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# Engaging Older Adults to Build Social Capital

Beverly Lunsford and Danielle Janes

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**Abstract – Countries are considering the healthcare implications as the proportion of older adults increases, including rising healthcare costs and resources needed as more adults want to "age in place" or continue living in the community. More in home resources and support services will be needed for older adults to continue living independently at homes. Older adults are an incredibly untapped resource with a continuing need to contribute to society and a willingness to help others. Older adults are working longer than ever before, so they have the potential to build their own social capital for meeting the needs of aging colleagues. This paper will explore the changing demographics of older adults globally, examine the capacity and potential of older adults for providing in home resources and supportive services for other adults in needs, and discuss the health policy implications of engaging older adults to build social capital. Singapore will be used as an example for illustrating how building social capital among older adults could have a positive impact on older adults and Singaporean society.**

**Keywords - Villages, TimeBanks, chronic illness, instrumental activities of daily living, community, aging-in-place**

## I. Introduction

Many countries are concerned about how to prepare for the increasing proportion of older adults. Healthcare costs are likely to rise, and more adults want to "age in place" or continue living in the community. However, this will require more in home resources and support services. But older adults may be an incredibly untapped resource with a continuing need to contribute to society and a willingness to help others. Older adults have the potential to build their own social capital for meeting the needs of aging colleagues. This paper will explore the changing demographics of older adults globally, examine the capacity and potential of older adults for providing in home resources and supportive services for other adults in needs, and discuss the health policy implications of engaging older adults to build social capital. Singapore will be used as an example for illustrating how building social capital among older adults could have a positive impact on older adults and Singaporean society.

## II. Global Demographics of Aging

Over the next decades, the number of older adults is expected to grow at epic proportions around the world. Since 1960, there has been an increase in the proportion of older adults from 10% to 20% of the population in developed countries with the greatest rate of growth for the world's oldest old, e.g. people 80 and over.[1] Even in less developed countries, 5% of people are over 65, and that number continues to grow.[2]

Certainly this "graying" of the world population will have an impact on the demands for healthcare by an aging population. Historically, communicable diseases and trauma were the leading causes of death. But as environmental conditions, nutrition, and healthcare improved, noncommunicable diseases, i.e. chronic illnesses have become the predominant cause of death for older adults worldwide.[3] The most common chronic health problems reported are heart disease 37% for men, 26% for women; hypertension 52% for men, 54% for women; stroke 10% among men, 8% among women; cancer 24% among men, 19% among women; diabetes 19% for men and 17% for women; and arthritis 43% for men and 54% for women.[4] Most of these diseases occur in combination and can cause progressive functional

[1] World Health Organization (2012). Are you ready? What you need to know about aging, World Health Day 2012- toolkit for event organizers. *World Health Organization*. Available at: http://www.who.int/world-health-day/2012/toolkit/background/en/

[2] Kinsella K, He W. *An Aging World: 2008*. Washington, DC: National Institute on Aging and U.S. Census Bureau, 2009.

[3] Olusoji, A.; Smith, O.; & Robles, S. (2007). *Public Policy and the Challenge of Noncommunicable Diseases*. Washington, D.C.: World Bank. Print.

[4] Center for Disease Control and Prevention (2006). Supplement on Aging & 2nd Supplement on Aging. 2006 National Health Interview Survey. Atlanta: Center for Disease Control and Prevention.

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decline and increased need for supportive assistance to remain independent. In addition, these listings do not include Alzheimer's disease and related dementias, which are recognized as the 6th leading cause of death in the U.S. [5] It too causes increasing frailty and cognitive impairment over many years requiring constant caregiving.

