Partial or Limited Frail Elder Waivers in Massachusetts—Minimizing Costs and Need for Institutional Care in Later Life

Elaine M. Eliopoulos[1], Christine Carter[2], Chris Gilleard[1], Paul Higgs[1]

[1]University College London, Faculty of Brain Sciences, Division of Psychiatry, London, UK

[2]Queen Mary University, Wolfson Institute of Population Health, London, UK

https://doi.org/10.38126/JSPG260101

Corresponding author: elaineeli@comcast.net

Keywords: Frail Elder Waiver; advanced old age; home and community-based services; institutional care

Executive Summary: Massachusetts will experience an exponential increase in adults living into advanced old age over the next several decades. Medicare and Medicaid costs to fund institutional care continue to rise. The Frail Elder Waiver program presents an opportunity to reduce institutional costs by providing essential support at home to older people who would otherwise require institutional care. These supports would allow the individual to remain at home longer and avoid or delay the need for institutional care. Eligibility for the waiver requires that individuals over 65 meet specific clinical requirements that may be safely managed at home with specific services. These services may include such essentials as environmental accessibility adaptation, medication assistance, supportive day programming, and home-delivered meals. Revising the waiver program to allow limited or partial services prior to the onset of substantial limitations would result in economic and quality of life gains.

I. General background

Current longevity and diverse socio-demographic trends accentuate the demand for cost-effective models of support essential to adequately serve an aging population. This has highlighted the need for policymakers to examine the costs associated with institutional care as the dominant recipient of federal funding for long-term care support for older people in the United States of America. In the 1980s, a shift in thinking toward a more community-based model of care arose (Saucier, Burwell, and Gerst 2005), leading to the Social Security Act, Section 1915(c), which empowered states to develop programs that enhanced access to home and community-based services (HCBS) for older people through Medicaid Waiver programs (Center for Medicare and Medicaid Services n.d.). Through the waiver program, states may expand eligibility requirements and benefits for Medicaid eligibility such as targeting specific population needs, benefit expansions in particular health areas, and making provisions to address social concerns (KFF 2025). State funding for the waivers varies year to year. The waivers must address public health concerns and follow a person-centered plan of care (Medicaid, n.d.) which is monitored by the Centers for Medicare and Medicaid Services to ensure quality.

Massachusetts is experiencing rapid growth in its 65+ population, outranking the national average slightly. (University of Massachusetts, Gerontology Institute 2018). Currently, those over 65 comprise 17.7% of the population with a projected increase of 31% over the next 20 years (US Census Bureau 2023). Of those 17.7%, 7.7% are 75+, where the potential for increased need for services exists.

HCBS will become increasingly important since these population projections exceed 11% overall population growth of the state. The majority of people 65+ wish to remain in their homes rather

than have institutional care (Naru and Beimesche 2024).

In Massachusetts, the Executive Office of Elder Affairs is responsible for the day-to-day operation of the federally funded Frail Elder Waiver (FEW) program administered through the individual states. Nearly 14,000 individuals receive support under a FEW in Massachusetts. (Medicaid, n.d.). Functionally and financially eligible waiver recipients may live in their own homes, with a family member, or in shared living accommodations. Residents of assisted living facilities, rest homes, or nursing homes are not eligible for a waiver. Recipients receive community-based services through the state by this Social Security Act, Section 1915(c).

Individuals must require nursing facility level of care to be eligible for a FEW (MassHealth and Executive Office of Aging and Independence 2025). Nursing facility level of care is specifically detailed within federal regulation 130 CMR 456.409 (Trial Court Law Libraries and Massachusetts Court System 2023). Nursing home level of care is defined state by state but generally refers to a person's ability to live safely for periods of time. This may include a range of disabilities, including ADLs. Cognitive, functional, behavioral, or the need for skilled medical services (e.g. G-tubes, catheters, ventilators, etc.) may impact this ability and require nursing home care.

The Comprehensive Data Set assessment tool used in Massachusetts determines the level of functionality, assesses clinical eligibility, and informs the types of appropriate supports indicated (Executive Office of Elder Affairs (EOEA) and MassHealth Office of Long Term Services and Supports (OLTSS) 2014). If eligible, individuals may receive an extensive array of home and community-based services designed to avoid institutionalization (MassHealth 2025). Current Massachusetts regulations for clinical eligibility for a FEW require individuals to need one skilled service under Federal Regulation Section 130 CMR 456.409(A) or three services under 130 CMR 456.409 (B) and (C), and at least one service under (C). (See Appendix).

