Sustaining Chicago's Informal Caregivers: an Age-Friendly Approach

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ABSTRACT *The concept of age-friendliness has been globally coined by the World Health Organization (WHO) to give value to the physical, social, and environmental factors that can promote or hinder older residents' ability to age in place in cities. The initiative has been very successful in raising awareness among public health policy makers about the generic needs of older adults and urban features that promote active aging. However, the movement has been less focused on highlighting divergent needs of different older adult populations and their informal caregivers. The objective of this mixed method study is to analyze the ratings of 397 caregivers of urban age-friendly features relative to the ratings of 1737 noncaregivers collected as part of a baseline assessment of the age-friendliness of the city of Chicago. Using the approved WHO Vancouver Protocol, the research team also conducted six mixed caregiver/noncaregiver focus groups (n = 84) and three caregiver-only focus groups (n = 21). Survey findings show that informal caregivers rate all eight age-friendly domains with less satisfaction than do noncaregivers. Discussion in focus groups highlighted some of the reasons for these less favorable ratings and foregrounded the domains and themes that mattered most to caregivers. In conclusion, while our study revealed few systematic differences between caregiver and noncaregiver survey satisfaction ratings, caregivers report significantly poorer health than do noncaregivers. In addition, caregiver-only focus groups foregrounded "missing" priority issues specific to caregivers such as respite and the quality of training and flexibility of home help care. Results suggest that one productive next step for researchers would be to widen the usual range of factors considered essential for maintaining the well-being of informal caregivers of community-dwelling older adults. The age-friendly domains provide a starting point for this. Another would be to develop integrated support and improve service responsiveness to particular caregiver/care recipient dyad's physical, psychological, and social needs.*

KEYWORDS *Age-friendly city, Baseline assessment, community wide survey, Informal caregiver*

INTRODUCTION

To date, 258 cities and communities in 28 countries covering 100 million people are members of the World Health Organization's (WHO) global network of age-friendly

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cities,¹ and there is a growing literature on the community characteristics that help or hinder communities from becoming age-friendly.^{2–5} This surge of interest in age-friendly initiatives coincides with an increased use of health equity frameworks by public health planners to address disparities and inequities among vulnerable populations of all ages, making it a significant time to work through the age-friendly and unfriendly factors limiting and enabling “access to resources, opportunities and environments that maximize health and wellbeing,”⁶ as well as compare the experiences of different populations. Research on the impact of disparities on assessments of age-friendliness (for example, low and high income) is emerging,⁷ but despite the WHO’s inclusion of informal caregivers in its original project, little has been published on caregiver ratings of essential indicators of age-friendliness. This article addresses this gap in the age-friendly literature by considering the ratings of 397 caregivers of urban age-friendly features relative to the ratings of 1737 noncaregivers collected as part of a baseline assessment of the age-friendliness of the city of Chicago. It also considers the implications of findings within the context of rich gerontological research on informal caregivers and interventions that support and improve their mental well-being.^{8–11} In the process, our research extends understanding of one key but often under-recognized factor at play in “keeping people healthy longer, delaying or avoiding disability and dependence”¹²—the impact that searching, selecting, and observing resource provision and service delivery have on informal caregiver health. It makes two original contributions to knowledge. First, the age-friendly model widens the usual range of factors considered essential to well-being in the informal caregiver literature.^{8,11} Previous research on caregiver well-being has focused on “burden” and mediating variables such as the cognitive status of the care recipient, as well as functional dependency.⁸ Caregiver satisfaction with built environment and outdoor space, housing, transportation, community support, and health services, for example, has not traditionally been considered significant to caregiver well-being in the literature to date. Second, exploring caregiver positive and negative ratings of the factors deemed essential for age-friendly well-being is important because research has suggested that a lack of positive impact in a caregiver’s quality of life can be indicative of problems in the caregiving role.^{13,14}

For the purposes of this study, we define an informal caregiver as “the family member or other natural person who normally provides the daily care or supervision of a frail or disabled person, or any family member or other natural person who contributes to and is involved in the caretaking responsibilities for such frail or disabled person. Such an informal caregiver may, but need not, reside in the same household as the frail or disabled person.”¹⁵

METHODS

In line with age-friendly protocols and guidelines,^{16,17} our study sample population was recruited from community sites such as senior centers, churches, and community health centers. These venues offer general support to caregivers rather than the more tailored support that can be found in hospital and disease-focused centers. Of the 397 caregiver survey respondents, 71 (25 %) listed their alderman as the source of hearing about the survey; this included information in aldermanic newsletters, ward events, block clubs, and other forms of information from the alderman. Fourteen percent of respondents heard about the survey from senior centers. A significant proportion of respondents (28 %) indicated they heard about

the survey from community organizations or faith-based groups other than senior centers.

