Quality Healthcare Requires the People Next Door:

A DOCUMENT TO INSPIRE VILLAGES FOR ALL FOR

• neighbors • caregivers • healthcare leaders • hospital discharge planners •
• home health providers • multifamily housing operators • healthcare insurers • policy makers •
• corporate volunteer coordinators • faith leaders • community leaders or

anyone invested in feeling more alive, reducing the costs of care, spreading health & well-being or boosting local economies.

Mary-Elizabeth Harmon, PhD

ABOUT THE AUTHOR

Dr. Mary-Elizabeth Harmon is a scientist turned storyteller, caregiver and founder of A Village for Life, a venture that seeks to inspire wonderful places to grow up and grow old by fostering caring communities and caring economies for and by neighbors.

A graduate of MIT and The Johns Hopkins School of Medicine, Mary-Elizabeth left the laboratory as a virus researcher and later joined the U.S. Department of Health and Human Services. There, she worked at the Centers for Disease Control and Prevention, as well as in the Office of Inspector General (OIG).

In OIG, Mary-Elizabeth evaluated programs and wrote reports for their improvement for Congress, including a compelling account of Medicare home health fraud that prompted regulatory changes and several indictments. For this and other work, she is a two-time winner of the Inspector General's Exceptional Achievement Award.

Through A Village for Life, Mary-Elizabeth is building relationships to create ways to connect neighbors of all ages to each other and to medical care at *or* close to home.

A Michigander who grew up in Kenya, Mary-Elizabeth has been fostering caring communities—villages—since returning to the U.S. for college.

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You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete.

— Attributed to Buckminster Fuller

A WELCOME LETTER
from Dr. Mary-Elizabeth Harmon

America is getting sicker and lonelier while trending older. The resulting care demands are great and growing. Generally called a “care crisis,” I call this an *opportunity* for us to course correct and take our personal and collective health and well-being to levels we’ve not achieved before.

Indeed, the difference between a crisis or an opportunity is a decision.

A report of the Surgeon General says, “The health of Americans is shaped in neighborhoods and communities outside the healthcare system.”[1] I would say “the *conventional* healthcare system” because I consider neighbors to be essential, but overlooked, contributors to quality healthcare.

This document imagines neighbors as more than users of healthcare but as *producers* of healthcare through the lens of wound care.[2]

Why wound care?

Because wounds are an area of growing public health significance.

And because, as a caregiver, wound care stopped me from getting a job, as I’ll explain shortly.

Though it’s impossible to say how many other caregivers in this country have also had employment derailed by wounds, whether a family member’s or their own, we know from an S&P Global and AARP report that of the nearly 48 million Americans who care for an adult family member or friend, 27% reduced their hours or shifted to part-time, and 16% stopped working entirely.[2]

This hurts employers and removes dollars from the pockets of millions of workers, which puts them in financial hardship and slows down economies.

Beyond the growing public health significance of wounds and their great potential to poorly impact workers and economies, wound care represents a significant source of spending that might be reduced through neighbor-driven interventions.

For example, neighbors can help wound care patients newly discharged from the hospital to return home and provide short- to longer-term everyday support to help them remain there. This can reduce hospital readmissions that are costly, in many ways, to families and hospital systems alike.

I appreciate the opportunity to expound on this idea and others.

Sincerely,

Mary-Elizabeth Harmon, PhD
hello@avillageforlife.com

1. U.S. Department of Health and Human Services (2021). *Community Health and Economic Prosperity: Engaging Businesses as Stewards and Stakeholders*. A Report of the Surgeon General. Chapter 2, How Neighborhoods Shape Health and Opportunity.
2. In this document, “healthcare” means the improvement or maintenance of health.
3. Cobbe et al. (2024). *Working while caregiving: It's complicated.* S&P Global & AARP.

PART 1:
How wound care stopped me from getting a job.

To tell this story, I'll first share how I became a caregiver.

In 2017, my father, who had dementia, was put on hospice and became bedbound.

At the time, he and my mother were living in a community for older adults in Chicago that offered both independent and assisted living options. The expectation when my parents arrived there was that they would get the support they needed without daily help from family. That didn't pan out.

My father needed the help of an aide for eating, drinking, bathing and toileting. My mother needed an aide to prep her breakfast and lunch and to assist with light housekeeping. But the aides commonly didn't show up or turned over so frequently that we never knew who or what to expect.[1]

To spare my parents from unreliable care in their senior living community, I became their full-time caregiver, and we moved into a standard apartment building soon after.

After months of getting a passable care system nailed down, I started weighing options to make an income (and get out of the house) by getting a part-time job. But two things stopped that: my father developed a bedsore and the cost of getting it treated would have exceeded my part-time earnings.

Nurses most often perform wound care. And in Alexandria, where my parents and I had moved, home health agencies billed $75 an hour for nursing services in 4-hour blocks. This would have rung up to $300 for around twenty minutes of labor total to clean a wound and apply a bandage.

Math and scheduling woes changed my role from family caregiver to de facto wound care nurse, at the expense of my earning a part-time income outside of the home.

My father's bandage needed changing at least three times a week. Three visits at $300 each meant $900 for wound care a week, or $3,600 a month. What's more, the nurse would need help to hold my father steady, but lining up a nurse's and aide's schedule was impossible.

The solution to all this was me abandoning the effort of getting a job and staying at home to be there when an aide arrived and learning to do wound care myself under the weekly supervision of my father's hospice nurse. Is my story like your story? Has my story sparked any ideas for you?

Read Part 3 to learn what this experience sparked in my mind.

