THE LONGEVITY CHALLENGE TO URBANISM

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The Challenge

Longevity was the great gift of the twentieth century. Learning what to do with this gift is the great challenge of the twenty-first century.

Americans born in 1900 would not have been able to drive a car, ride in an airplane, see a motion picture, work a crossword puzzle, use a washing machine, or talk on the phone. But they could do all of this and more by the time they were 30. Within the next forty years, they would have witnessed the construction of the interstate highway system, experienced the great suburban expansion, and even watched the first man walk, and then drive, on the moon. Cross-country and international travel, unheard of at the turn of the century, would have become a regular and frequent experience for thousands by the end of the century.

The tremendous creativity and innovation of the twentieth century changed the lives of individuals and families, radically redefining how we live in our neighborhoods, cities, and counties and how we carve out a role in an increasingly international economy and culture. Consider that Americans born before 1900 were far more likely to live just like those living in the two or three prior centuries—heating their homes by fire, growing almost all of their own food, walking or riding a horse for transportation, and communicating via postal mail at best. The incredible advancements of the twentieth century were not only numerous, they occurred at an almost incomprehensible pace. What is remarkable is that one of the most significant advances—longevity—went largely unnoticed and unaccounted for.

As with generations that came before them, most Americans born in 1900 would have lived on the same street as their parents and maybe even their entire extended families. But it's also just as likely that their children and grandchildren would live hundreds of miles away. Twentieth-century progress spread families and neighborhoods across much larger geographic areas than had ever been previously feasible. As homes dispersed across the landscape, public transit disappeared and the interstate highway system facilitated suburban sprawl, with its relatively uniform housing stock, reduced walkability, and lack of transportation choices, families and communities changed to fit their new environments. The attenuation of settlement patterns and social networks challenged urbanism: the spatial and cultural phenomena of place.

Now that the first suburbanites are aging, it's becoming quite clear that the twentieth-century progress that allowed us to spread out, live in larger homes with larger yards, and drive our cars to work, shop, and play cannot accommodate the brand new, and without precedent, experience of living much longer. Suddenly,

communities that were sold as a healthy refuge for families from the polluted and congested neighborhoods of the city are unable to support anyone who can't take care of their home and yard and drive their own car. Without sidewalks, trails, and, most importantly, destinations, these suburban neighborhoods make it difficult to maintain health and remain free of chronic disease. It's now very clear that suburbia was built while science and medicine were making it possible to live longer. But the designers, planners, architects, and financiers who made suburban living possible, along with the suburbanites themselves, invested billions of dollars without ever considering that the residents would grow and stay old much longer than ever before.

The gift of longevity very well may be the catalyst that returns Americans to a full appreciation of the urbanism we once had and can have again. We grow more reliant on close proximities in both physical and social relationships as we advance in age. "Urbanism" refers to close relationships in both respects: the compactly built environment and the collective sense of identity that such an environment fosters. Closeness is the operative condition of both the physical and social structures of urbanism. Until a movement is launched to shorten the lifespan or to halt the scientific and medical progress that is almost exclusively focused on extending life even further, communities will be forced to look back at how we used to live together—in urban environments—to ensure that longevity is a gift we are truly equipped to receive.

Demographic Revolution

For the first time ever, the older adult population will match in size the youngest populations on the planet. The traditional population pyramid will morph to a population rectangle (fig. 1.1). In the entire time human beings have populated the

Figure 1.1
Expanding Aging US Population. Information from "Aging and Cancer Research: Workshop Report"; National Institute of Health and National Institute of Aging, June 2001.[1]
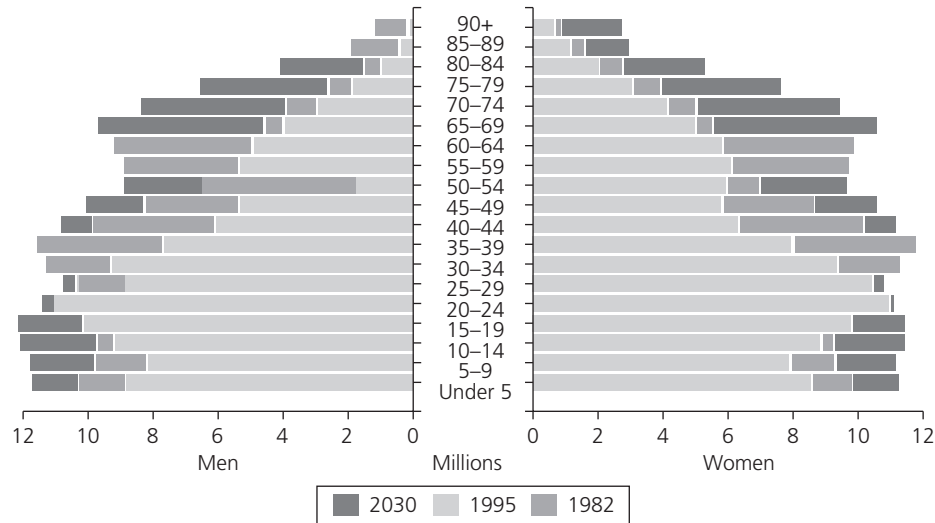
Source: US Census Bureau, Population Projections of the United States by Age, Race, and Hispanic Origin 1993–2050, P25-1104, 1993