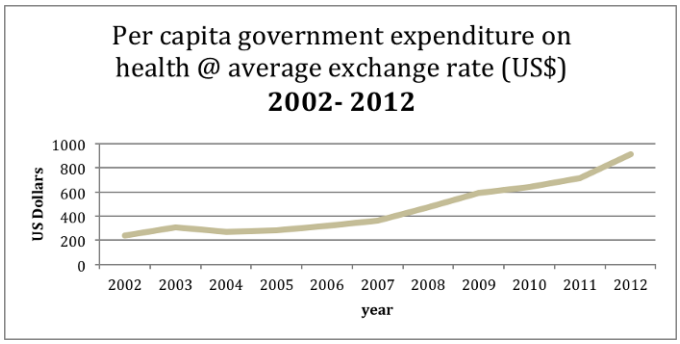
Injuries, accidents and short-term illnesses were the primary cause of death prior to the 1950s. People either lived, or died and our healthcare systems were built around these diseases that needed short-term rescue and acute care. Today, the predominant health problems are chronic and long-term requiring more in home and community care. Countries are struggling to redevelop systems of care to enable people to continue living safely in their homes and community.

## III. Health Care Concerns for Aging Adults

The country of Singapore will be used as a case study to examine the capacity for building social capital among older adults to meet the potential needs of the increasing number of older adults with attendant needs for in home and community supports. In Singapore, older adults live with chronic illness for many years. During that time they may develop significant disability and functional decline. In a 2009 survey of more than 2000 men and women over 65 in Singapore, 80% of men report no physical limitations in contrast to 52% of women who reported no limitation.[6] Then 28% of women, and 12% of men report 2 or more limitations in their ability to perform regular activities of daily living (ADL), i.e. bathing, dressing, preparing food, etc.

With the growth in long-term chronic health problems, it is not surprising to see the per capita government expenditure on health increased from $235 in 2002, to $912 in 2012 (U.S. dollars). [7] See Table 1. Between 2011 and 2012 alone, there was a sharp $200 increase per capita from $714 to $912 dollars.

Table 1. Rising Health Care Costs




Source: WHO (2013)

In addition to traditional healthcare costs, there is a growing crisis as families struggle to meet the demand for in-home caregiving, i.e. assistance with ADLs, as well as instrumental activities of daily living (IADL), e.g. transportation for food, medical appointments, and social activities. In Singapore, in home caregivers provide the bulk of home-based care for older adults. But this creates several limitations for family caregivers as they try to meet the growing demands. More than 50% of caregivers are 45-59 years of age, likely adult children. 30% are older and likely to be spouses or life partners. [8] In addition, the survey indicated that 52% of caregivers are working age, but only 23% have Eldercare leave. There were 38% who report flexible working arrangements, but in spite of this, as the older adult's need for care increases, many family caregivers leave their jobs, or cut back on working hours to accommodate the needs of older adults. In addition, the majority of caregivers are married (65%) and female (60%). If the caregiver is an adult child providing care for a parent, they may have family responsibilities of their own. Or if the married spouse is providing care for a partner, this may be physically challenging for them to maintain on their own.

People with financial means are able to hire Formal Caregivers who are employed as live-in maids in older adult households. [9] However, while the MCYS survey indicated that 17% of people hire Formal Caregivers, the majority of older adults (83%) receive Informal Caregiving.

[5] Alzheimer's Association (2015). Alzheimer's Facts and Figures. Chicago, IL: Alzheimer's Association. Available at: http://www.alz.org/alzheimers_disease_facts_and_figures.asp

[6] International Longevity Centre- Singapore (2011). A Profile of Older Men and Older Women in Singapore 2011. Ministry of Community Development, Youth and Sports (MCYS) Social Isolation, Health and Lifestyles Survey 2009. Singapore: Tsao Foundation.

[7] WHO (2013), n.d. Singapore statistics summary (2002 - present). Available at: http://apps.who.int/gho/data/node.country.country-SGP

[8] International Longevity Centre- Singapore (2011). A Profile of Older Men and Older Women in Singapore 2011. Ministry of Community Development, Youth and Sports (MCYS) Social Isolation, Health and Lifestyles Survey 2009. Singapore: Tsao Foundation.

[9] Ibid.

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The initial premise of this paper is that able-bodied younger older adults may be able and willing to provide resources and supportive services for older adults who are more limited in functional capacity and/or frail. If we consider that with the growing number of older adults, 80% of males, and 48% of women report no limitations with activities of daily living; these individuals may be very interested in participating in education and meaningful activities to build social capital to be able to care for themselves and other older adults more effectively.