1. According to a report by PHI, *Caring for the Future: The Power and Potential of America's Direct Care Workforce*, 42% of direct care workers—a group including personal care aides, home health aides and nursing assistants—require some form of public assistance due to low earnings and high rates of poverty. This contributes to high turnover rates. Among direct care workers, home care workers are the most likely to live in poverty, and that's for physically and emotionally demanding work that can not only place workers in unsafe settings but is often plagued by scheduling challenges and poor training and career advancement prospects.

PART 2:
The toll of wounds is significant and growing.

Despite the tremendous burdens that wounds place on individuals, families and care systems, they haven't attracted the same attention as other public health challenges.

Yet wounds affect 10.5 million people on Medicare (national health insurance for Americans 65+), and between 19% to 34% of people with diabetes worldwide are at risk of developing a diabetic foot ulcer in their lifetime.[1] [2] This could represent more than 13.5 million people in the U.S.[3]

10.5M

Medicare beneficiaries with a wound

This represents 1 in 6 enrollees.

13M+

People in U.S. at risk of developing a diabetic foot ulcer

From diagnosed and undiagnosed diabetes.

Close to 20% of people with a diabetic foot ulcer will require amputation, and the 5-year mortality rate of diabetic foot ulcers is almost 50%, exceeding the rate for all cancers combined at 30%.[2] [4] Due to climbing diabetes rates alone, the public health impact of wounds is only expected to grow.

50%

5-year mortality rate from diabetic foot ulcers

This exceeds the 30% rate of all cancers.

20%

Approximate rate of lower extremity amputation

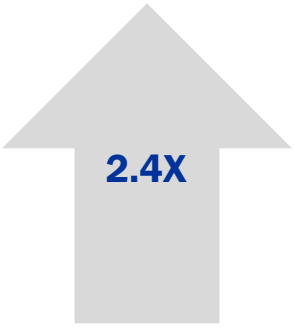
Due to diabetic foot ulceration.

Wounds are costly and increase hospitalization and readmission rates. But follow-up and proactive care can keep those rates down.

In 2019, Medicare spending on wounds as a primary diagnosis was $22.5 billion, with this number increasing to $60.7 billion for wounds as a primary or any secondary diagnosis.[1]

Though it's recognized that wounds increase hospitalization rates, a literature search didn't find definitive sources quantifying that increase.[5]

However, a retrospective review of 444 hospitalized patients who received wound care showed that 46% had been readmitted or died within 90 days of discharge, and that patients who didn't receive follow-up wound care had readmission rates 2.4 times higher than those who did.[6]



Hospital readmission rates

For patients who didn't get follow-up wound care compared to those who did.

- **Were older**
- **Had longer hospital stays**
- **More often discharged to skilled nursing facilities**

Characteristics

Patients who didn't schedule follow-up wound care compared to those who did.[6]

Another study showed that podiatry services covered by Medicaid (government health insurance for adults and children with limited income and resources) was associated with a 24% lower risk of hospitalization from foot infection in 19,605 individuals with a new diabetic foot ulcer.[7]

24% LOWER

Risk of hospitalization for foot infection

For Medicaid beneficiaries with foot ulcers who had covered podiatry services compared to those who didn't.

Chronic wounds disproportionally affect older adults and certain racial minority groups. Individuals with reduced mobility are also at risk.

Chronic wounds—those not showing signs of significant healing over many weeks—disparately affect older adults.[8] Among chronic wounds, diabetic foot ulcers may be the best studied.[8]

Hospitalization rates related to chronic wounds are 1.5 to 5.4 times higher in underrepresented groups than in the white population, and Black, Hispanic and Native American individuals with diabetes have up to a 2.9 times higher risk of lower extremity amputation than white individuals.[9]

Each year, 23% to 40% of wheelchair users with a spinal cord injury will develop a pressure ulcer, and nearly 95% will experience at least one over the course of their lifetime.[10] People who spend prolonged periods of time in bed are also at risk of pressure ulcers, or bedsores.

Transportation is a common barrier to consistent care.

Five percent of adults—more commonly those in low-income families—reported going without needed care in the previous 12 months because of difficulty finding transportation.[11]

The need for frequent wound care increases transportation challenges and the potential for missed appointments, which is a greater liability for patients needing special travel accommodations.

Home health can deliver consistent care.

Wound care occurs in wound healing centers, hospitals and outpatient clinics, but also in homes.

Medicare and/or Medicaid beneficiaries can get wound care at home without paying out of pocket if they meet certain criteria, such as being homebound or needing skilled care. Patients with other insurance, or none, may need to pay for in-home wound care or receive it from a family member.

Standard hospital and home health practices can limit the potential benefits of wound care at home.

For hospital patients prescribed follow-up wound care, poor coordination between discharging hospitals and home health agencies can delay the onset of care, which allows wounds to worsen before skilled nursing starts. Poor practices in these areas can also reduce the quality of care:

- Scheduling home health staff.
- Educating patients and family caregivers.
- Adopting digital wound care tools.

Scheduling solitary nurses to visit patients spread over large geographic areas contributes to nurse travel burnout while reducing time for patient care.

Also, studies in the UK and Denmark have shown that wound care dressing changes result in three home health visits per week, on average.[12] Scheduling multiple nurses per case increases the risk of communication breakdowns and possible wound deterioration between visits going undetected.

With proper education, patients themselves and family caregivers can become valuable partners in effective in-home wound care. The use of simple to advanced technology to capture images of wounds sent to an offsite team for guidance can also improve patient outcomes.[13]

PART 2 REFERENCES:

1. Carter et al. (2023). *Chronic wound prevalence and the associated cost of treatment in Medicare beneficiaries: changes between 2014 and 2019*. Journal of Medical Economics, 26(1):894–901.

2. McDermott et al. (2023*). Etiology, Epidemiology, and Disparities in the Burden of Diabetic Foot Ulcers*. Diabetes Care, 46(1):209–221.