Selection of essential age-friendly items for our community-wide survey followed an extensive environmental scan of current age-friendly urban indicators, focus groups with 106 older adults across the city, surveys with 99 government and professional stakeholders, and interviews with 41 stakeholders using a Q-sort prioritization methodology.¹⁸ The final survey included demographic items, a global health scale including scores for mental and physical health¹⁹, and tailored items for each age-friendly domain. Having obtained IRB exempt status (Northwestern University IRB no. STU00098390), we disseminated the community-wide survey in both online and paper forms. The survey was available in both formats in English, Spanish, Polish, and Chinese languages, and with the help of our partners, we strove to attain a sample population representative of adults age 50 and over throughout the city of Chicago. A total of 2134 older adults responded. Of these, 397 declared themselves caregivers to spouses, friends, or parents. The majority of caregiver respondents completed the survey in English (91 % [$n = 363$]).

To capture further insight into the “real” life experiences of the WHO age-friendly urban features, we also conducted focus groups using the Vancouver Protocol.¹⁶ A total of 47 caregivers participated in focus groups. Twenty-six participated in mixed caregiver/noncaregiver focus groups sponsored by the City of Chicago Department of Family and Support Services (DFSS). Twenty-one participated in three caregiver-only focus groups as part of a stand-alone analysis of caregiver needs and experiences. Sites for caregiver-only focus groups were selected with the help of the DFSS and The Salvation Army, who were partnering with the DFSS at the time of the study to deliver general informal caregiver support groups. Focus groups took place in senior centers located in the northwest, west, southwest, south, and center of the city. Caregiver focus group data was analyzed for coverage of the eight age-friendly city domains (housing, transportation, outdoor spaces and buildings, civic participation and employment, social participation, community support and health services, respect and social inclusion, communication and information) using NVivo software.²⁰ Key themes were identified concerning barriers and facilitators in each of these domains. A full report of the project methodology can be found in the age-friendly baseline assessment reports funded by The Chicago Community Trust and The Washington Square Health Foundation.^{21,22}

FINDINGS

Descriptive Summary Statistics

Chicago and is the third largest metro area in the USA, with a population of over 9.7 million residents, 2.8 million of whom reside within city limits. Of these, 397,170 are over 60 years of age, and 10.3 % of the population is aged 65 or over.²³ Older Chicagoans are also culturally and ethnically diverse. Of those aged 55 and older, 36 % are African American, 16 % are Hispanic, and 5 % are Asian. Thirteen percent of those aged 60 and over living in the Chicago metro area are also limited English speaking.^{24,25} Fifteen and a half percent of those 75 years of age and older live below the poverty line.²⁶ According to the city of Chicago, residents aged 65 and over (as of the 2000 census) are distributed across all community areas, with larger numbers evident in communities along the lake shore; at the northern, southern, and western edges of the city; and in proximity to both airports.²⁷ Given the limitations of using community area boundaries to highlight the distribution of

older adults living in the city,^{28,29} we collected self-reported city zip code information from survey respondents and used this data to create seven age-friendly caregiver survey regions. As Table 1 shows, there was a good geographic spread across Chicago, with the highest rate of caregiver response in the northern zip codes (35 %, *n* = 136) and fewer across the southern zip codes of the city (20.4 %, *n* = 71). There were differences in ratings of each domain by survey region, with informal caregivers in the central and northeast regions showing greater overall satisfaction with the age-friendliness of the city than other areas. Caregivers in northeast zip codes registered more satisfied with transportation than those in the south, suggesting that the city’s drive to create more equitable access to transportation options outlined in The Chicago Plan for Public Health System Improvement 2012–2016 will benefit older adults and their caregivers.⁶ Central caregivers were the most satisfied with community support and health services. Central west caregivers were less likely to report satisfaction with opportunities for social participation than other regions. Table 2 presents the demographic characteristics of the survey by self-reported caregiver/noncaregiver status. The majority of the caregivers included were women (66.75 %, *n* = 265) caring for a spouse (44.08 %, *n* = 175) or parent (27.20 %, *n* = 108). Twenty-four percent self-reported as Black, 21 % as Hispanic, and 11.8 % as Asian. The prevalence of Hispanic caregivers in our sample is in line with recent AARP estimates (2015)³⁰ which suggest that caregiver status is most prevalent among Hispanics (21.0 %), followed by African American (20.3 %) and Asian (19.7 %).