## IV. Stereotypes of Aging

There may be critical stereotypes to address before societies are willing to embrace the concept of engaging older adults in providing resources and support services for more frail older adults. Some prevailing stereotypes include the physical, mental and psychosocial capacity of older adults.

While people fear aging and the physical decline, in fact, many older adults continue to work, either because they choose to, or because they need to work for financial purposes. In 2003, 4.5% of Singaporeans over 60 were still working outside the home. This number has grown, so that in 2013, more than 11% of older adults are still in the workforce.[10]

In addition, older adults continue to participate in community activities. Many participate daily in resident committees (RC), community centers (CC), and community development center (CDC) events.[11] This level of activity for daily community activities, or at least weekly activities indicates that older adults are physically able to participate with some frequency in caring and befriending other older adults with greater need.

Another negative stereotype is the mental capacity of older adults, including the common myth that all older adults have memory problems. The research indicates that older adults may have changes in their cognitive processes, but loss of memory may be limited. When younger people lose something or can't remember something, it just happens! When older people lose something or can't remember it is because they are aging!

Expectations may actually influence our ability to perform, which was demonstrated in a study of two groups of adults, one older and one younger, who were given instructions for repeating a group of statements.[12] Each were given exactly the same statements except for emphasis on memory versus learning, i.e. one group was asked to remember statements from a list and the other group was asked to learn as many statements as they could. Each group was given the list of statements to study and then repeat for the researcher. There was a remarkable difference between older and younger participants' ability to repeat statements when instructions were to "remember" the list. However, there was no difference between age groups when the instructions were to "learn". So older adults may believe that they can learn, but less likely to believe they are able to remember.

In addition to having the physical and mental capacity for daily and weekly activities, there are psychological, social and spiritual needs that older adults possess that make them especially well-suited to build social capital for resource and support services for other older adults. Carstensen and other social scientists note a paradox in aging, e.g. despite major losses, emotional well-being is as good, if not better in older adults.[13] In research of experience sampling studies with younger and older participants, each participant recorded emotions with pagers during the day. The recordings reveal that negative emotions are experienced much less frequently by older adults, and positive emotions were experienced by both young and older at about the same frequency. The positive attitudes and interpersonal skills can be extremely valuable in caring for other people in need.

An additional social/spiritual attribute of older adults is the need to continue to contribute to society. This is illustrated in a study of older adults who had just transitioned into nursing home residential care. Researchers were studying the continuity of meaning in the lives of older adults recently moved from independent living to nursing home care.[14] While nursing home

[10] Older Adult Mid Year Labor Statistics in Singapore, by Age -- Under utilized Resource: Retired, Unemployed, and Underemployed, Ministry of Manpower- Labour Force in Singapore, 2013

[11] International Longevity Centre- Singapore (2011). A Profile of Older Men and Older Women in Singapore 2011. Ministry of Community Development, Youth and Sports (MCYS) Social Isolation, Health and Lifestyles Survey 2009. Singapore: Tsao Foundation.

[12] Chasteen, A. L., Bhattacharyya, S., Horhota, M., Tam, R., & Hasher, L. (2005). How feelings of stereotype threat influence older adults' memory performance. *Experimental Aging Research*, *31*(3), 235–260.

[13] Carstensen, L. (2006), "The influence of a sense of time on human development," *Science*, 312 (5782), 1913-915.

[14] Lunsford, B.; Ban-Hattori, Y.; & Janes, D. (Unpublished). Continuity of meaning among older adults transitioning for independent to nursing home life. Washington, DC: GW Center for Aging, Health and Humanities.

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residents may be considered more frail older adults, the respondents exemplify the capability and desire for continued meaning and sense of contribution to life. One of the predominant themes was that these older adults wanted to develop new relationships. While they had previous relationships with families, friends, grandchildren, now they were looking at meeting new people and staff within the facility. As one resident commented, "I like meeting new people and encouraging them".

Existentialism was another theme as people expressed reflections from their lifelong experiences. Some expressed religious themes of comfort. By and large people kept saying they were so fortunate to have lived this long and they still wanted to contribute and be doing as much as they could for other people. A resident said, "My purpose is to do as much as I can for myself and for others".

This need for older adults to be doing, especially helping others provides tremendous potential for building social capital to care for the growing numbers of older adults who are likely to need care and social connection as they age.