[1]National Institute of Health and National Institute of Aging (NIH/NIA), *Aging and Cancer Research: Workshop Report* (June 2001).
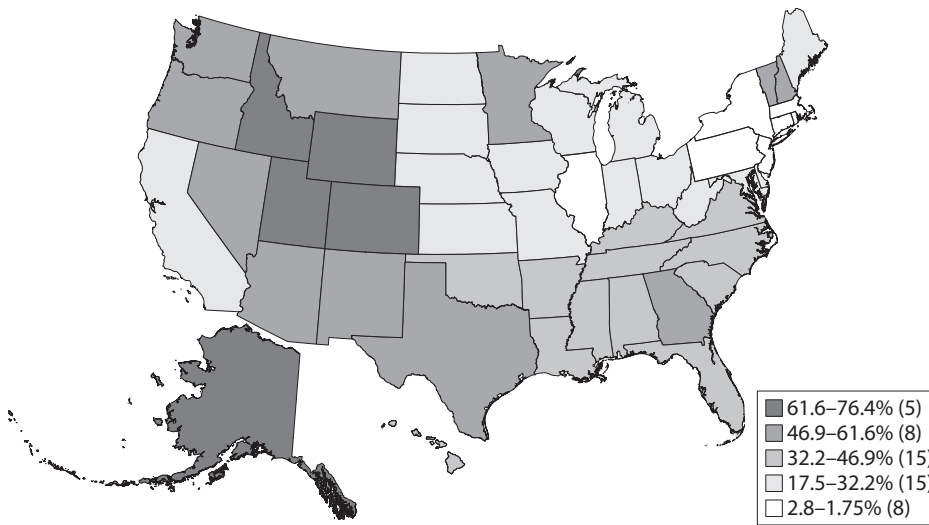
Figure 1.2
Percentage growth in elderly populations, 2000–2015.

Legend:
- 61.6–76.4% (5)
- 46.9–61.6% (8)
- 32.2–46.9% (15)
- 17.5–32.2% (15)
- 2.8–1.75% (8)

earth, this has never before happened. Communities have always been organized around a very young population, with the highest percentage of individuals being between zero and five years of age. Even as life expectancy grew, and people were more likely to survive childhood illnesses and live into adulthood, the relationship between the young and the old remained almost the same as it had always been. It was only when the increase in the older adult population began to outpace the growth in the youngest populations that the transformation began. With decreasing birth rates and increased longevity, this trend will continue well into the twenty-first century. While most people have become increasingly aware of this unprecedented demographic shift, the basic statistics are worth a review (fig. 1.2).

- By 2030, the United States will be home to approximately 71 million people over the age of 65, making one out of every five US residents an older adult.[2]

- The growth in the older adult population is driven by both the aging of the baby boomer generation and increased life expectancy. As a result, there will be a larger number of both older adults and old-older adults (those over the age of 85) than ever before.

- Of the approximately 71 million people over the age of 65 in 2030, 5 million will be over the age of 85, and still only a small number will be over the age of 100. In ten years (by 2040) however, it's estimated that 12 million people will be between the ages of 85 and 99, and 1 million people will be over the age of 100 (fig. 1.3).[3]

- The dependency ratio—the proportion of working-age populations (ages 15 to 64) compared to nonworking-age populations (ages 0 to 15 and ages greater

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[2]Centers for Disease Control, *The State of Aging and Health in America* (2007).

[3]www.cenus.gov

Figure 1.3

US Population Aging 65 Years and Older: 1990 to 2050. Information from "Aging and Cancer Research: Workshop Report"; National Institute of Health and National Institute of Aging, June 2001.[4]
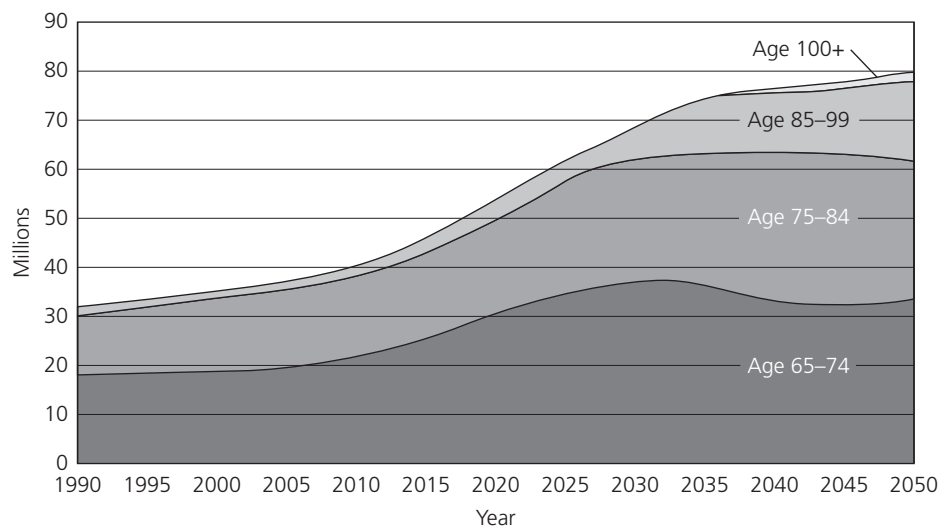
Source: US Census Bureau, Population Projections of the United States by Age, Race, and Hispanic Origin 1993–2050, P25-1104, 1993

