

Review Article

Community-Based Supports and Services for Older Adults: A Primer for Clinicians

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Received 25 September 2014; Revised 23 December 2014; Accepted 6 January 2015

Academic Editor: Barbara C. van Munster

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Although 20% of adults 60 years and older receive community-based supports and services (CBSS), clinicians may have little more than a vague awareness of what is available and which services may benefit their patients. As health care shifts toward more creative and holistic models of care, there are opportunities for CBSS staff and primary care clinicians to collaborate toward the goal of maintaining patients' health and enabling them to remain safely in the community. This primer reviews the half-century history of these organizations in the United States, describes the most commonly used services, and explains how to access them.

1. Introduction

Community-based supports and services (CBSS) are designed to help community-dwelling older adults remain safely in their homes and delay or prevent institutionalization. CBSS provide (and act as a link to) specific resources for older adults and their caregivers that include wellness programs, nutritional support, educational programs about health and aging, and counseling services for caregivers, as well as general assistance with housing, finances, and home safety. CBSS also provide opportunities for community and civic engagement through various volunteer programs [1] and can enhance individuals' skills and attitudes "to live in and gain more control over local aspects of their communities" [2].

More than 20% of older adults (i.e., those aged 60 and above) currently receive CBSS [3]. Older adults who use these services need them: over 90% of service users have multiple chronic conditions [4] and corresponding activity of daily living (ADL) deficits [5]. With the rapid aging of our population, even as overall health improves the number of older adults who could benefit from CBSS is expected to increase significantly in the coming years [6].

A recent nationwide survey of community-dwelling older adults found that a substantial majority were very interested in receiving information about CBSS [7]. However, respondents often did not know the range of services provided or where (or how) to access them. Survey respondents viewed health care providers as one of their major sources for information about CBSS and were less likely to contact community-based agencies directly [7]. Many older adults and caregivers feel most comfortable discussing health and social issues with their health care provider. As such, health care providers are ideally positioned to educate older patients and their caregivers about CBSS and to refer them for services and supports when appropriate.

There is little information in the literature about health care providers' knowledge of and referral patterns to agencies providing CBSS. One Canadian study published almost 25 years ago found that physicians lacked basic information about these services; almost half (47%) acknowledged that lack of information contributed to their failure to refer patients for CBSS [8]. Although we did not identify any recent studies on this topic, we suspect that most health care providers still lack basic knowledge about the types of

services provided by these agencies, which types of patients are eligible to receive them, and how to refer older patients (and/or caregivers) for services when appropriate.

This paper seeks to address this gap by (1) briefly describing the history of and funding sources for agencies providing CBSS; (2) defining the specific types of CBSS available and describing several types of agencies that provide them; (3) defining who is eligible to receive these services; and finally (4) providing practical tips about how to access CBSS. For the purposes of this paper, we define an agency providing CBSS as one that delivers services (e.g., home delivered meals) or programs (e.g., chronic disease management classes at senior centers) in a community-based setting. We exclude certified home health services (such as visiting nurse or home physical therapy) and state Medicaid waiver programs to focus the discussion on individual organizations less familiar to clinicians.

2. A Brief History of Agencies Providing Community-Based Supports and Services and Their Funding Sources

Although clinicians ultimately must look locally to find out what their patients need and which CBSS are available to help address that need, the origins of nationally supported CBSS begin in Washington. Locally run agencies providing CBSS owe their growth to a federal infrastructure that has enabled and supported them through funding for administration, services, and demonstration projects.

Federal funds were first allocated for social service programs targeting older adults in 1952 [9]. More than a decade later, the passage of the Older Americans Act (OAA) in 1965—the same year Medicare and Medicaid were established—created the formal framework for large-scale federal support of agencies providing CBSS. The OAA established the Administration on Aging (AoA) and mandated creation of state Agencies on Aging to promote delivery of social services to older Americans [9].

Currently, the AoA is one of the units of the Administration for Community Living in the Department of Health and Human Services. The AoA is divided into five offices: (1) Supportive and Caregiver Services; (2) Nutritional and Health Promotion Programs; (3) Elder Rights; (4) American Indian, Alaskan Native and Native Hawaiian Programs; and (5) Long-Term Care Ombudsman Programs [10]. The national aging services network through which the AoA promotes home and community-based services consists of 56 state (and territorial) units on aging, 629 area agencies on aging (AAA), 256 Native American and Native Hawaiian organizations, together with the tens of thousands of direct service providers and volunteers [3].