## V. Resource and Services Exchange Systems

There are evolving service exchange models globally that could be used for building the social capital of older adults in Singapore. Several models in the literature include the Local Exchange Trading System (LETS), time banking, an hours system, and Villages. The LETS system can be found in several countries, including Australia, Canada, Ecuador, Venezuela, German, Hungary, Czech Republic, Netherlands, Switzerland, Japan, South Korea, Spain, U.S. and U.K. It is frequently a group of people who democratically organize a non-profit enterprise to coordinate listing services people can do, and contact information for people who want to request services. There may be LETS credit for time invested in helping other people.

A time banking system is similar; but they are more likely to be organized by an organization and/or an agency as an activity to try to help meet some of the needs of the people within their organization. They are frequently organized in a naturally occurring community, particularly for an aging population. It tends to be a more successful system of local spending with a greater variety of services. They may be found in Argentina, Australia, Bermuda, Canada, Greece, Ireland, Monaco, New Zealand, Senegal, South Korea, Spain, Taiwan, UK and US. There is a formal trademarked term, i.e. TimeBank, but unless noted, this paper discusses a system where we are banking time to record for people who contribute and people who utilize services from the network.

Another model is simply called an hours system where a unit of exchange is a person hour. There is a collective of people who are involved in the hourly exchange system. They may be found in Canada, UK, Tunisia, Northern Ireland, Ukraine, and Australia. It is important to note in all of these models that it isn't necessarily one person exchanging services with another person, rather people "bank" credit for various activities and are connected to a network for other goods and/or services, which creates greater synergy.

A final model is the Villages, a neighbor to neighbor model to help each other stay independent in their homes. This is also membership driven and volunteers provide services within their community to assist more frail older adults.

Regardless of the model, there are several attributes of successful exchange systems, [15] which will also illustrate how the different systems work for building social capital. Five important attributes include the need for an administrative and accounting infrastructure, at least minimal funding, a means of engaging people in banking and requesting services, opportunities for social/community activities for networking, and local incentives from businesses and organizations. These requirements may be met in many different ways based on the assets and resources of the local community.

A basic administrative and accounting infrastructure may be managed by an existing organization, a paid coordinator supported by membership fees, or a member as part of their service contribution. An Internet posting board of services or goods may need minimal maintenance, but a system for recording credit exchanges may take more time. One organization had a member who was paraplegic. This person's contribution for the services received was calling people who were not computer savvy and collecting their time credit to record in the computer log of services provided and received.

Some exchange systems have an active core leadership of dedicated coordinators playing a strong role.

[15] Hinterlong, J. (2008). Productive engagement among older Americans, prevalence, patterns, and implications for public policy. Journal of Aging & Social Policy. 20(2):159.

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Others choose a more varied leadership, perhaps with an advisory board to provide support and advice to the coordinators. Other projects go light on leadership, and rely on individual members to manage various organizational needs. In many cases, coordinators earn time credits for the work they contribute.

Many exchange systems hire volunteer coordinators and/or social workers to assist in matching members' needs with available resources. Partners in Care (PIC), a Villages project in Baltimore, Maryland [16] has a social worker who conducts "asset mapping" so anyone who is admitted is evaluated for their specific needs. They also determine the member's ability to contribute. It is a critical aspect for people to recognize that they have assets to contribute as well, perhaps language skills, writing skills, telephone triage, social support, etc.

Examples of how an exchange system may start with a basic infrastructure are four formal TimeBanks in Cambridgeshire, U.K. Somersham was started first in October of 2011 by the county council and the Somersham Parish Council. They developed a steering committee to bring in other organizations and with additional funding they established 3 more TimeBanks in late summer 2012, Cambourne, Littleport and March. These organizations served people in need, so it was advantageous to enable people to support themselves within the community, thus making it possible to meet the growing needs for resources and support within a robust reciprocal services exchange.[17]

Funding for administrative and coordination services to maintain the system may be provided by participating organizations that contribute money, membership fees and/or other creative fundraising schemes. Some systems run from within an organization or agency with a non-profit mission. Many Villages projects in the U.S. charge approximately $500 USD per year for individual membership, $750 for couples, which may be subsidized for people who are not financially able to pay. The Villages project in Baltimore, Maryland operates a Boutique, which is a thrift shop for members to shop and/or earn time credit for volunteering. This provides approximately 25% of the funding for PIC income. Funding is also used for minor repair or member needs that require outside resources. Some exchanges apply to become a non-profit or nongovernmental agency, so they can seek foundation, governmental, and public funding.