3. Per CDC, 40.1 million people in the U.S. have diagnosed and undiagnosed diabetes; 34% = 13.6 million people at risk.

4. Siegel et al. (2026). *Cancer statistics*, 2026. CA: A Cancer Journal for Clinicians, Vol. 76, Iss. 1.

5. Christensen (2023). *Older Americans and Their Risk of Chronic Wounds*. Wound Care Advantage blog. Notes 6X higher hospitalization rates for Medicare beneficiaries with chronic wounds vs. those without.

6. Chen et al. (2026). *Social Drivers of Health and Communication Interventions Impact Wound Care Follow-Up Adherence*. Clinics and Practice, 16(2):42.

7. Luu et al. (2024). *Improved Diabetic Foot Ulcer Outcomes in Medicaid Beneficiaries with Podiatric Care Access*. Diabetology, 5(5):491–500.

8. Falanga et al. (2022). *Chronic wounds*. Nature Reviews Disease Primers, 8(1):50.

9. Cavalcante-Silva et al. (2024). *Racial/ethnic disparities in chronic wounds*. Wound Repair and Regeneration, 32(5):770–779.

10. Fogelberg et al. (2009). *Decisions and Dilemmas in Everyday Life: Daily Use of Wheelchairs by Individuals with Spinal Cord Injury and the Impact on Pressure Ulcer Risk*. Top Spinal Cord Inj Rehabil. Fall;15(2):16-32.

11. Smith et al. (2023). *More than One in Five Adults with Limited Public Transit Access Forgo Health Care Because of Transportation Barriers*. Urban Institute Health Policy Center.

12. Lindholm & Searle (2016). *Wound management for the 21st century: combining effectiveness and efficiency*. International Wound Journal, 13 Suppl 2:5–15.

13. Mohammed et al. (2025*). Clinical, Operational, and Economic Benefits of a Digitally Enabled Wound Care Program in Home Health*. JMIR Nursing, 8:e7153

OUR CREATIVE POWER LIES IN OUR IMAGINATION.

Our pressing task is to defer to imagination, not current conditions. To let ongoing matters stifle our vision is to let them stifle our future. It's time to allow ourselves to dream, without minding the details for now...

PART 3:
Connecting neighbors to make wound care at home more affordable, accessible and effective.

If healthcare were a human body, medical professionals would be the muscles and bones, but neighbors would be the connective tissue holding the body together.

"Neighbors" includes family caregivers. Valued at over $835 billion, if caregiving were a company, it would be the largest revenue-generating company in the world.[1] That means larger than Amazon.

Family caregivers aren't daughters, sons and other kin "doing their duty," but a workforce keeping formal care systems from collapsing. Neighbors who aren't family caregivers also hold tremendous value, but they, like family caregivers, need meaningful support to unlock their fullest potential.

Caring communities, or villages, for and by neighbors can produce health & well-being for all involved.

A vision of villages:

Each of us needs different care to feel and function at our best. By combining neighborhood assets with other resources, villages can make our care custom, nimble and dynamic: designed for us from the ground up and able to respond to unplanned events and changes that occur as we age.

BABY JOSEPH'S VILLAGE

Parents, Nana, Auntie Sue
Babysitter
Baby food preparer
Pediatrician

ESTHER'S VILLAGE

Nuclear & church family members
Long-distance besties
Walking club members
Small business club members
Primary care doctor
Community diabetes educator

BARBARA'S VILLAGE

Mahjong club members
Upstairs neighbor
Professional care coordinator
Transportation volunteers
Meal delivery service
Cleaning & laundry crew
Primary care doctor
Cardiologist
Home health nurse

PART 3 Continued …

There are five main kinds of villages that can be mixed and matched to meet our needs:

1. **Tiny villages** are comprised of three to five people.
2. **Affinity villages** are organized around a theme.
3. **Virtual villages** are operated from anywhere.
4. **Mobile villages** are dispatched to where we live.
5. **Neighborhood villages** are formed where we live.

Neighbors in a village can offer three levels of care:

LEVEL ONE CARE: Social & Other Supports	LEVEL TWO CARE: General Services	LEVEL THREE CARE: Personal & Medical Care
Individually or in groups, neighbors gathering neighbors to break bread, learn, play, exercise and more.	Neighbors offering free or paid services, like cooking, cleaning, transportation and care coordination.	Neighbors with certifications offering various in-home services as self-employed or third-party providers.

Villages can make wound care at home more affordable.

Home health agencies typically require a minimum of four hours per visit. While this makes sense from a billing and staff travel standpoint, it creates a financial burden for patients paying out of pocket who need frequent visits. Or it can stop skilled wound care at home from occurring at all.

By having one nurse, in one shift, provide services to proximate neighbors, or village members, it may be possible for 1) a nurse to be dedicated to a defined area and build patient rapport, 2) the agency to extend its reach by serving more patients and 3) families to share the costs of care.

Though cost sharing can make wound care more affordable, it may still be too expensive for some.

AN EXAMPLE COMPARISON OF PRIVATE PAY IN-HOME WOUND CARE MODELS:

Key Measures	Traditional Model	Village Model
Wound care visits per week	3	3
Patient cost per visit	$300 (4 hrs at $75/hr)	$75 (1 hr at $75/hr)
Patient cost per week	$900	$225
Patient cost per month	$3,600	$900
Families served per shift	1	4
Amount agency bills per shift	$300	$300
Consistency of care	Lower due to higher cost	Higher due to lower cost

PART 3 Continued …

Villages can make wound care at home more accessible.

By making wound care more affordable to patients who pay out of pocket, villages can make it more accessible. In cases where insurance covers the costs of in-home wound care, 4-hour home health visits can still create hurdles, especially for family caregivers working outside the home:

As noted, home health workers turn over frequently, which means that a caregiver needs to stay at home to orient ever-changing care providers when patients can't do it for themselves. It may also require a caregiver to be present while a comfort level is being established with unknown workers.