The OAA funds services under several different titles. Title III, which accounts for nearly three-quarters of the AoA's budget (1.2 billion dollars in 2012) [11], funds the State Units on Aging and AAAs. The target population consists of individuals aged 60 and over. Although there is no means testing, 30% of those receiving Title III services in fiscal year 2010 had an income below the federal poverty line [11]. People

who participate in OAA programs also often need and receive non-Title III services, as well. For example 29% of those who receive home delivered meals also receive Medicaid; 22% of those who receive homemaker services also receive energy assistance [12].

Federal dollars only partially fund AAAs and the organizations they support, and a community organization's funding is often quite precarious. Only 57% of senior centers received OAA funding in fiscal year 2012 [3]. New York City's AAA, the NYC Department for the Aging, is the largest in the country with a proposed budget of over \$262,000,000 for 2014-2015. Approximately 29% of this amount is expected to come from federal funds, with the remaining amount coming from state (14%) and municipal (57%) sources [13]. Thus, while the OAA has established an infrastructure to oversee, plan, and fund CBSS for older Americans, its budget is a fraction of what is needed to pay for all of the services provided by these agencies. The survival of the CBSS network depends on a combination of national, state, and local government support along with private contributions, business support, and other philanthropy.

3. Examples of Services and Supports Provided by Community-Based Organizations

Community-based organizations provide a broad range of programs for older adults and caregivers. Most health care providers are familiar with nutrition, homemaker, and transportation services as well as senior centers but many other services are available, including legal assistance and case management services for clients and counseling and respite services for caregivers. Table 1 lists the primary CBSS available for use by older adults and their caregivers; although broad in scope, the amount of services any one individual receives is often quite limited and not a substitute for formal or family caregiving.

The following section summarizes information about four commonly used community-based agencies that provide these services.

3.1. Nutrition Service Programs. Although often colloquially thought of as "Meals on Wheels," subsidized nutrition encompasses a far broader range of services. Elder nutrition services constitute the largest OAA program [14]; total federal expenditures for the three main programs (Congregate Nutrition Services, Home Delivered Nutrition Service, and Nutrition Services Incentive Program) totaled \$816,289,000 in fiscal year 2012. Despite this significant federal outlay, Title III support provides only 35% of funding for these meals; the rest of the funding comes from state and local government and philanthropic and private sources [3].

These Title III programs were designed not just to relieve "food insecurity" but also to promote socialization and physical health and well-being [14]. Socialization occurs in the setting of congregate meals that are served in the community through senior centers, day health programs, and other venues.

TABLE 1: Specific community-based supports and services.

Client services	Description
Home delivered meals	Meals delivered to the home of those who cannot prepare or obtain adequate nutrition
Congregate meals	Meals served in a community setting to those who cannot prepare or obtain adequate nutrition
Transportation	Includes subsidized mass transit, curbside-to-curbside paratransit and other assisted transportation, and driver education
Personal care	Hands-on or cueing to assist individuals with ADLs or IADLs
Homemaker services	Services designed to maintain a healthy home environment such as housekeeping, meal preparation, laundry, and shopping
Information and assistance	Used to help individuals or their representatives identify, access, and use support services (exclusive of case management)
Nutrition education and counseling	Assessment of and assistance in meeting of an individual's nutritional needs by a licensed nutritionist or dietician
Adult day care	Community-based program offering social, recreational, and health-related services in congregate setting
Case management	Professional management of an individual's health care; identification and assessment of biopsychosocial needs; monitoring use of services to ensure positive outcomes
Outreach	To inform and educate the public of the availability of services, benefits, and programs
Chore	Household tasks such as heavy cleaning and yard work
Legal assistance	Consultation and representation for consumer issues, housing, benefits, etc.
Caregiver services	Description
Respite	Can involve adult day care, in-home or brief periods out of home in a nursing home or assisted living facility
Access assistance	Assistance to caregivers to gain access to AOA programs
Counseling, support group, training	Miscellaneous: individual counseling; caregiver support groups; training in caregiving skills
Supplemental services	Extra services provided on a short term basis

From *Administration on Aging: FY 2012 Report to Congress* [3]. Each column is listed in descending order based on units of service.

Nutritional service programs are directed toward those with significant impairments. A 2009 survey of recipients determined that 41% of those receiving congregate meals and 63% of those receiving home delivered meals had 6 or more chronic conditions. In this same study, 9% of those receiving congregate meals and 31% of those receiving home delivered meals reported at least 3 ADL limitations [4]. The effectiveness of nutrition support programs has been studied; data suggest that home delivered meals can reduce nursing home admissions [15, 16].