II. Current Massachusetts landscape: disability rates and services

In 2022, the Centers for Disease Control and Prevention reported that 40.2% of those 65+ in Massachusetts have some kind of disability (Center for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, n.d.). This represents an increase of approximately a percentage point from 2021, with the weighted number of individuals increasing from 486,722 in 2021 to 511,771 in 2022. (Centers for Disease Control and Prevention, n.d.). Of those with a disability, the majority have a mobility disability (24.2%), followed by a hearing disability (13.5%) (Centers for Disease Control and Prevention, n.d.). Cognitive and independent living disabilities (such as the ability to attend a doctor's appointment, shop, or clean house) each make up less than 10% of reported disabilities, with vision and disabilities associated with activities such as bathing and dressing (6.8% and 5.2%, respectively) reported as the least occurring. Each of these disabilities may have a substantial impact on an individual's ability to safely and competently address activities of daily living (ADLs).

In addition to the increase in numbers of those 65+ experiencing some sort of disability, Massachusetts has seen worsening conditions for those 60+ for asthma, kidney disease, depression, and those with multiple chronic conditions. This has resulted in increased healthcare costs, including emergency room visits and readmissions after acute hospitalizations, with 59% of readmissions occurring among patients aged 65 and older (Center for Health Information and Analysis 2024).

Persons 65+ in Massachusetts' 351 towns and cities are served by 26 local Area Service Access Points (ASAPs) where aging services within communities are coordinated. (Executive Office of Aging and Independence 2025). While individuals requiring information and referrals for services may contact a few nonprofit organizations to facilitate connections for specific services regarding healthcare access and legal representation, they cannot make referrals for and provide services under a waiver program; this ability is reserved for local ASAPs. Despite a myriad of resources available to advise individuals over 65, few are empowered to directly provide services except for those approved for a FEW.

i. Nursing home costs versus in-home services

Nursing home costs in Massachusetts vary according to the region but average $162,425.00 annually, with lower costs in the western part of the state averaging under $150,000.00 for Worcester and Pittsfield

(American Council on Aging 2022). Since Massachusetts nursing home costs are higher than the $108,405.00 national average (CBS News 2023), there are compelling reasons to examine alternatives to nursing home care. In-home support services can be considerably less expensive if needed supports are provided under 130 CMR 456.409(B) and involve non-medical services, such as homemaking, cooking, and shopping.

III. Consequences of current eligibility requirements for FEW

The current FEW eligibilities requiring three services mean an individual is incapable of living at home without substantial support and that nursing home care is needed. Therefore, the individual suffers from disabilities that require an extensive plan of support, thereby contributing to Massachusetts' standing as one of the worst in the USA, 44th out of 51 in terms of avoidable hospital uses and costs associated with preventable medical situations (Rabson 2023). In a sense, the individual must be in a worsened state before any waiver would be granted and services provided. The three-service eligibility requirement guarantees a greater level of disability and likely adds to avoidable hospitalizations.

Thirty-six out of 1,000 hospitalizations for Medicare beneficiaries in Massachusetts were avoidable, exceeding the national average of 29 per 1,000. (America's Health Rankings, United Health Foundation 2022). Inpatient stays for ambulatory care-sensitive conditions are preventable with proper primary and preventive care such as that provided by HCBS available under a FEW.

Additionally, readmission rates for Medicare beneficiaries in Massachusetts to inpatient settings were 42 per 1,000 admissions within 30 days, exceeding the national average of 33 and ranking 50th out of 51 in this category. (Center for Health Information and Analysis 2024). While a focus on primary care is lacking in Massachusetts, extending HCBS can address these deficiencies in improving the health of older people with physical, sensory, or behavioral health needs (National Quality Forum 2017). Without such a willingness to extend HCBS services, these deficiencies will continue and possibly contribute to an 'unhealthy healthcare trajectory' that will adversely impact healthcare performance overall in Massachusetts.

IV. Policy options

Health, well-being, and the ability to remain in one's community for Massachusetts' older citizens depend upon the availability of comprehensive HCBS that could be made available through an expansion of the eligibility requirements for FEWs. To this end, granting partial or limited waivers will enable more individuals to remain at home with the appropriate support. We recommend two possible options.

i. Option 1

Allow the ASAPs the authority to grant partial or limited waivers for individuals who meet only two criteria under Federal Regulation Section 130 CMR 456.409 (B). The waiver could address limited HCBS specifically tailored to need, therefore enabling an individual to remain at home while possibly delaying further disability. Oversight and evaluation of the day-to-day services provided within the waiver would continue through the local ASAP.