Village members can take turns sitting in for each other during 4-hour home health visits or hire, or barter with, each other to do so. This at once can make wound care more accessible to patients and possibly help family caregivers to keep a schedule that allows them to earn outside the home.

It's also feasible that villages could help to improve working conditions for home health workers—and possibly slow worker turnover rates—by making patient rosters and travel more predictable, as well as by creating safe and nurturing communities in which workers can work.

Villages can make wound care at home more effective.

According to Abbott Nutrition Health Institute, "The presence of a wound increases a person's need for calories, protein, water, and other nutrients, including specific vitamins and minerals. A failure for wounds to heal in a timely way can lead to the development of chronic wounds."

The need for more nutrition to heal isn't the only way that people with wounds are at risk of not getting what their bodies require: a diabetic foot ulcer, for example, may limit a person's ability to stand and cook for themselves. Fellow villagers can assist with food preparation and delivery.

Villagers with wound care experience may also provide nutritional and other tips to hasten healing.

PART 3 REFERENCE:

1. Columbia University Mailman School of Public Health (2024). *America's Unseen Workforce: What will it take to change the future of family caregiving?* Sponsored by Otsuka America Pharmaceutical, Inc.

PART 4:
How toileting put my mother at risk for wounds and a stay in a nursing facility.

Thanks to what I learned by taking care of my dad, my mom's skin was fully intact when she entered the hospital at age 93 with a breathing issue.

Given the length of time that he was bedbound—over two years—my father had remarkably few bedsores. Biology was certainly on his side, but I also credit his hospice nurse telling me when I first started as a caregiver to think of bedsores as a nutrition issue as much as a pressure one.

Based on this, I did everything I could to maximize my father's intake of protein and green foods, which I supplemented with vitamins and minerals. His body did the rest of the work, and I was told that his smooth skin was a popular topic of conversation in hospice team meetings.

(His nutrition may also be why he was removed from hospice for a spell.)

My mother's skin was also in good condition, and I was determined to keep it that way.

Mom couldn't move about on her own in the hospital, which put her at risk for bedsores. I also knew that urine or stool could begin damaging her skin quickly.

I asked for my mother to get an external catheter to keep urine from compromising her skin. Despite this, she started developing a small wound. To keep it at bay, I helped the hospital staff with my mom's toileting to keep her skin as clean as possible, as much as possible.

Along with keeping her skin intact, I was concerned about my mother keeping strength in her legs. So I asked for her to get assistance with standing up regularly as soon as it was safe. My fear was that if her legs got too weak, she wouldn't be able to get to the toilet when she was back at home.

My fear was well-founded:

Time in a hospital bed made my mother unable to stand without two helpers, and a social worker told me to mentally prepare for her to go to a nursing facility.

My sister was in town and we hatched a plan. We'd take mom home and see if she could gain enough strength before my sister's departure for me to safely help mom to stand and walk her to the bathroom by myself. If not, she'd have to go to a nursing/rehab facility for physical therapy.

Physical therapy can happen at home, but the need for toileting doesn't happen on a schedule and I wouldn't have been able to do my mom's toileting in bed by myself in the days that her legs grew stronger. My stomach was in knots because going to a nursing facility is not without risk:

One in three patients experience harm in a skilled nursing facility, and almost 40% of older patients in one study didn't return home.[1] [2] Some patients died, others were readmitted into the hospital or moved to an assisted-living facility, and yet others remained in the facility 6 months after arriving.[2]

PART 4 Continued …

My mom dodged the facility, but I was troubled that she was almost put in one for a toileting issue and started pondering ways to support people leaving the hospital.

My mother had me for help with toileting. But how many other people who need that kind of help aren't so lucky? And how many are landing in a facility because of it, perhaps permanently? And how much more money is it costing the system while costing people quality of life?

When I became a caregiver, I decided from day one that I'd use my experience to make life easier for other caregivers and those in their care. And I daydreamed about that a lot.

Time after time, I returned to a dream that can benefit *ALL*, one of lively and caring communities and economies—or business, swapping and/or sharing activity—for and by neighbors.

I dreamed about on-call neighborhood toileting techs, and hyper-local menus of neighbor-produced goods and services that caregivers crave but aren't easy to find.

And I dreamed about Medicare and other health insurers paying neighbors directly for many of the services, without putting them through a treacherous administrative process that would make them think twice about taking insurance. Easy reimbursement would be good for everyone involved:

AN EXAMPLE COST COMPARISON OF RECOVERY IN A FACILITY vs. HOME:

Skilled Nursing Facility
Average Cost Per Day

$314

The national average for a semi-private room is about $314/day. But many patients worsen and are readmitted into the hospital, and others remain in the facility 6 months after admission.[2] That means much higher costs.

Neighborhood Toileting Tech
Example Cost Per Day

$60

1-3 neighbors paid for 3 daily toileting calls—helping people with soiled diapers to get clean or helping people to the toilet or with toileting in bed—could prevent a costly cascade of complications, like wounds or urinary infections.

Lively and caring communities and economies "for and by neighbors" doesn't mean that neighbors won't at times need the respectful support of professionals or institutions to do things with them or for them.

PART 4 REFERENCES:

1. The U.S. Department of Health and Human Services Office of Inspector General (2014). *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, Report No. OEI-06-11-00370.

2. Hakkarainen et al. (2016). Outcomes of Patients Discharged to Skilled Nursing Facilities After Acute Care Hospitalizations. Annals of Surgery, 263(2):280-5.