3.2. Senior Centers. The first senior center (William Hodson) opened in 1943 in New York City. Over the past 70 years, senior centers have proliferated nationwide (totaling 10,000 in FY 2012 [3]) and now serve as "community focal points" and gateways to health, educational, social, and recreational services for as many as 1 million older adults every day [17].

Although there is a general sense that senior centers improve physical and mental health, this is not well investigated. Many studies examining the effectiveness of senior centers have been cross-sectional or had methodological weaknesses [18]; a few controlled trials have examined specific interventions (e.g., exercise, education) delivered at senior centers and suggested improved outcomes [18, 19].

Over the past decade participation in senior centers has declined, especially for the younger, healthier segments of the older population [19], giving rise to a movement to

create more flexible and responsive models that will attract a broader range of individuals and be able to meet a diversity of needs. Pardasani and Thompson [20] have investigated and classified innovative models into six types, reflecting foci on greater age diversity, health promotion, and intellectual stimulation:

- (i) community centers for all ages,
- (ii) wellness centers for active adults over 50,
- (iii) lifelong learning/arts centers for adults over 50,
- (iv) continuum of care/transitions for older people to age in place,
- (v) entrepreneurial centers focusing in employment and productivity,
- (vi) café programs for adults 50 years and over that mix age groups and provide a community space for meals, education, and entertainment.

Although locating a convenient senior center is an important first step, it is important to determine if choices are available, and if so, which senior center could most closely serve a patient's needs.

3.3. Adult Day Services Centers. Adult day services (ADS) centers provide coordinated services in a community setting. There are three types: social, medical/health, and specialized

(e.g., providing programs for demented individuals) [21]. ADS use is growing. As of 2010, there were 4,601 ADS centers in the USA, 98% of which were open Monday–Friday. Two-thirds of participants attend at least 3 days/week [22]. Three-fourths of these programs offer medication management for mental health disorders [23].

As with other CBSS, it is difficult to measure effectiveness in the absence of randomized controlled trials. Some studies have failed to demonstrate clearly positive outcomes [24, 25], but others suggest that these programs may enhance quality of life and reduce stress [26, 27].

3.4. Naturally Occurring Retirement Communities: An Example of a Creative Solution to a Demographic Challenge. Formally known as Naturally Occurring Retirement Community-Supportive Service Program (NORC-SSP), this model of care is geographically based rather than service based. The first NORC was created in 1986 at a housing development (Penn South Houses) in New York City to support a group of the elderly who had aged in place but required a support system to enable them to continue to live independently in the community [28]. The development partnered with a local social service agency (United Jewish Appeal Federation of New York) to establish the services necessary to convert what was an apartment complex into housing that could meet the needs of those in declining health. NORCs are public-private partnerships and receive support both from local agencies and the federal government, via Title IV of the OAA [29].

There are approximately 100 NORCs, half in New York and the rest scattered throughout the USA [30]. NORCs are formal organizations, with paid staff and volunteers who provide services including socialization, care coordination, and transportation, in addition to expedited referrals to other community services such as home health, nutrition, or legal services [29]. A newer alternative, known as Villages, is membership-driven and privately funded, originating most often in areas of greater wealth [30]. Another option is independent senior housing programs that employ service coordinators who link residents to CBSS. Coordinators' positions can be funded locally or federally [31].

4. Locating and Determining Eligibility for Services and Supports

Navigating CBSS can be challenging. Eligibility for CBSS benefits depends upon a host of factors that are individual and agency/service-related. OAA requires only that clients be 60 and over; locally funded programs may require means testing. A brochure "You Gave, Now Save" published by the National Council on Aging lists the basic services and general information about eligibility and access: <http://www.ncoa.org/assets/files/pdf/center-for-benefits/You-Gave-Now-Save-Guide-to-Benefits.pdf>. Online, the Benefits Checkup (<https://www.benefitscheckup.org/>) helps a patient or caregiver determine eligibility for services and benefits by entering personal information about needs, assets, and expenditures.

The services themselves can be located via local or national sites. Nationally, the AoA sponsors the Eldercare

Locator, which is accessible via the web or phone. States or regions may have their own government information phone number or website offering assistance. Information about how to access CBSS is shown below.