than 64)—will also experience a record high, as fewer working people are available to support those who do not work. This means that there will be more people demanding services and less people available to deliver these services. Companies across the globe are working to understand and prepare for how this will impact their labor force. For example, 60 percent of all nonseasonal federal employees will be eligible for retirement by 2016.[5]

■ Current debates about deficit reduction highlight how the magnitude of this population dramatically affects both revenues and spending in the United States. Social Security was created when there were twelve workers for every one beneficiary and when average life expectancy was about 62. But by 2050, there will be two workers supporting each beneficiary. This program wasn't designed to support a population of people likely to live well into their 80s and 90s; therefore, we will continue to debate how to restructure it to meet the broad and growing needs coupled with a decreasing pool of workers contributing to the system.

■ Aging is also occurring for the first time on a large scale in the post–World War II suburbs. In 2000, 70 percent of baby boomers lived in the suburbs and accounted for roughly 31 percent of the total suburban population in 2000.[6]

■ Older men are far more likely to be married than older women. In 2008, 74 percent of older men were married but only 51 percent of older women were married. Even among the 85-plus population, 55 percent of men were married,

[4]NIH/NIA, *Aging and Cancer Research: Workshop Report* (June 2001).

[5]US Office of Personnel Management, *An Analysis of Federal Retirement Data* (March 2008).

[6]W. Frey, "Boomers and Seniors in the Suburbs: Aging Patterns in US Census 2000" (Washington, DC: Brookings Institute, 2003).

but only 15 percent of 85-plus women were married.[7] An increasing number of older adults live alone. With a comparatively higher divorce rate among baby boomers, the trend is expected to grow. In 2008, 40 percent of women over the age of 65 lived alone, while almost 20 percent of men lived alone.[8]

■ In 1959, the poverty rate among older adults was roughly 35 percent, compared to 11 percent today. But savings do not go as far today, and we are likely to see the poverty rate increase as boomers age.

It's clear that the aging population can no longer be simply considered as one of many subsets or specialized population groups. The rapid and expansive growth in the older adult population will reshape all parts of society and the more quickly we can understand and anticipate how and when these impacts will occur, the better prepared and more cost effective our response will be. This book makes the argument that with some design, as well as policy and regulatory changes, many of the solutions to the challenges of an aginng population lay within the neighborhood—the place where people lived when they were young and the place they want to live when they grow old.

The Scale of Response: Pedestrian Sheds and Neighborhoods

Older adults do not generally define their challenges as those of aging. In fact, aging is so relative that it can seem as if no one is doing it. Ask 65-year-olds at what age they become senior, and they are likely to answer 85. Ask 85-year-olds the same question and they are likely to say 92. So despite all the statistics showing an aging nation, it is very hard to find an aging American. But there are plenty of people living their lives, enjoying retirement or part-time employment, and wanting to stay in the homes and communities they have loved and invested in, sometimes for decades. Neighborhoods and the places people call home are the spaces in which they will age. To address the challenges of longevity, then, we must address the challenges of place. In his book *Elderburbia, Aging with a Sense of Place in America,* Philip Stafford makes a compelling argument that "Aging in Place" has been erroneously equated with aging in one's home. Stafford draws on sources as wide as Martin Heidegger, John Berger, and the geographer Yi-fu Tuan to detach the meaning of "place" from a home, and realign it with dwelling in a larger spatial, social, and spiritual sense. Stafford proposes that place is defined through a process of answering these questions:

> Can we fill our spaces with meaning and memory? Can we attain a sense of agency, where what we do makes a difference? Can we dwell in the other? Can we transform space into a place that reflects who we imagine ourselves to be?[9]

[7]US Census Bureau, Current Population Survey, *Annual Social and Economic Supplement* (2008).

[8]Ibid.

[9]P. B. Stafford, *Elderburbia: Aging with a Sense of Place in America* (Santa Barbara: ABC-CLIO, 2009), 14.

In examining the neighborhood and urbanism that is fostered at the neighborhood level, this book attempts to create physical and social environments beyond the home that assist in creating positive answers to Stafford's questions.

What Is a Neighborhood?

The neighborhood is a complex organizational structure that is both physical and social—a district that may overlap with others, shift over time, or tighten down, depending on the context in which it is being defined. There are however, basic physical building blocks that can be empirically determined that structure and support neighborhoods (fig. 1.4). Comfortable walking distances of quarter- to half-miles, known as pedestrian sheds, are these basic building blocks of the neighborhood. The pedestrian shed should gather the residents within walking distances of many daily needs, including transit, which is ideally placed at a central node next to shops. Other daily needs that are ideally balanced and mixed within the five-minute walking distance are shopping, work, school, recreation, and dwellings of all types. Neighborhoods continually come back to the quality of the pedestrian environment within the shed, not only as a value in itself, but also as an indicator of a variety of larger environmental, social, and health considerations.