Age-friendly mean scores were compiled from the eight survey domains and responses. Bivariate analyses were conducted to compare caregivers to noncaregivers. Caregiver versus noncaregiver mean health scores are presented in Fig. 1. Of particular note is the finding that caregivers reported poorer health than did noncaregivers, based on the PROMIS 10-item Global Health Measure.¹⁹ Furthermore, stepwise multiple regression used demographic features (including the age-friendly mean scores) to examine determinants of these health scores between the caregiver sample and their significance. Controlling for six variables: age, gender, race/ethnicity, education, income, and age-friendly score, caregivers had significantly lower mental and physical health scores when compared to

TABLE 1 Caregiver survey respondents by region

Region	Total	Percent (%)
Northeast	74	18.64
Northwest	62	15.62
North central	47	11.84
Central	56	14.11
Central west	39	9.82
Southeast	29	7.30
South	52	13.10
Missing	38	9.57

North zip codes: 60626, 60640, 60645, 60659, 60660; northwest zip codes: 60625, 60630, 60631, 60646, 60656, 60634, 60639, 60641; North Central zip codes: 60613, 60614, 60618, 60647, 60657; central zip codes: 60601, 60602, 60603, 60604, 60605, 60606, 60607, 60610, 60611, 60622, 60642, 60654, 60661; central-west zip codes: 60608, 60612, 60624, 60644, 60651, 60609, 60623, 60629, 60632, 60638; southeast zip codes: 60615, 60616, 60637, 60649, 60653; south zip codes: 60617, 60619, 60628, 60633, 60620, 60621, 60636, 60643, 60652, 60655

TABLE 2 Caregiver and noncaregiver survey respondent demographics

2014 Age-friendly community survey (N = 2601)					
	Noncaregivers		Caregivers		<i>p</i> value
	<i>n</i>	(%)	<i>n</i>	(%)	
	2134	(82.05)	397	(15.26)	
Age					<.0001
55–64	524	(24.55)	137	(34.51)	
65–74	950	(44.52)	141	(35.52)	
75–84	454	(21.27)	74	(18.64)	
>85	108	(5.06)	23	(5.79)	
Gender					.066
Male	564	(26.43)	127	(31.99)	
Female	1545	(72.40)	265	(66.75)	
Transgender	8	(0.37)	1	(0.25)	
Race/ethnicity					<.0001
White	1266	(59.33)	184	(46.35)	
Black	512	(23.99)	96	(24.18)	
Hispanic	152	(7.12)	48	(12.09)	
Asian	122	(5.72)	47	(11.84)	
Education					.951
<12th grade	180	(8.43)	37	(9.32)	
HS degree/GED	272	(12.75)	43	(10.83)	
College degree	604	(28.30)	115	(28.97)	
Grad degree	621	(29.10)	112	(28.21)	
Income					.655
Above FPL ^a	1615	(75.68)	297	(74.81)	
Below FPL	362	(16.96)	71	(17.88)	
Employment					.175
Employed	553	(25.91)	128	(32.24)	
Retired	1331	(62.37)	228	(57.43)	
AF mean score ^b	3.47		3.31		<.001

p Values calculated using chi-squared and *t* tests

^aFederal poverty line

^bAge-friendly range 1–5

noncaregivers ($p < .001$). Our predictor model accounted for 18.8 % of the variance for physical health and for 32.7 % of the variance in PROMIS mental health scores. Of these six variables, education was the only significant predictor variable for mental and physical health ($p < .001$) and the age-friendly scores were stronger predictors of mental health scores ($\beta = 5.96$) than physical health ($\beta = 3.33$).

Although caregiver satisfaction ratings and comments left by participants who answered survey questions were lower than noncaregivers, their priority rating of domains and domain items were mostly aligned. This was particularly evident in the domain of outdoor spaces and buildings, for example, where the condition of the sidewalk surfaces and snow removal were key factors restricting mobility, as well as safety concerns of being out in public after 6 p.m. in the evenings, and of cyclists riding on the sidewalks. More marked disparities were evident in the domain of community support and health services. Caregiver survey respondents were more likely to report lower rates of satisfaction for “the availability of trustworthy

**Statistically significant at <.001 level*
General population Mean = 50, SD = 10

FIG. 1 Caregiver versus noncaregiver health scores.

financial services and information” than noncaregivers and more likely to discuss using financial services. The stakeholders we interviewed also emphasized the financial literacy required for caregiving, as well as the challenges of managing another person’s money and the complications that can create for the caregiving relationship, as well as the older person’s independence. Other issues covered more comprehensively by caregivers in focus groups included home health help and respite.