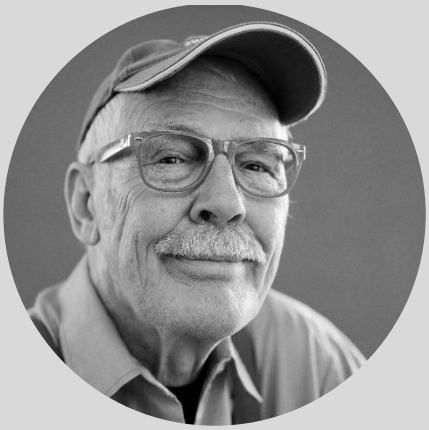
PART 5:
Forming villages of “hospital to home helpers” to assist in reducing readmissions.

The future of healthcare is in the home, but a safe homecoming after a hospital stay can be threatened by something as mundane as floorboards.

Hospital readmissions put patients at risk of hospital-acquired infections and other stressors. They are also costly to insurers and hospitals. In 2018, there were 3.8 million adult hospital readmissions at an average cost of $15,200.[1] Moving from the hospital to home is a vulnerable time for patients.

“Hospital to home” programs exist to help patients make successful transitions. They offer services like transportation, care coordination, medication reminders and sometimes home repairs.

Villages can also help patients to return home and are best suited to help them remain there by providing critical ongoing support with tasks like grocery shopping and picking up medications. Older adults are among those most at risk of adverse outcomes resulting from poor transitions.[2]



“It’s hard to say where I would be. They [hospital to home helpers] were just a saving grace sent by God, literally. … I didn’t know what I was going to do. They were telling me that I couldn’t come home because I couldn’t take care of myself.”

STEVE FROST
Hospital to Home program participant,
depicted by a stock photograph.

Hospital to home help in action:

Steve Frost had two consecutive hospitalizations lasting three months each. During the second stay, squatters entered his home and made it uninhabitable. Frost had nowhere to go.[3]

Sean McCollough was admitted into the hospital. The paramedics who transported him there from his home said that he shouldn’t return because holes in the floors made them unsafe.[3]

Despite the odds, both men returned home. Among other things, McCollough’s floors got fixed and Frost’s home was restored through a Hospital to Home program created by a partnership between UCHealth Memorial Hospital and a community-based nonprofit called The Independence Center.

PART 5 Continued …

Villagers as hospital to home helpers can improve current practices.

A study of 48 articles describing the integration of community organizations into hospital to home interventions found that while many proved to be effective, limitations existed:[2]

- They predominantly focused on a subset of all people who needed support.
- They were typically delivered by health care providers.
- They were time-limited.
- They were offered in select settings.

The study noted that these limitations leave a large proportion of individuals who may have longer-term needs, live in rural or remote areas or require culturally tailored support to be left unserved.

Individuals who may have longer-term needs may particularly describe people with wounds: All wounds can become chronic, and chronic wounds can take months, or even years, to heal.

Because the primary drivers of villages are neighbors living where people in transition from hospital to home live themselves, villages are well-suited to operate where current interventions fall short by offering culturally tailored support to people wherever they live for varying amounts of time.

Steve Frost's home was vandalized during a long hospitalization. Unlike other hospital to home programs, a village can keep an eye on the properties of hospitalized neighbors 365 days a year.

Villagers can ease transitions from hospital to home. And to heaven.

With the proper partnerships and financial support, villages have the capacity to exceed the effectiveness of existing hospital to home programs, or others, for one fundamental reason:

Villages are not programs to fix problems. Rather than a focus on tackling what's wrong, villages focus on using what's strong in our neighborhoods to unlock true prosperity—*aliveness*—for all. From birth to beautiful death.

Transitioning people from the hospital to home doesn't mean that they'll thrive there. Thriving requires the understanding that we all have gifts and none of us is only a giver or receiver. A person can both need help with tasks like getting dressed AND *be needed* to lead a singing group.

Helping people to thrive takes more than helping them to meet their basic needs. Thriving asks us to ask people what they'd love to do in the places where they live and to facilitate those things.

PART 5 REFERENCES:

1. Weiss A. and Jiang H. (2021). *Overview of Clinical Conditions With Frequent and Costly Hospital Readmissions by Payer, 2018*. Agency for Healthcare Research and Quality; Statistical Brief #278.

2. Nelson M. (2025). *Supporting Transitions from Hospital to Home by Engaging Volunteers of Third Sector Organizations: A Scoping Review*. International Journal of Integrated Care, 2025; 25(4): 19, 1–14.

3. Emery E. (2020). *Breaking down barriers to a safe hospital discharge through a new community partnership and Hospital to Home program*. Available online at www.uchealth.org.

So often when we label people as vulnerable, or as deficient, or as problematic, what we actually do, is we define them out of community and redefine them not as friend and as neighbor but as client in a service system. And I think that when we do that, we take some of the soul away from the person, all in the name of helping them.

— Cormac Russell

PART 6:
How living with my parents in different settings inspired my vision of vertical villages for all ages.

Setting 1: A community for older adults.

For about six months, I lived with my parents in a community for adults 62 and over. There were certain things that I liked about the place:

- My parents didn't become invisible, which often happens to older people in the U.S.
- There was assisted living onsite to meet my father's needs as his dementia progressed.
- The residents had their meals provided.
- There were common areas besides the dining room where people gathered for activities.
- My mom had access to an events room where she hosted well-attended singalongs, which gave her purpose, maintained her piano playing skills and made people happy.
- Residents got free rides to the store and devotional services.
- A podiatrist and beauty practitioners visited the community to offer their services.
- There was a small care agency onsite to provide help in a pinch.

But there were also downsides:

- The atmosphere of the place seemed to age my parents faster.
- The residents tended to be ill or have limited mobility, so it was harder to help each other.
- The meals were neither nutritious nor delicious, so my niece, sister or I did the cooking.
- Because room and board were bundled, my parents paid for 1500+ meals they didn't eat.