Figure 1.4

The Prototypical Traditional Neighborhood Development is designed to support a variety of housing types, commercial and civic enterprises, recreation, and pedestrian activity all within a quarter mile radius. This neighborhood type is particularly well suited to support the needs of older adult residents. Daily needs are met by shops that are a short walk from homes. Opportunities for social engagement are supported by the pedestrian-oriented streets and strategically positioned community spaces.
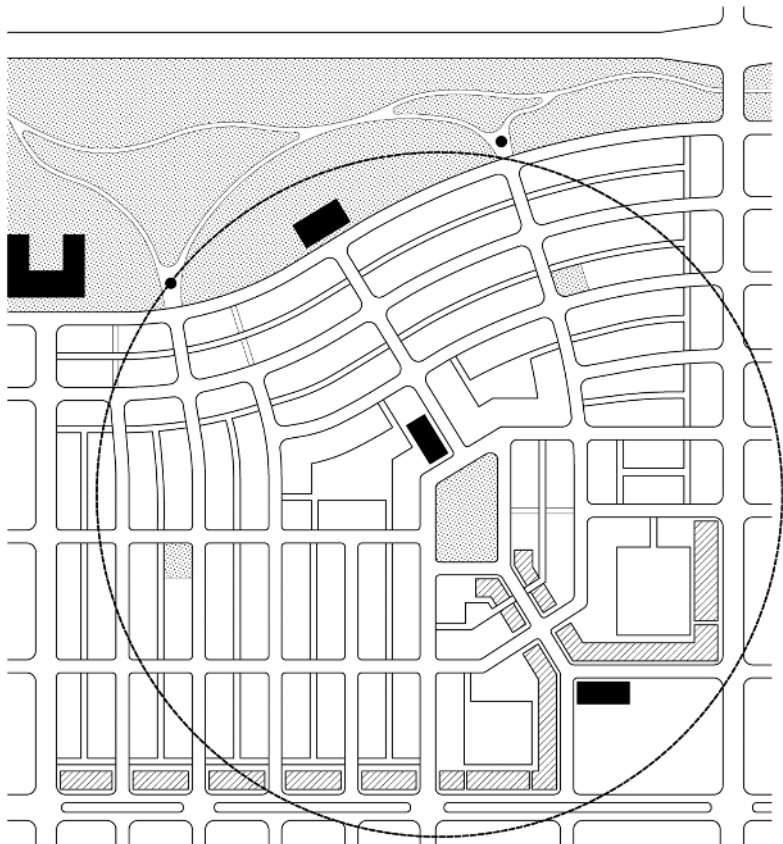
Multiple pedestrian sheds may combine and interact across an identified neighborhood district. Pedestrian-oriented urban form has some clear physical characteristics at the pedestrian shed scale, as well as more complex and subjective cultural characteristics across the whole neighborhood. The edges of neighborhoods should be porous and continue the surrounding street, path, and green space networks to the greatest extent possible. Age-segregated, senior living developments have tended to be constructed as secured compounds rather than connected neighborhoods, and this is not a trend that should be continued, if for no other reason than the over-supply of gated retirement communities. A neighborhood edge should be defined by perceptual boundaries that define a neighborhood without segmenting and separating it from the larger community via hard barriers like gates. The mix of clearly demarcated and more loosely adjoining passages of neighborhood boundaries are animated by the interplay of the walking limits of our bodies and the extensibility of our cultures projected over topography.

The neighborhood environment is at the core of urbanism. If neighborhoods hold solutions for an aging population, then aging and urbanism must also be explored. In their book *The Urban Web: Politics, Policy, and Theory,* Lawrence Henderson and John Bolland delve into the spatial/social complexities contained within the word "urban":

> Urban comes from the Latin, Urbs. The word derives from the palings or palisades that were once used to surround and protect a settled place from intruders. From the earliest of times, those who lived in settled, protected places developed a characteristic way of life associated with a nonagricultural, non-nomadic existence. Our English word *urbane* came into the language about 1500 AD, and with it came a sense of the qualities of life and mind that are traditionally associated with lives lived in an urban setting.
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> The word *city* is also of Latin in its derivation. *Civitas,* to the Romans, carried in its meaning the idea of citizenship and the rights and privileges of those who were citizens.
>
> The meanings that attach to the word *city* have mostly to do with its legal and governmental status, while the meanings that attach to the word *urban* have to do with what is commonly called the culture of cities: their architecture, lifestyle, sociology, and economics.[10]