Focus Group Descriptive Analysis

According to the 2015 joint AARP and National Association for Caregiving Report³⁰ six in ten caregivers are female and care for an older adult with a long-term physical condition. The majority of the 47 caregivers who took part in the study’s mixed and caregiver-only focus groups were women (*n* = 36, men *n* = 11), and caregivers in the caregiver-only focus groups reported arthritis (*n* = 13), diabetes (*n* = 4), and high blood pressure (*n* = 6) most frequently among the conditions of the older adults they were caring for. When asked how many hours they typically spent caregiving per week, 44 % (*n* = 7) self-reported 0–10 h, 36 % (*n* = 6) >71 h, and 19 % (*n* = 3) 11–20 h. All except one respondent had been caregiving for 2 years or more. Focus group participants self-reported as Black (*n* = 27), Hispanic (*n* = 6), Asian (*n* = 1), and White (*n* = 13).

The most densely discussed domains by caregivers taking part in all focus groups were community support and health services. Civic engagement and employment had the least discussion around it. From qualitative analysis of caregiver-only contributions to focus group discussions, we were able to establish how caregivers perceived and experienced specific urban features deemed essential to promoting active aging. Experiences in some domains were better aligned with noncaregiver conversations and comments than in others. Conditions of sidewalk surfaces and snow removal, for example, were shared experiences evident both in survey comments and in focus group discussion. Experiences in other domains were more diverse. We present three caregiver-specific issues presented by focus group participants.

Availability of Affordable Trustworthy Financial Services and Information One of the survey items caregivers were more likely to rate fair or poor (39.6 %, $n = 78$) than noncaregivers (24 %, $n = 408$) was the availability of affordable trustworthy financial services and information. Insight into this finding is provided by focus group contributions to community health support and services discussions, where caregivers highlighted their experiences of using health, dental, and eye insurance coverage and support services. For some, the issue was not one of whether or not there were affordable financial services. Rather, they and those they cared for were constrained by limited insurance policies. Focus group members in one group talked about having to seek multiple combinations of policies. For example, one caregiver commented that her 64-year-old mother uses a “medical card,” but that there was a limit to what she could and could not do with this insurance. To address the needs not covered by the card, the mother was on her son’s air force medical insurance. However, in order to use that insurance, she had to travel to a specific veterans facility 40 miles from the city center, far from their home. Others talked about being excluded from financial support for healthcare services because of their final retirement incomes.

Caregivers also shared stories about how their lived experiences were not always understood by insurers. For example, one caregiver talked about his struggle explaining why his wife needed a stair lift:

“Insurance company say they didn’t, they didn’t think it was necessary, but hell, she can’t even walk up the steps? What are we supposed to do? But right now, you know, she still can cook, in the house, like she’ll come down stairs... and she will—before we put in the stairlift—this was Monday—in the morning, and then she’ll go back upstairs, and then she’s upstairs for the rest of the night. ... and I would leave, I would come and work out, or you know and whatever, and you know, she’s there. One time she fell out the chair, somehow, the legs gave out, and she’s on the floor, and she couldn’t get up. And finally she crawled over, and got to one of the chairs, and she was able to get up, but it took about an hour.”
(Male caregiver, aged 65–74)

Current research evidence about how older adults negotiate their own homes and how autonomy and independence are enabled or disabled through current health and well-being services is often targeted at demonstrating the added value of design and technological intervention or assessment of cost effectiveness.^{31,32} Our findings suggest that caregiver perceptions of service industry responsiveness to the lived experience of care recipients may also be a factor which modulates caregiver distress and the impact of caregiving.³³

Availability of Affordable Trustworthy Home Help The caregivers who participated in the caregiver-only focus groups also had a lot to share about the age-friendly and unfriendly aspects of home help. First, they felt that many home help services expected them to fit with the home help organization’s timetable rather than adapt to the caregiver’s needs. Secondly, they felt that many of the home aids they had welcomed into the homes of those they cared for were not trained to personalize care. Caregivers commented that the home helps should know more about the personal history of the person whom they were employed to help. As one caregiver noted, “*there should be a folder on the client, to state what that client can eat and what they can’t eat.*”