Setting 2: A standard apartment building.

Moving from the 62+ community into a building without an age restriction was a mixed bag:

- The place had a livelier energy and my parents' spirits perked up.
- My parents saved over $1500 per month in housing costs.
- The apartment was sunnier, more spacious and had a better layout.
- My mom was the only "old lady" in the building and lost socializing with her peers.
- The building didn't have regular programming to bring residents together.
- I had to chase down in-home podiatry and other services that my parents needed.
- With no care agency onsite to help me with my father when his aides didn't show, I often enlisted the help of my then 89-year-old mother.

My father lived for years longer than expected, and I became so exhausted that I fantasized about jumping off our balcony. It seemed nuts to be on the brink of death by a thousand cuts in a building full of people, some of whom I imagined would have helped me if they knew what was happening.

In my despair, I got the idea of fostering what I call vertical villages.

PART 6 Continued …

Imagine a fun, tall community center where people live and get care. Now, imagine all kinds people of all ages thriving there.

You've just imagined a vertical village,
or a caring community for & by neighbors of all ages in multifamily housing.

In America today, there are many forces unsupportive of vertical villages. Age segregation and policies that prioritize paying for treating illness above paying for shaping health are two examples.

To requote the Surgeon General report:
"The health of Americans is shaped in neighborhoods and communities…."

Decision makers will one day see the wisdom in directing more health spending to the places where health is shaped. But we mustn't wait for that day to act.

In the same way that we must vote at the polls to garner political support, we must vote with our engagement as neighbors to gain financial support for villages.

Today is the best day to vote for neighborhood villages, vertical or horizontal.

We've seen how villages can be an asset in meeting significant and growing needs for wound care, as well as transitioning people from the hospital to home. But they hold far greater promise:

Countless people globally are feeling powerless, unseen or lacking in purpose. All of that can be erased through the power of a neighborhood village.

Here's a glimpse at some of the wonders a neighborhood village can produce:

- Uniting people.
- Connecting villagers to resources.
- Promoting healthy living.
- Reducing loneliness and social isolation across ages.
- Nurturing youth and helping older adults to live in community.
- Sparking creativity and joy!
- Providing home-based volunteer and business opportunities.
- Providing opportunities to learn and teach skills.
- Creating a culture of care and support networks for caregivers.
- Reminding us that we're the same and interdependent.

The main ingredients to produce these wonders and more?

Neighbors, imagination and action.

The beautiful thing about creating caring communities is that regardless of your skills or what you love to do, YOU as a neighbor HAVE WHAT IT TAKES to help grow a village!

PART 6 Continued ...

Villagers come in three main flavors: Inspirers, Cultivators & Activators.

Inspirers

Village inspirers are dreamers and wishers: folks who aren't shy about sharing what they want to help other villagers to make it happen!

Cultivators

Village cultivators are "doers and shapers": folks ready to lend hand-on help, even if they're not exactly sure what they want to do or where to start.

Activators

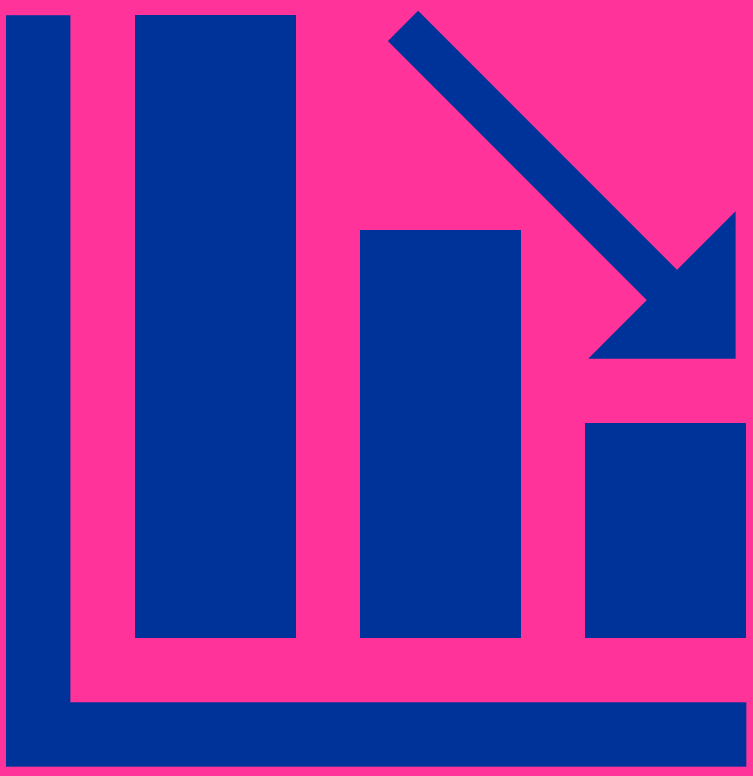
Village activators are discoverers and connectors: folks eager to find community gifts and resources, then putting them to use by matching them with neighbors.

But even villagers need a village!

Growing neighborhood villages will require new thinking and an alliance of neighbors, healthcare and housing providers, local and national leaders, funders, advisers and all who are interested.

Continue to the next section to learn why neighborhood villages must be included in conversations about quality healthcare or thriving economies. Or **CLICK HERE** to join the Vertical Village Alliance to help unlock widespread neighborhood villages, both vertical and horizontal.

Our families, care systems and economies only do as well as the people who keep them going.



Unless we act, our future prosperity looks bleak because care workers and family caregivers—needed workers in all sectors—aren't doing well.

PART 7:
Why neighborhood villages must be included in conversations about quality healthcare or thriving economies.

When it comes to care, America needs all hands on deck or she could break.