Urbanism is a set of spatial/cultural relationships that emerge when a place is sufficiently defined and sufficiently close to engender group identity and collective behavior. The word "urban" is not synonymous with the word "city." Hamlets are urban settlements in rural communities, neighborhood centers are urban areas in suburban communities, town centers form urban nodes around metropolitan areas, and cities are closely packed clusters of distinct urban neighborhoods whose interactions can take on the larger order of collective behavior know as cosmopolitanism. Urbanism exists in all of these environments. *Livable Communities for Aging Populations* advocates for a return to urbanism, but this does not imply a Stalin-like effort to move the population into mass-produced, Soviet-style high-rises. Rather, it is a way of incrementally nudging our existing communities, in whatever rural or city context, over time into a more centered, better structured, and more compact settlement pattern, one better

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[10]L. J. R. Henserson and J. M. Bolland, *The Urban Web: Politics, Policy, and Theory* (Chicago: Nelson-Hall Publishers, 1990), 5.

suited to an aging population with changing mental, physical, occupational, social, and emotional needs. A return to urbanism is a process of evolving a range of environments, not a migration of the population to a single city-like environment.

The connection between health and planning is not new. There is a long history of debate in the planning profession over whether the social determinants of health (S-DOH in professional parlance) or the physical determinants of health (P-DOH) should be the primary focus of healthy planning initiatives. Positing these two determinants as exclusive or oppositional requires a type of theoretical construct that is neither based in the realities of developing, maintaining, or residing in neighborhoods nor particularly helpful to advancing either cause. Even so, the dichotomy between S-DOH and P-DOH is alive and well today in planning profession dialogue and was recently raised again by Jason Corburn.[11]

As Corburn reminds us, the S-DOH/P-DOH debate reached a crescendo at the first "National Conference on City Planning" in 1909. At that conference, Fredric Law Olmsted, Jr., presented observations on emerging planning practices in Europe, stressing the artful ways in which planning issues were coordinated. As a rebuttal to the Olmstead presentation, Benjamin Marsh and Robert Anderson Pope advocated for institutionalized and technically oriented planning efforts that would focus on correcting the significant social disparities reinforced by the built environment. Thus the battle lines were drawn: physical determinists versus equity advocates. In the end, this debate and the internal struggles it precipitated served mostly to help dismantle both the City Beautiful movement led by Olmstead and the social equity movement led by Marsh. The planning profession that emerged in its wake is often oriented toward neither beauty nor equity, but instead toward narrowly framed, formulaic institutional considerations. Looking back on developments over the past fifty years, it is hard to argue that the shaping and maintenance of the built environment has been guided by any larger vision of either harmony or mutuality. The S-DOH and P-DOH advocates have ended up on the same side of the table, or, more accurately, share a common exile from decision-making tables.

Meanwhile, the prestige of the planning professions has fallen. Recall that the keynote speaker at the 1909 conference was House Speaker Joseph Cannon, and that both Marsh and Olmstead had to hurry out of the conference to testify before various congressional committees on hotly debated planning issues widely perceive to be of national importance. Imagine planners testifying today. What would they say? What would Congress ask? Enhancing the quality of all places, working to ensure that social diversity is supported in codes and regulations, improving the processes through which residents are included in decision making, and elevating the position of neighborhoods in the metrics and policies that shape our regional, state, and interstate transportation systems—these are timely, appropriate topics, commensurate with the planning profession's current challenges and spheres of influence.

The value this book places on physically distinct and identifiable neighborhoods makes it easy to associate it with the City Beautiful movement of Olmstead, rather than with the social justice movement of Marsh. However, we now have too much empirical evidence on the influence of urban form on social behavior and community

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[11]J. Corburn, "Toward the Healthy City: People, Places and the Politics of Urban Planning."

health for distinction between S-DOH and P-DOH to be of value as independent measures. The compartmentalization of the two subjects is counter to the very premise of approaching healthcare from a holistic, environmental perspective. We know that residents receive many tangible well-being benefits from living in beautiful, high-quality, and well-appointed neighborhood settings, and that both individual and collective health is harder to maintain in unattractive, low-quality neighborhoods without adequate public spaces or amenities. We also know that community organizing can powerfully transform and revitalize even the most blighted of communities, and the act of participating in neighborhood stewardship can improve an individual's mental and physical health in any community. Lastly, we know that development or redevelopment efforts that are heavy handed, and purely top-down will be hard to initially lease or sell and harder to sustain over time in today's economic climate. All planners should hold these truths as self-evident. Perhaps planners should again be testifying before Congress. Given changing demographics, they might be invited by a House committee on Medicaid and Medicare, and make the case for the health benefits of aging in an urban environment, or by a Senate housing committee, where they might advocate for integrating supportive housing models into vibrant urban communities with flexible transit and modern, café-style senior centers.

Seniors Housing Communities as Change Agents

Neighborhoods are a good scale for action: physically defined, culturally defined, or in the true meaning of urban, defined by both culture and form. The nation now has decades of history with community development organizations, neighborhood planning units, housing associations, and informal civic associations that demonstrate that the neighborhood is an effective scale of operation for organization and mobilization. Many types of development financing structures have emerged over these same decades that also work well at the neighborhood scale: everything from new subdivisions to urban redevelopment initiatives to continuing care retirement communities have been regularly carried out at the 100- to 200-acre scale that is the basic building block of neighborhoods.