Caregivers and stakeholders shared their recommendations for the ways in which home help services could be even more responsive. These are presented in Table 3. As the range of home health and help options grows, it may become even harder for caregivers to evaluate the best match with their needs. Although communication and information was the domain with the highest overall satisfaction rating from both caregivers and noncaregivers, caregivers in all focus groups expressed specific concerns about “*not knowing what you don’t know*.” As one stakeholder commented, “*caregivers don’t know services like [the] DFSS and [the] Agency on Aging exist—they have to absorb a brand new set of info*.” Trust in relaying financial information to government agencies was also repeatedly reported as a barrier to accessing services.

Civic Engagement, Employment, and Respite The domain of civic engagement and employment had the lowest amount of coverage by caregivers in focus groups. Analysis of participant discussion suggests why the concepts of employment, volunteering, and civic engagement are not core determining factors with regard to the health of older adults from the caregiver perspective. Instead, these were factors impacting the health of the caregiver themselves. Many caregivers either had given up their current employment to care or were struggling to manage two parallel lives. They talked about the schedules they had in place for caregiving and the tasks they needed to complete on a daily basis:

It’s hard because, you know... I might leave my house at 7:30 in the morning and she needs something I go to the grocery store, and I don’t have to be at work until 9:30... so I’ll go to the grocery store and get it and on my way I will drop that stuff to her house. My sister stays with her and my brother so they kind of help her at home, you know, as far as that, but... um, it’s still hard trying to balance everything out. Because they call me for everything, you know... To—cause I’m the decision-maker, you know, so... anything that needs to be done, they call me for it, you know, so it’s it’s it’s ... it gets kinda hard, you know, trying to like, take care of two houses. (Female caregiver, under 55 years old)

Caregivers self-reported long hours but did not regard what they were doing as employment:

For me I don’t look at it as paid, I’ve been doing it for 5 years, I have not had time yet, everybody been telling me “you can get paid you can get paid,” but I’m so busy with doing so many other things along with providing care that I - I

TABLE 3 Caregiver recommendations

1	Six monthly training refresher courses (particularly cooking and cleaning)
2	Networking with friends to observe home aids in action to see whether they would be a good fit
3	Help for informal caregivers facing up to the fact you need help
4	Ratings for care services online
5	Certification and training of anyone delivering healthcare in the home
6	Accessing support from churches and retired healthcare professionals who are members of churches (e.g., caregiver ministry)
7	Providing a vacation home for a week for the people you are caring for
8	Guidance on how to record important information relevant to healthcare

haven't even had an opportunity or even taken an opportunity to fill out paperwork to say ok you can get paid for 4 h or however many hours so... for me I don't look at it what I do as paid. I do it out of love. (Female caregiver, aged 65–74).

In line with informal caregiver research, respite emerged as a valuable intervention for caregivers³¹; notably, this is not included in the WHO checklist.¹⁷ For focus group members, respite meant institutional respite, where the care recipient stays for a short time in a safe place. As one caregiver noted, “*we need a center where you can bring your care—your loved one to, so you yourself can get a break from what you do, 356 days out of the year, 24 h a day.*” For another, the need for respite was the single message she wanted to convey: “*I’m really serious ... when you have to do it 24 h around the clock, you need a break.*” For these caregivers, respite did not mean being educated in how to de-stress, or joining caregiver support groups to learn about caregiving; what they wanted was active intervention to get away from the caregiver role. Several craved a physical trustworthy space where they could take the older adult they cared for a week and which would “*actually [enable] your mind to be free.*” Others talked about support groups “*where you don’t talk about caregiving.*”

DISCUSSION

Several findings merit further discussion. The first is the evidence that caregivers reported significantly poorer health than noncaregivers, which is a finding that aligns with existing research confirming a high degree of stress and burden among caregivers.^{34–40} This finding aligns with other caregiver research showing caregivers reporting lower levels of self-esteem, loss of self-confidence, and greater psychological distress.⁴¹ While our study revealed few systematic differences between caregivers and noncaregiver survey satisfaction ratings or focus group discussion themes, the significance of being able to predict mental health scores using an age-friendly score suggests that being responsive to the multiple age-friendly domains may be an effective way to relieve informal caregiver stress and sustain informal caregiver mental health, which is a key factor in maintaining quality of life (Fig. 2). Caregivers themselves identify specific interventions which might alleviate what the research literature terms “caregiver burden”.^{31,32,42} These include increased respite services and continued access to support groups, which are things that other researchers have found to be effective.