Engaging people as members in the exchange system is a critical feature for any time banking system. There needs to be enough services offered, as well as people to request services to attract participants to the system. One way this occurs is when multiple organizations are involved in the planning and organization of the time banking system, such as with the Cambridgeshire group of TimeBanks involving the county council, community organizations and faith-based organizations. Each of these organizations may be involved in recruiting people who provide services, as well as referring people in need of services. Surveys of this TimeBank to the end of October 2013 indicated a total of 2,366 hours were exchanged, with participation by 166 active individuals and organizations. The more organizations involved, the more individuals are involved in contributing time and services, i.e. Somersham had 79 active individuals with 12 active organizations, Cambourne had 37 individuals and 7 active organizations, and Littleport with 25 individuals and 6 active organizations. March was too new to count at the time of the survey. See Table 2.

TABLE 2. RELATIONSHIP OF ORGANIZATIONS TO INDIVIDUALS

| Timebank | Active individuals | Active organisations |
|---|---|---|
| Somersham | 79 | 12 |
| Cambourne | 37 | 7 |
| Littleport | 25 | 6 |

Source: Burgess (2014)

Engaging people who provide services and people who want or need the services in a reciprocal exchange system may be viewed as a building block of social capital, i.e. the pattern and intensity of networks among people, and the shared values that arise from those networks. This includes information sharing, mutual aid, bonding networks for people with similar interests, collective action and recognition that everyone has assets to contribute. The concept of social capital supports a novel means of volunteering based on reciprocal service that enables people to age in place, living more independently with choices and help to reduce loneliness

[16] Huston, B. & Poor, S. (2011). Villages network and partners in care – exchanging time and creating community for older adults. Baltimore Maryland: Partners in Care. Available at: http://timebanks.org/wp-content/uploads/2011/08/Village-Networks-and-Partners-in-Care.pdf

[17] Burgess, G. (2014) Evaluation of the Cambridgeshire Timebanks. Cambridge Centre for Housing and Planning Research: Cambridge.

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and isolation. This promotes active citizenship, community empowerment and community skills. It also forges new relationships and opportunities for individuals and communities.[18]

Reasons people may want to join an exchange system are illustrated by some of the assets and resources available. Services certainly vary among groups, which also illustrates the importance of these systems arising out of the resources and needs of naturally occurring communities. In Cambridgeshire, the top 10 activities and the hours logged in the 2013 survey, include attending social events (379 hours), serving (267), gardening work/advice (140), initial set up (136), leafleting (124), help with social events (109), donation to community pot (94), orchard work (65), shopping (61), collating magazines (59). These are contrasted with a survey in Maine of the top 10 activities, which include transportation, clerical, massage, acupuncture, gift wrapping, computer assistance, minor home repair, haircuts, etc. Resources really vary based on people in each community and somewhat on the needs because many of the organizations who start this for people in need try to engage people who have particular skills.

In addition to maintaining a robust network of appealing resources and services, opportunities for community/social activities are important to enhance the network. It draws more people in to learn about community resources and what's happening, as well as to encourage them to consider what they have to offer. It also serves to build trust among the network, which enables people to more readily ask for help.

Local investments and incentives can be valuable to attracting membership, funding unexpected member needs, and providing incentives for health and safety. Many exchange systems seek incentives from businesses and services so that members might get discounts or vouchers for certain things like the Lifeline home health aid or other health and safety items. Many communities' central governments are talking about premiums and/or tax reductions for people who are contributing and based on their amount of contribution.