Continuing Care Retirement Communities (CCRCs) offer a complicated example both of how senior housing can form a supportive neighborhood and how regulation can undermine the effectiveness of a model and its desirability for older adults. CCRCs are single communities that provide smaller scale, no-maintenance housing for older adults and offer a variety of housing types to meet different needs, most often including assisted-living facilities and nursing howes. In effect, CCRC developers have been designing and building neighborhoods, even if the end product does not always reflect a neighborhood aesthetic or the diversity that would normally be associated with a neighborhood environment. The CCRC industry has a market perception problem: The vast majority of the population does not want to move to a segregated seniors-housing development. This poor public perception is largely due to the fact that senior housing is viewed as providing care in settings that force the customers to leave their homes and communities.

In part, the for-profit Medicaid-dependent wing of the industry has earned this perception by mounting powerful lobbying campaigns to steer an array of public funds and insurance reimbursement policies toward their developments and away from home-based care models. To receive support, an individual must move to an instituation, most often a nursing home. The fact that Medicaid defaults to institutional care provision and requires a "Medicaid Waiver" to fund home-based care is a powerful testament to the success of these lobbying campaigns. Though 95 percent of the public never accesses a seniors housing facility of any type, Medicaid, the country's largest payer of long-term care services, considers nursing homes to be the normative environment for publicly funded care.

On the other hand, the negative public perception is not a fair assessment. The evolution of seniors housing over the past half century is a record of institutional care models moving progressively closer to more neighborhood or neighborhood-like settings. Early nursing homes (in the mid-twentieth century) grew out of the medical model and looked like hospital buildings both inside and outside (see Chapter 3). Over the past three decades, alternatives to highly institutional skilled nursing facilities have evolved, each moving progressively closer to more familiar neighborhood forms and styles. Compared to someone's home of three decades, a seniors housing development may seem institutional, but compared to the hospital system from which they have sprung, these developments are as close as the medical model has come to providing care in a neighborhood environment.

For the past fifty years, seniors housing developments have been approached as specialized suburban forms that are usually organized around recreation facilities, medical supports, or both. The developments have been age-segregated, often regulating the amount of non-senior residents and the duration of stays of non-senior visitors. Most constitute some form of internally oriented compound that contains common spaces for dining, recreation, and some type of medical support or daily assistance. Like Sun City, Arizona (fig. 1.5) these developments clearly meet a need and address a market, but do so in a highly specialized, age homogenous, autonomous urban form set apart from the surrounding community.

Figure 1.5
Sun City, which began development in the 1960s, is the prototype for thousands of active living retirement communities that followed. Circular neighborhood pods are oriented toward their centers where specialized recreation amenities and care services are provided. The plan's radial geometries are reminiscent of crop circles. The plan reflects its era, a time when heroic urban redevelopment efforts were proposed as the solution to a wide range of social problems. Sun City is designed to address, at an urban scale, the lack of social and economic roles for retired, healthy older adults by creating an expansive community tailored to their specific needs.

Seniors housing has evolved separate from its larger urban context, not out of any specific needs of the aging, but because communities have prevented it from growing organically in the neighborhoods where older adults live. The nation's built environment is in many ways not capable of supporting an individual's needs across a lifespan. In some areas, seniors housing is the only appropriately sized alternative to large lot, detached single-family homes. Local zoning boards are often only willing to allow more dense multifamily arrangements when they are restricted to the elderly and not made available as low income housing for the general population. As mobility functions decline, seniors housing communities may be the only places to find the appropriate accessibility features incorporated throughout the entire environment. Accessible and appropriately structured spaces for social interaction and community engagement are not widely available outside of seniors' facilities in many areas. Older adults are more susceptible to illness, and seniors housing serves as an alternative arrangement to our current hospital-oriented medical system: an alternative to either checking into a hospital for a long stay or remaining at home and foregoing adequate care. With communities and families alike becoming ever more attenuated, senior housing may be the only place an older adult could reliably expect to be able to get help in a crisis event.

However, the real differences between housing for the elderly and housing for the rest of the population are relative rather than categorical. Older persons on the whole require more emphasis on certain aspects of living arrangements than the rest of the community, but the differences are of degree rather than kind. There are benefits to supporting aging in the general built environment. Most of our communities would benefit from increased housing diversity, increased attention to continuous, accessible, walking routes, intentional social spaces, convenient access to daily needs, and easier access to both health care and crisis assistance. These are all qualities that provide value for all in any community. Seniors housing incorporates design features that are necessary for older adults but beneficial for the rest of the population, and a community that works well for older adults will provide benefits to all across their life spans. The housing challenges of older adults may be better approached, for the most part, as a general upgrading of the entire built environment rather than perfection of specialized and age-segregated urban forms. The seniors housing industry is beginning to shape a role in this general upgrading process.