FIG. 2 Caregiver and noncaregiver mean domain scores.

However, the negative impact of caregiving on mental health does not represent the total range of the caregiver experience represented by our data. A notable feature of our focus group transcripts is the omission of the term “burden”; no caregiver uses this term. Instead, caregivers report caregiving out of love, or caregiving as a way of saying thank you to the loved one for the time they spent bringing up a family. None of them were looking to be paid. This finding aligns with other literature that highlights the positive effects of caregiving,^{43,44} questions the usefulness of caregiver burden as global outcome measure for evaluating interventions effectively,⁹ and proposes additional studies to help more accurately determine factors that modulate caregiver response.³³

Another informative finding is the caregiver observations of specific interventions in action, for example, home health. Unofficial estimates suggest that between 10 and 15 million older Americans are in receipt of informal home health-related services.⁴⁵ These services can include home help, visits from community workers, and community nurses, as well as care provided by family caregivers. Home help and healthcare is an important service, with the potential to prevent or delay transition to formal care services. However, as Leff and Madigan argue, it is an under-acknowledged area of the current healthcare system.⁴⁵ Home health is also central to the success of the healthy aging policy agenda. If older adults are to age in place in their own homes, the argument goes affordable and available, and that accessible home health is essential to enable this to happen and delay the impact of declining capacity.¹⁷ While home health emerged as an area where the city of Chicago and public and private agencies have been responsive—focus group members commented on emergent options including “*health care communities in which home health visits are available to folks*”—caregivers also talked about their dissatisfaction with home health and help in practice. Specifically, caregivers highlighted the lack of personalized care for the older adult and lack of training in relating to older adults. The idea that service providers’ responsiveness and education can impact a caregiver’s mental health is not one that has been discussed in the intervention literature, where the focus is on the education of the caregiver.^{9,11}

The composition of the informal caregivers participating in both survey and focus group is also worth to comment. Traditionally, caregiver recruitment takes place through partnership with the disease focused support provided by community health centers and hospital sites. Our study was unusual in targeting caregivers through generic community-based support groups. As a result, caregivers unable to reach these sites—particularly those caring for older adults with the most needs, such as those with dementia—may have been excluded. However, the high incidence of informal caregivers recruited through community sites suggests that these sites also have an important role to play in supporting caregivers. The caregiver stakeholders we interviewed also made this point: “*Senior centers can be a place for caregivers to come to socialize and be supported.*” Another added: “*having support groups in informal locations gives people reasons to go—the senior can attend senior activity and [the caregiver] has an opportunity for respite.*” Further study might usefully compare informal caregiver support provided within the community with that provided more formally through the health infrastructures supporting the specific health condition of the older adult in need of care’s condition. Questions might include the following: what is the added value to both the caregiver and older adult loved one of support provided in community settings (e.g., libraries, parks, senior centers) compared to formal healthcare settings (e.g., hospitals)? How might access to resources provided in both of these settings be maximized? For example, more caregivers reported proximity to eye doctors

(37.3 %) than noncaregivers (17.15 %), yet fewer reported mental health services and physical therapy within a mile of home suggesting caregivers access these services less. It would be useful to follow up this finding to compare the degree to which caregiver use of these services is impacted by geographic location as opposed to insurance coverage, and whether caregivers might make more use of more localized healthcare options if they were available.

In conclusion, our findings have implications for both the age-friendly policy initiative and the gerontological research focusing on the outcomes of caregiving. Caregiver self-reports of lower mental health scores supports further investigative and comparative research into a wider range of factors and interventions than those currently covered by terms like “burden” or “well-being.” As societies work to deliver more age-friendly communities and cities and more older adults age in place at home, the role of caregiver as navigator for older adults and the services they need will become pivotal to the successful realization of this new social contract. As a result, no single intervention will be able to answer all relevant psychological, physical, and social needs. It will become important to consider caregiver satisfaction with factors impacting the health of the loved one they are caring for, such as the health awareness of home care aids, responsiveness of financial service providers, and the self assessment of the impact the caregiving role has on their own health.

ACKNOWLEDGMENTS

This research was supported with funding from the Washington Square Health Foundation, The Chicago Community Trust, and the Department for Family Support Services, city of Chicago. Mayor Rahm Emanuel and the city of Chicago were awarded age-friendly status by the WHO in 2012. This study is part of an ongoing baseline assessment of the city's age-friendliness.

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