



Healthy Aging Summit

July 27-28, 2015 ■ Washington, DC

Summary of Proceedings

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Overview

Older Americans are a key part of our urban and rural communities and have spent their lifetimes contributing to all aspects of society. According to estimates, more than 72 million adults in the United States will be age 65 or older by 2030. Encouraging healthy lifestyles, along with improving the delivery of preventive services, can help older Americans stay healthier longer and improve their quality of life in later years.

The 2015 Healthy Aging Summit, held in Washington, DC, on July 27 and 28, was cosponsored by the American College of Preventive Medicine (ACPM) and the Office of Disease Prevention and Health Promotion (ODPHP), within the U.S. Department of Health and Human Services (HHS). The Summit featured sessions on key topics for policymakers, researchers, clinicians, educators, and public health practitioners facilitated by thought leaders in the fields of cognitive health and aging.

Specifically, the goals of the Healthy Aging Summit were to:

- Explore the science on healthy aging
- Identify knowledge gaps that need to be filled
- Promote the role of prevention and preventive services in improving quality of life in later years
- Mobilize action to improve the delivery of care for those aging in place or in transition

More than 600 stakeholders from government, academia, public health, and health care attended the Summit. In addition to plenary discussions on critical issues related to healthy aging, the Summit included concurrent panel sessions, poster sessions, and sponsor tables.

During panel sessions, national experts shared research, model practices, and new initiatives related to healthy aging across 4 tracks:

- Neighborhood and Built Environment
- Quality of Life in Aging
- Social and Community Context
- Health and Health Care

These 4 tracks correspond with the Social Determinants of Health (SDOH) framework established by Healthy People 2020 from ODPHP.

Immediately following the Summit, ODPHP – with the Association of State and Territorial Health Officials (ASTHO) and the National Association of States United for Aging and Disabilities (NASUAD) – held a 1-day workshop with state health officials and leaders in the field of aging to help state teams identify priorities for promoting healthy aging using knowledge gained during the Summit. Forty-five states and the District of Columbia participated in the state workshop. State teams left the workshop with key priorities for their state's joint healthy aging agenda and action steps for developing state plans to improve outcomes for older adults.

Keynotes and Plenary Sessions

The Summit plenary sessions emphasized the importance of leveraging a nationwide, coordinated effort to address the challenges associated with healthy aging. These sessions highlighted the following key themes:

- Policymakers, governments, businesses, and society need to work collaboratively.
- Strong leadership is needed to modify the model of care to be more holistic.
- Aging is a global concern and the international community has innovations to share.

Comorbidities and cognitive health are pivotal concerns for improving the health span of aging adults, which has not kept pace with increases in lifespan.

Below are brief summaries of the keynote and plenary sessions.

Opening Remarks

Dr. Karen B. DeSalvo, Acting Assistant Secretary for Health at HHS opened the Summit by speaking on the importance of addressing the challenges of healthy aging through the coordinated efforts of national stakeholders. She referred to the increase in this country's older population as a "silver tsunami" that has both cost and workforce implications. But the greatest concern, she noted, is the quality of life of older adults – for example, only half of adults older than age 75 years receive recommended preventive services.

This Summit, she said, is an important step toward bringing the diverse communities of providers and researchers together to better serve older adults. Dr. DeSalvo added that key components of better meeting the health needs of older adults include educating the health care workforce on new research, leveraging the lessons learned globally, and providing more opportunities for cross-collaboration between public and private entities. She stressed that the design of the social determinants of health (SDOH) framework constitutes an inclusive and collaborative approach to meeting the needs of older adults across the spectrum of environments and service providers.

Keynote: Changing the Way We Age

Colin Milner, CEO of the International Council on Active Aging (ICAA) and a leading authority on the health and well-being of older adults, delivered the Summit's keynote session address on the possibilities surrounding population aging. Specifically, he highlighted how policymakers, government, businesses, and society at large are addressing the current and future challenges of an aging population by evaluating everything from societal contracts and policies to the way we envision the life course itself.