Culture Change is a national movement led by a small group of practitioners that have organized as the Pioneer Network, which advocates for the transformation of older adult services in both facility and community-based settings. This movement seeks to re-center health systems on the needs of individuals receiving care, as well as the individuals who provide that care, rather than on the needs of the institutions and structures of care delivery. The goals of the Culture Change movement are to provide a more familiar, empowering, and hospitable care environment for individuals giving and receiving care. In "Culture Change in Nursing Homes: How Far Have We Come?" authors Michelle Doty, Mary Jane Koren, and Elizabeth L. Sturla observe:

> In the culture change model, which has gained momentum over the past decade, seniors enjoy much of the privacy and choice they would experience if they were still living in their own homes. Residents' needs and preferences come first; facilities

operations are shaped by this awareness. To this end, nursing home residents are given greater control over their daily lives—for instance, in terms of meal times or bed times—and frontline workers—the nursing aides responsible for day-to-day care—are given greater autonomy to care for residents. In addition, the physical and organizational structure of facilities is made less institutional. Large, hospital-like units with long, wide corridors are transformed into smaller facilities where small groups of residents are cared for by a consistent team.[12]

Toward the Development of Lifelong Neighborhoods

Spurred on in part by the Culture Change movement, Continuing Care Retirement Communities (CCRCs) have become the cutting edge of community-based medical care provision, representing a significant extension of the medical model into the daily life carried out in neighborhood settings. If this evolution toward community-like forms continues, senior housing developments could begin to blur distinctions between institutional and home-based care, perhaps even becoming so ubiquitous as to be considered an extension of community-based aging in place rather than an alternative to it. The nation's most innovative CCRCs are leading examples of what may eventually become Lifelong Neighborhoods. CCRCs have a substantial track record of accomplishment in the fields of environmental health, geriatric care, inter-industry coordination, complex financing, and creative lease, purchase, and fee structures. They have provided spaces and services that make up for deficiencies in our environmental, social, and economic systems. Both market demand and societal needs would be better served if these resources were better deployed to contribute to and draw on the wider community. Seniors housing has an opportunity to become a major civic contributor and would benefit from this engagement in terms of bottom line, public perception, market penetration, and social relevance.

Simultaneous to the built environment trends in seniors housing, there has been a trend to interact more with the surrounding community through service programming. In a 2009 article published in *Seniors Housing & Care Journal*, the authors presented the results of a survey of Midwestern CCRCs representing responses covering nearly 350 properties. Half or more (depending on community size) indicated they expect to be offering services to those not living on the campus (defined as homebound) by 2013, and 17 to 30 percent are already doing so.[13]

Providers who have traditionally served the market-rate elderly population through facility-based models are also increasingly offering home- and community-based services. This deepens and extends their reach. Life Care at Home Health, Inc., an outfit that provides home health, hospice, and private duty services in nine states across the nation, represents an early example of bringing services into the

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[12]M. M. Doty, M. J. Koren, and E. L. Sturla, "Culture Change."

[13]S. B. Brecht, S. Fein, L. Hollinger-Smith, "Preparing for the Future: Trends in Continuing Care Retirement Communities," *Seniors Housing & Care Journal* 17 (2009): 84.

community while connecting community-integrated residents to a system that might eventually serve them in the facility-based campus environment. In other cases, outpatient services (such as rehabilitative therapy) are provided out of a facility embedded in the housing development that serves the development's residents and surrounding community alike. The effect of these outpatient and home-based care services is a flow of people into and out of the development that helps break down the strict delineation between life inside the property boundary and life outside. Services delivery and urban form are increasingly blurring the distinction between a seniors housing development and its surrounding community.

In efforts to better reach a broader community, some seniors housing developers have begun to move toward Traditional Neighborhood Development (TND) types that blend more easily with neighborhoods. This effort is beginning to despecialize the form of seniors housing as well as create a more engaged and reciprocating relationship with the surrounding community. The Summit in Lynchburg, Virginia, is an existing example of the driving force that older adult development could play in coming years (fig. 1.6). A co-venture of the Disciples of Christ and Central

Figure 1.6
Area plan showing the Summit seniors housing campus (ingrat) prominently featured in the Wyndemere master plan.

Health System, it is a modestly sized retirement community with approximately 100 independent living apartments and town homes, a 120-bed skilled nursing facility, a health center, a rehabilitation center, 43 assisted living apartments, and a relatively small commons building. Located eight miles outside of Lynchburg's center city, the seniors housing development was planned from the very start as an integral part of Wyndemere, Lynchburg's first traditional neighborhood development effort. A striking feature of the town is the prominent position occupied by the Summit along the central axis of the through corridor. Summit holds a position in the community that reflects the founding role Disciples of Christ and Central Health System played in developing the entire community.