Accessing Community-Based Services

- (1) National Eldercare Locator: <http://www.eldercare.gov/>:
 - (a) by zip code,
 - (b) by service,
 - (c) toll-free number: 1-800-677-1116.
- (2) Family caregiver alliance navigator: <https://caregiver.org/family-care-navigator>.
- (3) Area Agency on Aging Network:
 - (a) national websites that list links (these may not be up to date, if a site has moved):
 - (i) National Association of Area Agencies on Aging: <http://n4a.membershipsoftware.org/content.asp?contentid=146>,
 - (ii) Administration on Aging's AAA finder: http://www.aoa.gov/AoA_programs/OAA/How_To_Find/Agencies/find.agencies.aspx,
 - (b) search at the state level: office or department of aging (which will usually list the AAAs by county),
 - (c) search by county (e.g., "Area Agency on Aging, Cayuga County, New York").
- (4) Web search for the individual service:
 - (a) example 1: nutrition:
 - (i) search globally (rather than just "meals on wheels") for home delivered or congregate meals or nutrition assistance,
 - (ii) counseling and other forms of nutrition support may be available,
 - (b) example 2: senior centers:
 - (i) these will usually be called senior center but they may be listed as a subcategory under community resources or congregate meals,
 - (c) example 3: adult day services centers: <http://nadsa.org/consumers/choosing-a-center/>,
 - (d) example 4: naturally occurring retirement communities: <https://www.norc.org/>.

A newer model of agency, already available in 52 states/territories (as of 2013, 70% of the population was covered), is the Aging and Disability Resource Center [32]. These centers are programs jointly managed by the Administration for Community Living and Centers for Medicare and Medicaid Services (and in some cases, the Department of Veterans Affairs) to expedite and simplify access to long-term care services and hence the motto: "No wrong door." The programs offer assistance with care transitions in order to help individuals avoid long-term institutionalization; they also help people access benefits such as Medicaid [33].

5. Counseling Patients and Caregivers Who Would Benefit from Community-Based Supports and Services

CBSS are underutilized by older adults and caregivers for several reasons, including a lack of awareness, reluctance, unavailability, and unaffordability [34]. Clinicians can address the first two of these barriers directly; social work services are occasionally necessary to help patients gain access to services that may substitute for those that are not local or require payment.

Even when services and programs are available, older patients and caregivers sometimes refuse them. They may lack experience in accessing services or have difficulty accepting that they need them [35]. They may resist congregating with “old people” or feel that services are not sensitive to their ethnic group. They may resent subjecting themselves to unnecessary requirements or loss of control; they may feel judged or may feel services are not specific to their needs [36]. It may be useful to anticipate these attitudinal barriers and provide evidence for the usefulness of local programs.

Assessing a patient’s faith community may also help the clinician when thinking about options for community support. Religious institutions are commonly a well-trusted component of affiliated seniors’ lives, especially in ethnic minorities where a level of mistrust of medical institutions can influence their receptiveness to medical senior/social services. Older adults are more likely to be affiliated with religious congregations and attend services (67–69% above age 65), with an even greater percentage participating in ethnic minority communities [37]. Many of these congregations have some sort of senior outreach, ranging from home visitations to more formalized programs.

Finally, visiting CBSS programs and meeting the staff can be invaluable for the clinician to provide personal experience and anecdote to go along with the generic advice. Local programs generally welcome the opportunity to have clinicians come in to do presentations on specific topics related to health; both the clinician and the CBSS can establish a mutually beneficial collaborative relationship.

6. Conclusion

Clinicians should develop familiarity with CBSS and the agencies that provide them. Knowledge of and coordination with CBSS are essential if clinicians are to create more flexible and responsive models of care (e.g., medical homes) for their older patients [38, 39]. Services and supports provided by these agencies can be a critical link in helping older adults remain in the community.

Conflict of Interests

Dr. M. Carrington Reid has been a consultant for Endo Pharmaceuticals. Dr. Eugenia L. Siegler receives royalties from Springer Publishing Company. There is not any other potential conflict of interests reported by the authors.

Authors’ Contribution

Eugenia L. Siegler contributed to the concept and design, literature review, and drafting of the paper, and took primary responsibility for its content; Sonam D. Lama performed the literature review and drafting of paper; Michael G. Knight carried out the drafting of the paper and critical revision of the paper for important intellectual content; Evelyn Laureano carried out the drafting of the paper and critical revision of the paper for important intellectual content; M. Carrington Reid contributed to the concept and design, drafting of the paper, and critical revision of the paper for important intellectual content.

Acknowledgments

The paper was supported by a grant from the John A. Hartford Foundation and an Edward R. Roybal Center for Translational Research on Aging Award (P30AG22845).