## VI. Exchange Systems Research

Two recent studies by the Joseph Rowntree Foundation and the Fan and Samuel Fox Foundation provide insight into how resource exchange systems work and how they build social capital. Joseph Rowntree Foundation in 2013, surveyed 120 older people in the UK with high support needs, living in domestic households of their own.[19] They were not necessarily engaged in formal time banks, but the survey investigated how people were getting their needs met. Participants shared their experiences across four fieldwork sites in the UK, i.e. Dorset, Swansee and Gower, Leeds, and Oxford. Another 50 people took part in 6 in depth case studies examining the design experiences and outcomes of specific models.

What emerged were two different models, formal (e.g. shared lives, homeshare, time banks) and informal (e.g. mutually supportive relationships) exchange systems. The formal networks included TimeBanks in Bromley and across Northern Ireland, and senior co-housing in Fife and Glasgow. The informal networks were mutually supportive communities in Suffolk and self help networks in Cambridge. See Table 3.

TABLE 3. TYPES OF NETWORKS

| | |
|---|---|
| 1. | Formal Networks |
| | • TimeBanks (In Bromley and across Northern Ireland) |
| | • Senior Co-Housing (In Fife and Glasgow) |
| 2. | Informal Networks |
| | • Mutually supportive communities (In Suffolk) |
| | • Self Help Networks ( In Cambridge) |

Source: Bowers (2013)

This study illustrated the benefits and potential options of many types of exchange systems for people aging in place based on mutuality (people supporting each other) and/or reciprocity (people contributing to individual and group well-being). Both formal and informal models of support build social capital with alternatives to traditional forms of long-term care, widening support at a local level and overcoming cultural and structural barriers that older people face.

The second survey, funded by the Fan Fox & Leslie R. Samuels Foundation, Inc., was administered by

[18] Burgess, G. (2014) Evaluation of the Cambridgeshire Timebanks. Cambridge Centre for Housing and Planning Research: Cambridge, U.K.

[19] Bowers, H. (2013). Widening choices for older people with high support needs. Joseph Rowntree Foundation. York, U.K. http://www.jrf.org.uk/publications/widening-choices-high-support-needs.

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the Visiting Nurse Service of New York (VNSNY) Center for Home Care Policy and Research.[20] The study surveyed active older members (ages 60 and over) to gauge the impact on their lives of the TimeBank established by VNSNY to provide resources and services for clients in need.

All members (100%) reported they benefited from TimeBank membership. One person said, *"Now that I'm sick, my TimeBank friends have come to see me, and most importantly, I feel that they care about me as much as I care about them."* The people who indicated the most benefit were participants with the lowest self-reported annual income and those who took surveys in Spanish. There were 73% of participants with an annual income of less than 9,800. Participants indicated they were able to save money, with almost ¾ of participants who were living at the poverty level indicating that TimeBank participation helped them save money.

There were 98% who reported the ability to use their skills to help others. One person said, "*We all have something to give and even if we think we don't TimeBank helps you see you have much to give."* Even those who were vulnerable and needy frequently learned what they had to give back.

One person demonstrated the importance of an exchange system for aging in place, when they said, "*Now I have a broken hand. They cook, clean my house, changed my curtains. They visited yesterday and they call every day*." And 67% reported an increased access to health and other community services because, "*if you're sick or need someone to go with you to the doctor, there's always someone to call*". Ninety-three percent saw TimeBank as a place to obtain information of services and community. One person said, "*There are always more services in the community than most of us know about, but we learn about them by talking to other people who have found them useful.*"

Respondents reported improvements in self-rated physical health (48%) and mental health (72%). One person said, "*they helped me during my most difficult time, the death of my only sibling. If it wasn't for my friends in TimeBank, I would have died of pain and loneliness*."

[20] Visiting Nurse Service of New York (2009). Impact of the TimeBank on its Membership Research Study Results VNSNY Center for Home Care Policy and Research. Available at: http://www.vnsny.org/system/assets/0000/1267/VNSNY_TimeBank_study_results_summary.original.pdf?1273605850

The potential for building social capital among older adults is indicated by the increased relationships reported, i.e. 90% of them gained new friends, 71% reported contact with new friends at least weekly, 82% reported the quality of their life increased, and 92% reported that since joining the time bank, it's easier for them to ask for help. One person said, *"Most of us have trouble asking for help and it doesn't get any easier as you start getting needier. You tend to just isolate yourself and that's a real problem."*

## VII. Health Policy Implications

To illustrate the potential impact of this for Singaporeans, the largest amount of income for Singapore Seniors comes from family, i.e. 43% for older men and 75% for older women. The second largest amount of financial support comes from work income, i.e. 28% male and 12% female. So a services exchange system that could provide critical supportive resources for older adults could significantly reduce the burden of caregiving, increase the ability of older adults to save money, and perhaps reduce the public financial burden. In particular, it was the older adults without children who used a larger amount of public benefits and may benefit from outside resources and support. A services exchange system could really help provide critical resources for people and perhaps reduce the financial and family burden of providing care for seniors.