The Summit began in 1988 as a mission of the Reverend Ken Burger, who had visited nursing homes to visit members of his congregation and felt called to find a better environment for older adults. Over the next decade, Reverend Burger rallied his congregation at Disciples of Christ around the mission. In 1997, the church had developed enough momentum to start investing in land and met with the city of Lynchburg's Office of Economic Development to make the city aware of their intention to develop a CCRC. The city had been considering the acquisition of right of way to establish a new connection between highways 221 and 460, two major arterials that radiated out from Lynchburg. The disconnected highways had been overrun by strip retail development, and the city wanted to work in coordination with landowners abutting the proposed new road to ensure that better development would occur when the road went in. Interestingly, the city withheld purchase of the right of way until development plans were prepared for the new corridor, and it used the construction of the new road as leverage in negotiating how development would take place alongside it. The 400 acres on which the Wyndemere community now resides, then comprised two tracts held by different investment companies who were both interested in selling. The city, interested in the vision Reverend Burger presented of a state of the art seniors development, helped broker the discussion between Burger and the landowners. Unable to afford the entire property or to move fast enough to secure them on his own, Reverend Burger brought a prominent local developer into the conversation, Bill Jamerson of J.E. Jamerson & Sons. Jamerson, Burger, and the city worked together with the local planning firm Sympoetica to plan Wyndemere as Lynchburg's first Traditional Neighborhood Development (TND) and to create the city's first TND zoning ordinance. As part of the effort, Jamerson underwrote and built a YMCA into the community early in the development process.[14]

Now a decade has passed since ground breaking, and the community has grown to a full neighborhood with nearly 2,000 residents, a variety of housing types, retail shops, restaurants, and a regional YMCA that offers an array of lifelong services, including those specialized for older adults. While the Summit has its own

[14]Interview with Reverend Ken Burger, May 17, 2011.

self-contained facilities, it is located off of the main arterial, directly across the street from the Wyndemere town center (fig. 1.7) and only a short three-block walk to the YMCA.

Wyndemere, the Summit, and the YMCA would not exist but for the cooperative efforts of stakeholders, the for-profit developer of Wyndemere, the nonprofit sponsors of the Summit and the YMCA, and, equally important, the jurisdictional planning and zoning officials of Lynchburg—all working together with the goal of creating a livable, walkable, sustainable, mixed income, and intergenerational community (fig. 1.8). As evidence of its success, Wyndemere was conceived as a ten-year-long development project, but it achieved completion in five years. The YMCA doubled its membership projections immediately upon opening and is currently undergoing its third expansion. While the basic forms of seniors housing are still recognizable, and while the Summit does not offer services outside of the facility, the role that this seniors housing development played in instigating a pedestrian-oriented neighborhood serves as an early example of the prominent role the seniors housing industry could play in upgrading the built environment.

The Summit development and Wyndemere are harbingers of things to come. The evolution of America's residential fabric can be seen as a physical record of the

Figure 1.8
The Summit terminates the vista of Wyndemere's main street.

Photo by Ken Burger

maturation of a single generation. This nation first built housing on a mass scale to accommodate returning World War II GIs and their new families. As their children became young adults, production switched to starter homes that sheltered the young "baby boomers" who were striking out on their own. As the boomer generation has progressed to its peak earning years, the market has continued to cater to their needs, supplying the suburban developments and larger estates that the boomers can now afford.

The next stage in the maturity of the boomer generation—that of retirement and aging—will require more than just the increased supply of a specific housing type; it will require developing new relationships between facility-based care, neighborhood, and community-based supports. Housing and supports will not easily be pushed to the edges of town as the baby boomers may demand them, but rather they will occupy increasingly prominent roles in developing and detailing our city, town, and neighborhood centers.

Conclusions

Aging affects the entire community, young and old. Everyone grows older each day. In geriatric circles, the standing joke is that while aging isn't fun, it's better than the alternative. You will have gotten older while reading this book. There are different opinions about wrinkles versus botox, gray hair versus color treatment, and individuals make their own choices about these matters. But there are a few elements of aging that most people share and fear and, which, by their nature, require community solutions, not just individual choice. Whether it's their knees or their mind that

goes first, whether they seek out plastic surgery or complete a daily crossword puzzle to ward off Alzheimer's, everyone wants and attempts to maintain the highest quality of life. Independence and choice are shared values among the very diverse current and future older adult populations. While they can be impacted by genetics, the opportunity to save, and availability of family support, a person's quality of life, independence, and choice can be largely determined by the physical community: the housing stock, the transportation network, and the available services. Unfortunately, the last century has done nothing to prepare communities for an aging population. In fact, policies, programs, financing, and regulations have actually made it more difficult to age in the community, despite the fact that it is the stated preference of almost every older adult. Given the scale of the aging population, these are not and cannot just be the concerns of a specialized subset of the population. *How* and *where* to age well is a community issue that affects families and places almost as much the older persons themselves.

There is a short window of time to address these issues cost-effectively, and they will require a transformation of multiple systems, all of which have stakeholders and vested interests. Housing and transportation must be delivered, funded, and regulated differently if communities are going to be able to address the needs of their aging residents. Services, most importantly health services, must be located and administered differently if they are going to keep people active and healthy thereby decreasing costs to the medical system. Policy is important and incentives must be realigned if change is going to happen on any reasonable scale. But real success will come when professionals work across lines to foster innovative and interdisciplinary solutions. It was professional planners, architects, bankers, builders, and designers who constructed the communities of the last fifty years. These same professionals will now need to reach out to doctors, hospital administrators, and public health, aging, and mental health providers in order to invent and in many cases rediscover how communities can support people of all ages and abilities.