Advantages

Since current FEW eligibility requires three areas of need with ADLs, those three areas likely entail increased service hours and provider involvement. If the waiver was available before the development of three areas of need, this may prove to enhance functionality over the long term. Recipients would receive the benefits of more minimal and less expensive support before further decline. This involvement at an earlier point in time may also serve to facilitate primary care that may contribute to slowing the progression of chronic diseases (Kruk, Nigenda, and Knaul 2014) minimize readmissions and delay the need for more skilled interventions, which may not be possible at home (Obbia et al. 2019). All FEW recipients are connected with a case manager who works with them to develop a comprehensive plan for services, ensuring culturally responsive care in familiar settings that promote their well-being (MassHealth and Executive Office of Aging and Independence 2025).

HCBS waiver program extensions have not resulted in higher costs for long-term care but rather associated with service provision at a lower cost per recipient than nursing home costs (McGarry and Grabowski, 2023.) HCBS may allow currently institutionalized older people to return home and reduce Medicaid costs associated with the services in a nursing home.

Disadvantages
Initially, access to limited waivers at an earlier point in time would involve added expense. However, the current eligibility scheme may cause greater expense if eligibility is deferred until an increased need is identified. Evidence has shown that community-based care waiver programs present substantial savings when compared to the costs of institutional care (Harrington, Ng, and Kitchener 2011).

Another difficulty lies in access to sufficient geriatrically trained providers. Serving individuals in remote areas may limit the possibilities for the type of services needed. Caregiver burnout could be exacerbated by situations involving intensive home care services.

ii. Option 2
Provide a hierarchy of need for FEW eligibilities under Sections (B) and (C). Federal Regulation Section 130 CMR 456.409(B) details those ADLs that, in combination with (C), would constitute a need for NFLOC. For example, if a person was incontinent of bowel or bladder and required assistance with ambulation/mobility, that would constitute a substantial impediment to remaining in one's home without support. Eligibility could be granted when the specific ADL deficiency presents such a substantial obstacle as to render independent living impossible.

Advantages
Creating a hierarchy of need could expand FEW eligibility requirements when the deficiency presents a significant obstacle to independent living. There may be combinations of ADL deficiencies that, without (C) deficiencies, would prevent a person from living in their home safely. The hierarchy would allow the ASAPs to make person-centered determinations of eligibility with the flexibility to permit individuals to remain at home for as long as possible when they begin to have challenges navigating everyday life.

Disadvantages
Similar disadvantages would be present as with Option 1. The long-term impact of a transition to more HCBS may not be easily quantifiable for a period of years. Current disability rates for those in advanced old age are not readily identifiable, as most data collected is relative to those 65+. This would make it difficult to develop a hierarchy of needs for ASAPs to identify infrastructure to meet all needs.

V. Limitations
These policy options require greater involvement by the ASAPs in assessing needs and ensuring a tailored approach to providing services. While ASAPs do monitor the services provided under a FEW, these policy options may require a more intensive monitoring effort with the flexibility to adapt and change services as FEW recipients change. An extension of eligibility will also involve additional upfront expense but likely at a lower cost than services required when an individual has three different service needs.

VI. Policy recommendations
We recommend Policy Option 1 to enable the ASAPs to grant a FEW when the individual has moderate needs that would likely worsen if support were withheld. This would enable individuals to receive proactive support and likely increase access to primary care services, resulting in earlier identification and management of conditions that might contribute to disability. This, in turn, would reduce emergency hospitalizations and ultimately lower healthcare costs.

Engaging with older people proactively as they begin to experience medical challenges would serve their needs most efficiently at a lower cost. Most older people want to preserve their autonomy, remain in their familiar settings close to family and friends, and preserve their ability to remain as independent as possible (National Institute on Aging 2023).

Access to the types of home and community-based services a person would receive if granted a FEW increases the likelihood of remaining at home with support for as long as possible.

Appendix: 456.409: Clinical Eligibility Criteria

456.409: Clinical Eligibility Criteria To be considered clinically eligible for nursing facility services, a member or MassHealth applicant must require one skilled service listed in 130 CMR 456.409(A) daily, or the member must have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C). Additionally, to be considered clinically eligible for nursing facility services, a member or MassHealth applicant younger than 22 years of age must also meet criteria as determined by the multi-disciplinary medical review team coordinated by the Department of Public Health.

(A) Skilled Services. Skilled services must be performed by or under the supervision of a registered nurse or therapist. Skilled services consist of the following: (1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding; (2) nasogastric-tube, gastrostomy, or jejunostomy feeding; (3) nasopharyngeal aspiration and tracheostomy care, however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services; (4) treatment and/or application of dressings when the physician or PCP has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions); (5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema); (6) skilled nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure); (7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (a urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled nursing care). However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection); (9) gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting; (10) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record); (11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and (12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician or PCP and be designed to achieve specific goals within a given time frame.

