for the gas, maintenance and liability insurance, and service is operated by Stay at Home in Little Compton, a local senior home care service. The van takes people to the Little Compton Community Center Senior Lunch 3x a week, to the Little Compton Senior Citizen's Club and every other week to grocery shopping. Also used to transport seniors to church on Sundays and to out-of-town events such as PPAC. Stay at Home, which does the bookings, also offers rides using privately owned vehicles to reach medical and other individual appointments. Volunteers drive the seniors, in their own cars or the client's car to appointments within a 30 mile radius for a fee of $5 per trip. For medical trips beyond the 30 mile radius paid drivers are used at an hourly rate of $22. Other fees include donation requested for trip to the senior lunch and most pay $2/day; $5 for group trips organized by Stay at Home; trip costs may be negotiated depending on the size, distance and nature of the trip. (Source: Margaret Tirpaeck, manager of the Stay at Home program)
Middletown	Town does not offer Transportation. RIPTA Flex bus service is used
Narragansett	Van service on Mondays, Tuesdays and Fridays for local medical appointments in addition to the community center for bingo on Wednesdays and to shopping on Thursdays. It is free to any Narragansett resident.
New Shoreham	New Shoreham does not provide rides for seniors and only has public transportation (cabs) in the summer. An informal group of volunteers provides transportation when needed and a Senior Advisory Council tries to coordinate needs of seniors. Source: Nancy Dodge, Town Manager
Newport	None provided by City
North Kingstown (Beechwood)	2 buses: 1 for door to door service to the Senior Center, 1 for grocery shopping, medical trips in town, bank, library, pharmacy, special trips . (For the most part, people finding Logisticare difficult to deal with and they tend to avoid it.) (source: Melissa Smith, Transportation Coordinator for Town)
North Providence	(1) Van (2004 Ford) owned by Town plus a spare van owned by Senior Center. Transportation to and from Center ($1 fee each way), local markets, bank, and local nursing homes ($2 round trip fee) Source: Karen Testa

North Smithfield	None at this time. Formerly had a limited service which was discontinued due to lack of funding. (Source: Peter Branconnier, volunteer who administered the mini-bus program for North Smithfield.
Pawtucket	2 vans for transportation of residents 55+ to variety of locations (Ctr, grocery stores, banks, pharmacy, hairdresser/barber, special trips and monthly DMV)
Portsmouth	Town does not offer any transportation
Providence	No Transportation Program, but does provide busing to special events for seniors run by the City. (source: Sue Robbio, Senior Services Director)
Richmond	No Transportation Program
Scituate	Has two 12 passenger WC lift equipped vans; one of the vans is new, replaces a 10 passenger retired RIPTA vehicle and was purchased with a mix of Town funds and grants.
Smithfield	Town-owned van provides free trips for Senior Center members to Center for meals program, shopping and other errands and to local nursing homes within the Town by appointment. Source: Judith Antirose, Senior Center Assistant
South Kingstown	The town provides non-medical transportation for Town 60+ residents in need of assistance. No fee for rides to the Center and a fee of $.50 is charged for shopping, errands, hairdressing/barber appointments, banking, government center visits, filling prescriptions, volunteering, visiting at South County Hospital or area nursing homes. Source: Senior Center staff
Tiverton	Service provided Tuesdays and Wednesdays to shopping and 1x every two weeks to the Mall. Ridership currently between 10 and 12 persons per week.
Warren	16-passenger Town bus: 5 days/wk for Warren residents for medical appts, shopping, Senior Center activities and meal site
Warwick	Operates Transwick Bus Service with 8 handicapped buses. Had 500 unduplicated riders at end of 3rd quarter averaging 3084 rides/month to Senior Center, shopping, hairdressers, banks, retail shops, nursing home visits and recreation trips. Daily user fee is $1 and recreational trips fee varies. Roll of 20 tokens for $10 available at local Stop and Shop. Provides rides for persons age 55 and over or those with a disability. Entirely funded by user fees and City. (source: Bob Smith, Transportation Planner/Transwick)
W. Greenwich	No response
West Warwick	(1) 12 passenger bus & (1) 14 passenger bus with WC lift (broken at time of survey). Provides free transportation to meal site for West Warwick residents
Westerly	Senior Center coordinates Town transportation program for seniors (1van) for trips (shopping, library, hairdressers, nursing home visits, malls). 2 x month transportation to Crystal Mall and Warwick Mall. Flex service and Logisticare used for meal site and medical appointments
Woonsocket	Delivers meals to meal sites. People use Flex service to attend meal site and RIDE/Logisticare for medical appointments

Sample of RI Volunteer Driver Programs

1. **FISH (Volunteers to Service in Humanity) – (295-1121 reaches the coordinator)**

   Contact: Kathy Isenberg, Chairman (294-7677)
   FISH is a non-profit that started in the 1960's that operates out of North Kingstown and serves persons in North Kingstown and Exeter who need rides for medical, dental and social service appointments. It is an entirely volunteer program managed by the officers and board. Currently have 29 volunteer drivers and since June 2015, they provided slightly more than 1300 trips. Drivers must have their own liability insurance and FISH provides supplemental coverage through an insurance agency at a cost of approximately $400/year. The drivers are paid a stipend for mileage and that expense is paid for by the North Kingstown Salvation Army up to $1100/month. Private donations make up the full cost of mileage. Ms. Isenberg is in the process of encouraging Rotary Clubs in East Greenwich, North Kingstown and Wakefield to start their own FISH programs

2. **Southern RI Volunteers**

   Contact: Deb Turner (552-7661)
   This is an RSVP program that serves Charlestown, East Greenwich, Exeter, Hopkinton, Jamestown, Narragansett, North Kingstown, Richmond, South Kingstown, West Greenwich, and Westerly**.** They provide volunteer drivers and have liability coverage for volunteer drivers (2016 cost is $1,475). From 23-41 persons a month use the service to go to medical appointments anywhere within the state. Grocery shopping can be arranged.

3. **West Bay RSVP**

   Contact person: Donna Smith, Volunteer Coordinator, 732-4666 x 121)
   West Bay RSVP has 8-10 volunteer drivers at any one time. They require the driver to have their own liability insurance and supplement this through West Bay Community Action. Such insurance is a requirement of the Federal program that helps funds the RSVP volunteer programs which are a part of the National Senior Corps. They provide stipends of up to $.25/mile to cover cost of gas. About 50-100 persons use the program and they can not accommodate more due to lack of volunteer drivers.

4. **TAPIN (Touching Persons in Need)** (website: http://www.tapinri.com)

   Contact: Sue Holmes, Co-President (247-1444)
   Tapin is an all-volunteer outreach program serving East Bay residents in need. (247-1444). The program which covers Barrington, Bristol, East Providence and Warren has 31 volunteer drivers. Insurance coverage of $1,000,000 cost is $1000 for the year. (Source: Sue Holmes, Co-President)

5. **Gilbert Burton VFW Post 4487 in Middletown**

   Provides volunteer drivers for veterans needing medical transport**.**

Percentage of Aging Individuals in RI by U.S. Census Tract

April 2016

The Aging (≥ age 65) represent 14.4% of Rhode Island's Population