Mr. Milner noted that research has dispelled many myths associated with aging and that society needs to reexamine the aging process through a new lens. ICAA, in partnership with other organizations, has been working to overturn ageist stereotypes and demonstrate the value of promoting active aging and involving older adults in life-affirming activities, such as work, physical activity, and social engagement. He emphasized that the medical community needs to encourage healthy lifestyles throughout the life spectrum to improve quality of life for older adults.

Leadership in Aging and State of the Science

Speakers from ASTHO, the Administration for Community Living (ACL), AARP, the National Institute on Aging (NIA), and the University of California, Los Angeles (UCLA) highlighted critical activities to help accelerate research, policy, and practice related to improving the quality of life for older adults. They emphasized a need to focus on research that shows the greatest promise for helping Americans stay healthy across the lifespan – for example, studies related to the positive impact of exercise on health (both physical and cognitive) and new strategies to manage multiple chronic conditions.

Policymakers and educational leaders must also nurture the next generation of leaders and foster more collaboration among local providers. Leaders engaged in

communication and national strategies should encourage society to reject age-related stigmas and embrace aging Americans. This is an important way to encourage young professionals to pursue careers related to healthy aging.

Finally, speakers emphasized the importance of looking globally for models that can be leveraged within the United States, most notably the World Health Organization (WHO) Global Network of Age-friendly Cities and Communities, which reduces barriers for older adults aging in place. This network was also discussed in more detail during a session in the Neighborhood and Built Environment track titled "Can Age-Friendly Communities Improve the Quality of Life in Older Adults?"

Geroscience and the Biology of Aging

Speakers from NIA, the Mayo Clinic, and the Buck Institute for Research on Aging led a discussion on geroscience, the interdisciplinary field that aims to understand the relationship between aging and age-related disease. They noted that the health span has not kept pace with advances to extend the lifespan. Focusing on the overall health of an individual – rather than merely treating the disease – can help delay the onset of morbidity and compress the period of decline.

Earlier in life, genes and the environment are the determinant factors for chronic diseases such as cancer, diabetes, dementia, and chronic obstructive pulmonary disease (COPD). However, for older adults, aging itself is a risk factor for chronic disease. Delaying the onset of age-related health problems for even a few years can have a significant impact on quality of life and reduce health care costs associated with comorbidities.

Because multiple chronic conditions are so common in older adults, national researchers suggest a paradigm shift away from the traditional "War on disease X" model of addressing health. Instead, experts recommend taking a more holistic approach towards improving overall health that takes into account the interrelational impact of multiple chronic conditions.

Cognitive Aging in America

Dr. Ron Petersen, a leading expert from the Mayo Clinic, shared his research findings, which have become the basis for a number of multisector "opportunities for action" in improving cognitive health across the age spectrum.

The Mayo Clinic Study of Aging¹ is a population-based study of 3,000 participants age 50 years and older who have not been diagnosed with dementia. The long-term goal of this project is to describe trajectories of successful aging, typical aging, and impaired aging from a cognitive perspective. Ultimately, the study aims to identify a model that could help predict which of the 3 aging trajectories an individual will follow. When disease-modifying therapies become available, this model could help clinicians decide when and how to intervene with patients. This study provided 9 recommendations for actions that can be implemented at multiple levels, ranging from the individual to policymaking.

Cognitive health was also discussed in more detail during a session in the Quality of Life in Aging track titled Maintaining Cognitive Health: Research, Policy, and Practice.

Preserving Cognitive Health and Preventing Cognitive Impairment

New initiatives are influencing public health approaches to reduce risk factors for cognitive impairment. Academic thought leaders from across the country identified key research findings on public perceptions of dementia and Alzheimer's disease, aerobic exercise and brain health, and the effects of new learning on cognitive and neural functions in older adults.

The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, developed by the Alzheimer's Association and the Healthy Aging Program at the Centers for Disease Control and Prevention (CDC), has provided an outline to help state and local public health agencies promote cognitive function, address cognitive impairment, and meet the needs of care partners in their community. Another program, the Dallas Lifespan Brain Study, represents one of the largest and most systematic investigations of the relationships among neural structure, brain function, and cognition across the lifespan (including middle age).