(B) Assistance with Activities of Daily Living. Assistance with activities of daily living includes the following services: (1) bathing when the member requires either direct care or attendance or constant supervision during the entire activity; (2) dressing when the member requires either direct care or attendance or constant supervision during the entire activity; (3) toileting, bladder or bowel, when the member is

incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care; (4) transfers when the member must be assisted or lifted to another position; (5) mobility/ambulation when the member must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone or appropriately and requires the assistance of another person; and (6) eating when the member requires constant intervention, individual supervision, or direct physical assistance.

(C) Nursing Services. Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of medical eligibility: (1) any physician- or PCP-ordered skilled service specified in 130 CMR 456.409(A); (2) positioning while in bed or a chair as part of the written care plan; (3) measurement of intake or output based on medical necessity; (4) administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions; Commonwealth of Massachusetts MassHealth Provider Manual Series Subchapter Number and Title 1. Program Regulations (130 CMR 456.000) Page 4-9 Nursing Facility Manual Transmittal Letter NF-63 Date 10/01/23 (5) staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental health professional; (6) physician- or PCP-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals); (7) physician- or PCP-ordered nursing observation and/or vital signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention; and (8) treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician or PCP orders, or routine changing of dressings that require nursing care and monitoring (Mass.gov. n.d.).

References

American Council on Aging. 2022. "2021 Nursing Home Costs by State and Region". https://www.medicaidplanningassistance.org/nursing-home-costs/.

America's Health Rankings, United Health Foundation 2022. "Preventable Hospitalizations in Massachusetts". https://www.americashealthrankings.org/explore/measures/prev_hosp_b/MA

CBS News 2023. "How Much Does a Nursing Home Cost?" accessed March 15,2025. https://www.cbsnews.com/news/how-much-does-a-nursing-home-cost/

Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. "Disability and Health Data System (DHDS) Data". accessed March 15, 2025. https://dhds.cdc.gov

Center for Health Information and Analysis. 2024. "Hospital-Wide Adult all Payer Readmissions in Massachusetts: SFY 2011-2021." accessed November 18, 2024, https://www.chiamass.gov/assets/docs/r/pubs/2024/Readmissions-Report-2011-2023.pdf

Center for Medicare and Medicaid Services. n.d. "National Overview of 1915(C) Waivers." accessed November 18, 2024, https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/ltss-ta-center/info/national-overview-1915-c-waivers#:~:text=The%20Medicaid%20Home%2D%20and%20Community,in%20their%20homes%20or%20communities.

Executive Office of Elder Affairs. n.d."Clinical Assessment and Eligibility Program: Best Practices Guide."EOEA and OLTSS, https://umassmed.typepad.com/files/cae-guide-version-1.02-11.4.14-full-version.pdf.

Executive Office of Aging and Independence 2025. "Find Your Regional Aging Services Access Point". https://www.mass.gov/info-details/find-your-regional-aging-services-access-point-asap

Executive Office of Aging and Independence 2025. "Massachusetts Aging and Disability Resource Consortia (ADRC) Member Agencies. https://www.mass.gov/location-details/massachusetts-aging-disability-resource-consortia-adrc-member-agencies

Executive Office of Elder Affairs (EOEA) and MassHealth Office of Long Term Supports (OLTSS) 2014. "Clinical Assessment and Eligibility Program: Best Practices Guide". https://umassmed.typepad.com/files/cae-guide-version-1.02-11.4.14-full-version.pdf

Harrington, Charlene, Terrence Ng, and Martin Kitchener. 2011. "Do Medicaid Home and Community Based Service Waivers Save Money?" *Home Health Care Services Quarterly* 30 (4): 198–213. https://pubmed.ncbi.nlm.nih.gov/22106902/.

KFF 2025. "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State". https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

Kruk, Margaret, Gustavo Nigenda, and Felicia Knaul 2015. "Redesigning Primary Care to Tackle the Global Epidemic of Noncommunicable Disease - PMC." *American Journal of Public Health* 105 (3): 431–7. doi:10.2105/AJPH.2014.302392. https://pmc.ncbi.nlm.nih.gov/articles/PMC4330840/.

Mass. gov. 2025. "Eligibility for People Age 65 and Older and People Who Need Long Term Care Services." n.d. accessed March 14, 2025. https://www.mass.gov/info-details/eligibility-for-people-age-65-and-older-and-people-who-need-long-term-care-services

MassHealth and Executive Office of Aging and Independence 2025. "Frail Elder Waiver:information for applicants and participants". https://www.mass.gov/info-details/frail-elder-waiver-information-for-applicants-and-participants#ii.-eligibility-criteria-for-the-frail-elder-waiver-.