References

- [1] National Association of Area Agencies on Aging, *The Maturing of America—Communities Moving Forward for an Aging Population*, National Association of Area Agencies on Aging, Washington, DC, USA, 2011, http://n4a.membershipsoftware.org/files/Maturing_of_Ameria.11.pdf.
- [2] N. Chaudhary, A. Vyas, and E. B. Parrish, “Community based organizations addressing South Asian American health,” *Journal of Community Health*, vol. 35, no. 4, pp. 384–391, 2010.
- [3] K. Greenlee, *Administration on Aging: FY 2012 Report to Congress*, Washington, DC, USA, 2013, http://www.acl.gov/News-Room/Publications/docs/AOA_2012_AnnualReport.pdf.
- [4] R. Kleinman and L. Foster, *Multiple Chronic Conditions among OAA Title III Program Participants*, Administration on Aging Issue Brief, Washington, DC, USA, 2011.
- [5] A. Barrett and J. Schimmel, *OAA Title III Services Target the Most Vulnerable Elderly in the United States*, Mathematica Policy Research, Washington, DC, USA, 2010.
- [6] Congressional Budget Office, “Rising Demand for Long-term Services and Supports for Elderly People,” 2013, <http://www.cbo.gov/publication/44363>.
- [7] N. Brossoie, K. A. Roberto, S. Willis-Walton, and S. Reynolds, *Report on Baby Boomers and Older Adults: Information and Service Needs*, Virginia Polytechnic Institute and State University, Blacksburg, Va, USA, 2010.
- [8] M. A. Craven, N. Kates, and P. Raso, “Assessment of family physicians’ knowledge of social and community services,” *Canadian Family Physician*, vol. 36, pp. 443–447, 1990.
- [9] Administration on Aging, *Historical Evolution of Programs for Older Americans*, 2013, http://www.aoa.gov/AOA_programs/OAA/resources/History.aspx.
- [10] Administration for Community Living, “ACL Organizational Chart,” 2012, http://acl.gov/About_ACL/Organization/acl_org.aspx.
- [11] C. O’Shaughnessy, “Older Americans act of 1965: programs and funding,” in *National Health Policy Forum*, pp. 1–10, Washington, DC, USA, 2012.
- [12] A. Barrett and J. Schimmel, *Multiple Service Use among OAA Title III Program Participants*, Mathematica Policy Research, Washington, DC, USA, 2010.