Here are the facts:

1. We'll all need or give care eventually.

People 85 and over are the fastest-growing age group in America, and by 2035 older people (65+) will outnumber younger people for the first in U.S. history.[1] Of people 65+, 69% will need long-term care for an average of 3 years.[2] Younger people also have substantial and growing care needs.

2. Long-term care is especially broken, and families are bearing the brunt.

Medicare doesn't cover long-term care. Neither do most insurance plans. And the median yearly cost of a home health aide is now $80,080.[3] The high cost of long-term care means that families provide it most, leading to $3 trillion in lost wages and benefits for 10 million caregivers over 50.[4]

The number of family caregivers has grown by 20 million in the last decade to 63 million in 2025.[5] That's 1 in 4 U.S. adults 18 and older. There are an estimated 5.4 million child caregivers too, and their health and school performance suffer for it.[6] This robs potential from the children and society.

3. Broken care puts our prosperity and security at risk.

Caregiving takes jobs and costs employers billions:

"Caregiving is the single most common reason people aged 25-54 give for not working," and lost productivity from caregiving is estimated to cost U.S. businesses between $17-$34 billion a year.[7] [8]

In addition to lost productivity resulting from employees being absent or distracted, hidden costs of caregiving include turnover costs, such as lost knowledge and replacing workers who resign.[8]

Caregiving drives up healthcare costs:

Caregiving health declines add an estimated $28 billion to healthcare costs a year.[9] About 40% of family caregivers of people with dementia suffer from depression (vs. 5-17% for non-caregivers).[10] There's a 73% increase in ER visits for people with dementia whose caregivers have depression.[11]

Direct care workers are in short supply, and physicians are taking their own lives:

Between 2024 and 2034, 9.7 million total direct care jobs will need to be filled, including new jobs and job vacancies that will be created as existing workers exit to change careers or for other reasons. Direct care workers is a group that includes home health aides and nursing assistants.[12]

In regard to physicians, estimates of successful completion of suicide go up to 2.3 times the rate achieved in the general population.[13] For female physicians, the suicide completion rate is up to 4.1 times the rate of women in the general population.[13] Nurses are also taking their own lives.

PART 7 Continued …

A lack of access to healthcare aids the spread of misinformation:

The spread of misinformation is tied to despair.[14] Despair is considered a public health crisis and a risk to national security.[14] In the last decade, "Deaths of Despair"—premature deaths from drugs, alcohol or suicide—have lowered our national life expectancy.[14]

Moreover, people in despair are more prone to manipulation by players with nefarious intent.[15]

4. Loneliness is pervasive and lethal.

Loneliness is the feeling of being alone, despite social connections. Social isolation is a lack of social connections. This can lead to loneliness, which is associated with increased death by 26%.[16]

- 33% of adults in the U.S. report feeling lonely.[17]
- 51% of U.S. mothers of young children feel serious loneliness.[18]
- 61% of young adults in the U.S. aged 18-25 feel serious loneliness.[18]

Loneliness and social isolation can increase our risk of dementia, stroke, heart disease, depression, anxiety, suicide, hospitalizations, ER visits and avoidable health spending. The risk of dementia goes up by 50%, stroke by 32% and heart disease by 29%.[19]

Something has to give—let's change course on care so it's not our country.

The costs of staying the course on care—in jobs, health, lives, national security—aren't ones that our nation can pay and hope to remain intact:

- Family caregivers keeping care systems afloat will burn out or revolt.
- Economies will stall as more workers have their incomes removed and future earnings reduced by caregiving or despair.
- Over half of young adults will fail to flourish.

And yet, all is not lost:

VILLAGES HEAL.

Though loneliness is associated with increased death by 26%, an analysis of 148 studies found that social connection increases our odds of survival by 50%.[16] In addition, cancer patients who feel satisfied with their level of social support have a greater chance of survival.[20]

For the healing power of social support, neighbors matter more than doctors. Neighborhood villages can help to reduce loneliness and make lighter work for caregivers. They're not a cure-all, but broken care won't be cured without them.

And for as long as care is broken, economies will be weakened.

We must elevate villages to give our future prosperity a chance.

"I remember living in a community where most of the residents were mostly preoccupied by their work. For almost 3 years a single friend I was able to make was a housewife as me with 2 children but one afternoon I had a chance to meet [a neighbor] who was new in the building. …

And she will become one of our great friends my children and I, asking if I need help, stopping by to check on us. During the pandemic she texted constantly to ask if I have everything. She will just take a list, shop and drop off."

VIVIANE
Depicted by a stock photograph

PART 7 REFERENCES:

1. U.S. Census Bureau at www.census.gov.

2. Administration for Community Living. *How Much Care Will You Need?* Available at www.longtermcare.gov

3. Genworth Financial 2025 cost of care calculator at www.carescout.com.

4. MetLife Mature Market Institute (2011). *The MetLife Study of Working Caregivers: Double Jeopardy for Baby Boomers*
Caring for their Parents.

5. AARP and the National Alliance of Caregiving (2025). *Caregiving in the US 2025.*

6. The Caregiving Youth Research Collaborative (2023). *Report of Caregiving Youth in the U.S.*

7. Federal Reserve Bank of Minnesota (2023). *Who's not working? Behind the full-time caregivers leaving the workforce.*

8. MetLife Mature Market Institute research (2006). *The MetLife Caregiving Cost Study: Productivity Losses to U.S. Business.*

9. Columbia University Mailman School of Public Health (2024). *America's Unseen Workforce: What will it take to change the future of family caregiving?* Sponsored by Otsuka America Pharmaceutical, Inc.

10. Family Caregiver Alliance. *Caregiver Statistics: Health, Technology, and Caregiving Resources*. Available online at www.caregiver.org

11. Guterman et al. (2019). *Association Between Caregiver Depression and Emergency Department Use Among Patients With Dementia.* JAMA Neurology. 76(10):1166-1173.