So looking back on the needs of older adults in Singapore, there are some important public policy implications for lowering healthcare and long-term care costs, and increasing the potential for individual's ability to save financially. In the VNSNY survey members reported increased and earlier access to health care that could result in reducing the cost of healthcare by preventing or mitigating healthcare problems. Members also reported being able to live at home longer with potential reductions in the cost of long-term care. Participants in exchange systems report an increased ability to save, which may result in a reduction in the reliance on public benefits.

There are additional savings in caregiver expenses and outcomes, because work productivity may increase as workers who are also family caregivers may need to take less time off to care for elders. This can reduce job turnover as fewer workers resign to take care of elders. If older adults are able to save money, they may have more

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to spend on other goods and services. And finally with the reduction in potential costs of care and increases in personal savings, taxes are less likely to rise, or rise more slowly with reduced public cost of care.

Building social capital among older adults who want to continue to contribute, who have neighbors and colleagues who may need resources and support, and who would benefit from the social connection and services themselves creates a win-win situation for families, community and society. There needs to be greater awareness of how to develop these networks, but also greater awareness as demonstrated by the Joseph Rowntree Foundation survey, that these systems already exist in formal and informal ways. Healthcare professionals must be able to recognize and utilize these systems for the benefit of the older adults and families served in traditional healthcare systems.

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[2] Burgess, G. (2014) Evaluation of the Cambridgeshire TimeBanks. Cambridge Centre for Housing and Planning Research: Cambridge, UK.

[3] WHO, (2013). WHO (2013), n.d. Singapore statistics summary (2002- present).Available at: http://apps.who.int/gho/data/node.country.country-SGP

## AUTHORS' PROFIEL

**Dr. Beverly Lunsford**, R.N. is an Assistant Professor in the School of Nursing (SON) of George Washington University, USA and the Director of the GW Center for Aging, Health and Humanities. Dr. Lunsford develops interprofessional collaborations in research, education and clinical innovations with GW faculty and others to improve care of older adults. She advocates for the integration of humanities and creative arts in the education of healthcare professionals to teach a more person-centered approach to care. Dr. Lunsford developed two certificate programs at GW. The first was Spirituality and Healthcare Certificate Program, and the second was Palliative Care Nurse Practitioner Program. Dr. Lunsford has been PI for grants to improve the care of older adults, including the Washington DC Area Geriatric Education Center Consortium, Adult Gerontology Nurse Practitioner Education 2015 and Geriatric Education Using a Palliative Care Framework. With these grant projects, Dr. Lunsford collaborated with GW interprofessional faculty and many community organizations to build capacity of the geriatric workforce to provide more comprehensive and continuous care of older adults and their families. Other research has focused on the meaningfulness for older adults in long term care, the importance of creative arts to enhance health and wellbeing, and community resource and support services for older adults and their families. Dr. Lunsford is a Board Member and Director of Research for Health Ministries Association. She is also a member of several professional organizations, including American Nurses Association, Sigma Theta Tau International and Gerontological Society of America.

**Danielle Jane** is a registered nurse receiving her BSN degree from Johns Hopkins in 2007. She continues to work at UCLA Medical Center in the Neuro-Trauma ICU while pursuing dual masters degrees in Public Health and Public Policy. Her interests include aging, medical reimbursement models, futile care, and advance directives. In 2014, as a Somers Long-Term Care Research Intern with the National Academy of Social Insurance, Danielle researched qualitative measures of patient-centered care and community resource and support services for older adults under the supervision of Dr. Beverly Lunsford at George Washington University, School of Nursing.

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