- [13] L. Barrios-Paoli, *NYC Department for the Aging Annual Plan Summary*, NYC Department for the Aging, 2013, http://www.nyc.gov/html/dfta/downloads/pdf/dfta/dfta_aps.sept1314.pdf.
- [14] K. J. Colello, *Older Americans Act: Title III Nutrition Services Program*, 2010, http://s3.amazonaws.com/zanran_storage/aging.senate.gov/ContentPages/1112032523.pdf.
- [15] K. S. Thomas and V. Mor, "The relationship between older Americans act title III state expenditures and prevalence of low-care nursing home residents," *Health Services Research*, vol. 48, no. 3, pp. 1215–1226, 2013.
- [16] K. S. Thomas and V. Mor, "Providing more home-delivered meals is one way to keep older adults with low care needs out of nursing homes," *Health Affairs*, vol. 32, no. 10, pp. 1796–1802, 2013.
- [17] National Council on Aging, *Senior Centers Fact Sheet*, National Council on Aging, Washington, DC, USA, 2013, http://www.ncoa.org/assets/files/pdf/FactSheet_SeniorCenters.pdf.
- [18] T. S. Dal Santo, *Senior Center Literature Review, Reflecting and Responding to Community Needs*, California Commission on Aging, Sacramento, Calif, USA, 2009, http://www.calseniorcenters.org/Literature_Review.pdf.
- [19] I. Jellineck, M. Pardasani, and B. Sackman, *21st Century Senior Centers: Changing the Conversation*, Council of Senior Centers and Services of New York City, New York, NY, USA, 2013, <http://cscs-ny.org/files/FINAL-WHOLE-REPORT.pdf>.
- [20] M. Pardasani and P. Thompson, "Senior centers: innovative and emerging models," *Journal of Applied Gerontology*, vol. 31, no. 1, pp. 52–77, 2012.
- [21] National Adult Day Services Association, "About Adult Day Services," 2013, <http://nadsa.org/learn-more/about-adult-day-services/>.
- [22] MetLife Mature Market Institute, *The MetLife National Survey of Adult Services*, MetLife Mature Market Institute, New York, NY, USA, 2010, <https://www.metlife.com/assets/cao/mmi/publications/studies/2010/mmi-adult-day-services.pdf>.
- [23] H. Dabelko-Schoeny, K. A. Anderson, and J. Guada, "Adult day services: a service platform for delivering mental health care," *Aging and Mental Health*, vol. 17, no. 2, pp. 207–214, 2013.
- [24] E. Iecovich and A. Biderman, "Use of adult day care centers: do they offset utilization of health care services?" *Gerontologist*, vol. 53, no. 1, pp. 123–132, 2013.
- [25] M. Baumgarten, P. Lebel, H. Laprise, C. Leclerc, and C. Quinn, "Adult day care for the frail elderly: outcomes, satisfaction, and cost," *Journal of Aging and Health*, vol. 14, no. 2, pp. 237–259, 2002.
- [26] S. H. Zarit, K. Kim, E. E. Femia, D. M. Almeida, J. Savla, and P. C. M. Molenaar, "Effects of adult day care on daily stress of caregivers: a within-person approach," *Journals of Gerontology B: Psychological Sciences and Social Sciences*, vol. 66, no. 5, pp. 538–546, 2011.
- [27] S. H. Zarit, K. Kim, E. E. Femia, D. M. Almeida, and L. C. Klein, "The effects of adult day services on family caregivers' daily stress, affect, and health: outcomes from the Daily Stress and Health (DaSH) study," *The Gerontologist*, vol. 54, no. 4, pp. 570–579, 2014.
- [28] F. Valdeck, *A Good Place to Grow Old Again: New York's Model for NORC Supportive Service Programs*, United Hospital Fund, New York, NY, USA, 2004.
- [29] E. A. Greenfield, A. E. Scharlach, C. L. Graham, J. K. Davitt, and A. J. Lehning, *An Overview of Programs in the National NORCs Aging in Place Initiative: Results from a Organizational Survey*, Rutgers School of Social Work, Brunswick, NJ, USA, 2012, <http://agingandcommunity.com/wp-content/uploads/2012/12/National-NORC-FINAL.pdf>.
- [30] E. A. Greenfield, A. E. Scharlach, A. J. Lehning, J. K. Davitt, and C. L. Graham, "A tale of two community initiatives for promoting aging in place: similarities and differences in the national implementation of NORC programs and villages," *Gerontologist*, vol. 53, no. 6, pp. 928–938, 2013.
- [31] American Association of Service Coordinators, "What is a service coordinator?" December 2014, <http://www.servicecoordinator.org/AboutUs/WhatisaServiceCoordinator.aspx>.
- [32] Administration for Community Living, *Aging and Disability Resource Center Fact Sheet: 2013*, Department of Health and Human Services, Washington, DC, USA, 2013, http://www.adrc-tae.acl.gov/tiki-download_file.php?fileId=32537.
- [33] ADRC Technical Assistance Exchange, "Aging and Disability Resource Center, Options Counseling, Care Transitions, Systems Integration and the Enhanced Options Counseling Initiatives," November 2013, <http://www.adrc-tae.acl.gov/tiki-index.php?page=ADRCHomeTest>.
- [34] B. L. Casado, K. S. van Vulpen, and S. L. Davis, "Unmet needs for home and community-based services among frail older Americans and their caregivers," *Journal of Aging and Health*, vol. 23, no. 3, pp. 529–553, 2011.
- [35] J. M. Longman, J. B. Singer, Y. Gao et al., "Community based service providers' perspectives on frequent and/or avoidable admission of older people with chronic disease in rural NSW: a qualitative study," *BMC Health Services Research*, vol. 11, article 265, 2011.
- [36] M. Silverstein, J. Lamberto, K. Depeau, and D. C. Grossman, "'You get what you get': unexpected findings about low-income parents' negative experiences with community resources," *Pediatrics*, vol. 122, no. 6, pp. e1141–e1148, 2008.
- [37] W. D. Hale and R. G. Bennett, "Addressing health needs of an aging society through medical-religious partnerships: what do clergy and laity think?" *Gerontologist*, vol. 43, no. 6, pp. 925–930, 2003.
- [38] A. Garg, M. Sandel, P. H. Dworkin, R. S. Kahn, and B. Zuckerman, "From medical home to health neighborhood: transforming the medical home into a community-based health neighborhood," *Journal of Pediatrics*, vol. 160, no. 4, pp. 535.e1–536.e1, 2012.
- [39] *Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs*, 2011, http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/understanding/guidelines_pcmh.pdf.



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