12. PHI. *Caring for the Future: The Power and Potential of America's Direct Care Workforce*. Available at www.phinational.org

13. MedScape (2022). *Physician Suicide*. Available at www.medscape.com

14. Graham. C. *Despair Undermines our Misinformation Crisis*. John Templeton Foundation "Grantee Voices."

15. The Brookings Institute (2021). *Addressing America's crisis of despair and economic recovery*.

16. Holt-Lunstad J. (2022). 29th annual Martin B. Hickman Outstanding Scholar Lecture, as reported in *Loneliness and Isolation Present Serious Mortality Risks—Antidote Found in Acts of Kindness* by Rachel Summers. Available online at www.byu.edu

17. CDC (2024). *Health Effects of Social Isolation and Loneliness.* Available at www.CDC.gov

18. Harvard Graduate School of Education (2021). *Loneliness in America: How the Pandemic Has Deepened an Epidemic of Loneliness and What We Can Do About It*. Available at www. mcc.gse.harvard.edu

19. U.S. Surgeon's Advisory (2023). *Our Epidemic of Loneliness and Isolation.* Available at www.hhs.gov

20. Boen et al. (2018). *Social Relationships, Inflammation, and Cancer Survival*. Cancer Epidemiology, Biomarkers & Prevention, 27(5):541–549.

PART 8:
How my mother saved her neighbor's life.

All it took was waving, paying attention and using a key.

My mother met her neighbor at church. The neighbor was a solo ager—one of the millions of older adults in the U.S. without a reliable support system—who entrusted my mother with her house key.

My mother and her neighbor waved to each other every day. But one day, the neighbor wasn't standing in her window as usual. She was missing the next day too and didn't answer her phone.

Sensing that something was wrong, my mother called my brother, and they entered her neighbor's house to discover that she'd fallen, couldn't move and was close to dehydrating to death.

EMS told my mother that if she hadn't called, her neighbor would have died overnight.

Important elements of this story:

- My mother and her neighbor stayed connected only by waving at each other.
- The neighbor wasn't too "fiercely independent" or untrusting not to give someone her key.
- Had the neighbor not given her key to someone who saw her regularly—that is, a trusted neighbor—she could have died before anyone noticed that she was missing.
- All it took was small actions to save a life.

Neighbors make great first responders…and dog walkers and money savers.

I once had a neighbor who had a chronic illness. He had a lockbox on his door so that someone could access his key and enter in case of an emergency. Although he had family living in the same city, I could get to him faster because I lived closer: one floor down in our apartment building.

My neighbor trusted me with the combination to his lockbox. I never had to use it. But I often walked his dog when he didn't have the energy, which saved him money on dog walkers. I'd also send him the occasional text asking if he wanted me to pick up a few things for him at the store.

And a wonderful thing happened:

He started sending texts like that to me.

Important elements of this story:

- A lockbox on a home's front door allows family members, neighbors or EMS to enter.
- A chronic illness doesn't make a person chronically unable to contribute.
- Our actions can inspire our neighbors to respond in kind, for better or worse.

None of us is too ill, old or anything not to have gifts to give.

The gift of noticing each other is simple to offer and can literally save lives.

PARTING WORDS

This document may have left you feeling inspired, overwhelmed or both.

It's clear that care isn't working but doing something about it might feel too big for us or that our efforts don't matter. In those moments, let's invoke the words of Founding Father Thomas Paine:

"We have it in our power to begin the world over again."

Paradoxically, I think that requires most of us to look softly at the world but squarely at our own corners of it. Or to tend to our own villages, as it were. But given that we generally don't know our neighbors, tending to our own villages means planting villages to have any to tend.

The world would begin again and could thrive if we—neighbors, healthcare and housing providers, healthcare insurers, local and national leaders, funders, advisers and all others—committed to growing or supporting neighborhood villages.

But let me be frank:

Just as growing apples takes time, growing villages won't produce fruit overnight.

The growing process could be slow and will certainly take us into unfamiliar terrain. Unfamiliarity is often uncomfortable, but our choice is to face our discomfort and grow intentionally or languish and "invite" escalating harsh realities to break us free of old patterns THROUGH to a better world.

Assuming that we don't delay too long and let harsh realities break us DOWN first.

We have much reason to hope for a brighter tomorrow if we make a commitment today. Even if the commitment is to play!

Play is essential for the health and well-being of people of all ages. And we "can discover more about a person from an hour of play," Plato said, "than in a year of conversation."

I wonder how many of society's ills would disappear if we simply lightened up, learned something about our neighbors and gave them a basic level of care.

The counterbalance to a fearful world is light-heartedness and kindness.

If you agree and believe in the power of caring and connected neighborhoods to begin our world again, please join or support me in the effort to unlock widespread villages.

Below are three steps that you can take:

1. Join the Vertical Village Alliance.

Vertical Village Alliance is an emerging coalition to foster cross-sector partnerships to unlock caring communities for and by neighbors—especially in multifamily housing—enhanced with home-based or close by medical care. **CLICK HERE TO JOIN**.

2. Share this document with everybody.

To borrow from urbanist Jane Jacobs, “[Villages] have the capability of providing something for everybody, only because, and only when, they are created by everybody.” “Everybody” includes organizations and business entities as well as family, friends and professional networks.

3. Contact me about funding sources.

If you know of a funder who may be aligned with the work of fostering neighborhood villages—or if you are interested in lending financial support—please contact me: **hello@avillageforlife.com**.

Please accept my thanks for your precious time and attention.

I look forward to beginning the world over again with you.

Sincerely,
Mary-Elizabeth

Take a method and try it. If it fails, admit it frankly and try another. But above all, try something.

— President Franklin D. Roosevelt