McGarry, Brian and David Grabowski. 2023. "Medicaid Home and Community-based Services Spending for Older Adults: Is there a "Woodwork" Effect? " *Journal of the American Geriatrics Society* 71 (10): 3143–3151. https://doi.org/10.1111/jgs.18478.

Medicaid.gov. n.d. "Massachusetts On-site Review Summary Report." Accessed March 17, 2025. https://www.medicaid.gov/medicaid/home-community-based-services/downloads/MA-hw-summary-rpt.pdf

Naru, Lauren and Erica Beimesche. 2024. "U.S. News and World Report Aging in Place with Assistive Tech Survey." *U.S. News and World Report*, 5. https://www.usnews.com/360-reviews/services/senior-tech-aging-in-place-survey.

National Institute on Aging 2023. "Aging in Place: Growing Older at Home". https://www.nia.nih.gov/health/aging-place/aging-place-growing-older-home

National Quality Forum. 2017. "NQF Report of 2016 Activities to Congress and the Secretary of the Department of Health and Human Services". https://www.qualityforum.org/Publications/2016/03/2016_NQF_Report_to_Congress-2147446595.aspx.

Obbia, Paola, Clair Graham, Raymond Duffy, and Robbert Gobbens. 2020. "Preventing Frailty in Older People: An Exploration of Primary Care Professionals' Experiences - PubM." *Int J Older People Nurs* 15 (2:e12297). doi:10.1111/opn.12297. https://pubmed.ncbi.nlm.nih.gov/31873984/.

Rabson, Barbra. 2023. "Unsustainable: An Honest Assessment of Massachusetts Healthcare Performance." . https://www.mhqp.org/2023/07/13/unsustainable-an-honest-assessment-of-massachusetts-healthcare-performance/.

Saucier, Paul, Brian Burwell, and Kerstin Gerst. 2005. "The Past, Present, and Future of Managed Long Term Care." *Intl J Older People Nurs*: 1–29. https://aspe.hhs.gov/reports/past-present-future-managed-long-term-care-0.

Trial Court Law Libraries and Massachusetts Court System 2023. *130 CMR 456.00: Longterm Care Services,* Public Law Mass. Register #1505, . https://www.mass.gov/doc/130-cmr-456-long-term-care-services/download.

University of Massachusetts Boston, Gerontology Institute. 2018. *HEALTHY AGING DATA REPORT Highlights from Massachusetts 2018*. 2018:. https://mahealthyagingcollaborative.org/wp-content/uploads/2018/12/MA_Healthy_Aging_Highlights_2018.pdf.

USA.gov. "Disability and Health Data System (DHDS)." Centers for Disease Control and Prevention., accessed November 1, 2024, https://data.cdc.gov/Disability-Health/Disability-and-Health-Data-System-DHDS-/k62p-6esq/about_data.

U.S. Census Bureau 2023. "ACS Demographic and Housing Estimates." accessed March 17, 2025, https://data.census.gov/table/ACSSDP1YCD1192023.DP05?q=DP0

Elaine Eliopoulos recently received her PhD at University College London in gerontology. Elaine is a public defender attorney representing older people and psychiatric patients in judicial proceedings designed to substitute a decision-maker, involuntarily place them in a nursing home or other institutional setting. Elaine pursued a PhD to transition to a policy career to ensure equitable and inclusive treatment of marginalized populations.

Christine Carter is a nurse, post-doctoral research associate at Queen Mary University in the Wolfson Centre for Population Health. She is working on a research project which examines the practices and experiences of minority ethnic groups in East London who experience dementia. Her doctoral research explored how active aging policy reconfigured experiences of those with mild cognitive impairment.

Chris Gilleard is an Honorary Associate Professor in the Faculty of Brain Sciences, Division of Psychiatry at University College London. He has published extensively on advanced old age, the "fourth age" and the theoretical limitations of current depictions of aging. His most recent publication, co-authored with Paul Higgs, suggests a reorienting of later life whilst considering Beck's theory of cosmopolitanization.

Paul Higgs is a Professor of the Sociology of Aging in the Faculty of Brain Sciences, Division of Psychiatry at University College London. He has published extensively on the theoretical considerations in aging policy. He was elected a Fellow of the Academy of Social Sciences in 2012 and a fellow of the Gerontological Society of America in 2013. In 2021, he received a 50th Anniversary Outstanding Achievement Award from the British Society of Gerontology.