International Perspectives in Healthy Aging

Researchers from across the globe presented research and innovations related to improving the lives of older adults with dementia.

The Netherlands has made a national commitment to improve prevention efforts, health care, and support for people with dementia. One example of this is Dementia Village, a residential community that blends the concept of a village with the resources of a traditional nursing home. For example, residents of Dementia Village live in units with

1 Roberts, R.O., Geda, Y.E., Knopman, D.S., Cha, R.H., Pankratz, V.S., Boeve, B.F., Ivnik, R.J., Tangalos, E.G., Petersen, R.C., & Rocca, W.A. (2008). The Mayo Clinic Study of Aging: Design and Sampling, Participation, Baseline Measures and Sample Characteristics. *Neuroepidemiology* 30(1), 58-69 (<http://doi.org/10.1159/000115751>)

people who share similar interests. Compared with residents of traditional nursing homes who generally experience a steady decline in activity, residents of Dementia Village tend to experience little change in their activity level prior to a rapid decline at the end of their lives.

Researchers in Japan have developed PARO, a therapeutic robot used to care for people with dementia. The robot, which looks like a stuffed seal, can produce the documented benefits of animal therapy in environments such as hospitals and extended care facilities where live animals present logistical difficulties. PARO has been shown to reduce anxiety, stress, pain, loneliness, aggression, and wandering. Studies have also shown the use of PARO improves overall communication and social interaction. So far, PARO has been used in 30 countries – for both institutional and home-based care).

Lessons Learned From Across the Globe

In the closing plenary, WHO's Dr. Somnath Chatterji shared best practices and lessons learned in working with less developed countries regarding some key determinants of healthy aging. Populations around the world are rapidly aging, with some of the fastest change occurring in low- and middle-income countries. Aging has a disproportionate impact on poor populations, since they must often continue to work and engage in household activities while bearing the burden of chronic disease later in life.

The “feminization of aging” must also be addressed – women live longer than men and are more likely to have been poor or sick throughout their lives. In lower income nations, there is less recognition and treatment for women with chronic conditions.

Earlier this year, WHO issued a call for case studies to highlight examples of good practice in terms of policies, programs, and other measures in its *World Report on Ageing and Health: Call for Case Studies*.

Concurrent Tracks

Below are brief summaries of each panel presentation organized across the 4 concurrent tracks. More detailed summaries for each panel presentation are included in [Appendix B](#).

Neighborhood and Built Environment Track

The Neighborhood and Built Environment track focused on SDOH, which play a critical role in healthy aging within communities. Featured presenters included representatives from government agencies (local, state, and federal), academic and research institutions, and the nonprofit sector. Sessions explored how physical and social environments affect quality of life and health outcomes for older adults.

Emergency Preparedness and Home Safety

From medical devices that rely on electricity to adequate supplies of prescription medications, older adults have distinct needs during emergencies. During Hurricane Sandy, nearly 60 percent of the people who died were age 60 years or older. During the presentations, experts shared the following emergency preparedness and home safety resources:

- CMIST (Communication, Maintaining Health, Independence, Support/Services/Self-Determination, and Transportation) is a framework for integrating considerations for at-risk individuals with access and functional needs into emergency preparedness, response, and recovery planning at all jurisdictional levels.
- Universal design can be used in building or retrofitting homes to ensure safety and functionality for older adults. This tool expands the functionality of an environment to meet the needs of everyone — for example, building wider hallways to accommodate the use of wheelchairs and walkers.
- Remembering When is a program from the National Fire Protection Association (NFPA) designed to help prevent injuries and deaths among older adult caused by fires and falls.
- During emergencies, emergency plans with an “aging lens” can save the lives of older adults, who are more vulnerable than the general population. It was emphasized that plans should be developed using input from older adults.

Can Age-Friendly Communities Improve the Quality of Life for Older Americans?

A number of communities have made efforts to change neighborhoods to improve the quality of life for older adults. For example:

- The Atlanta Regional Commission (ARC) launched its Tactical Urbanism intervention project to make neighborhoods both safer and more aesthetically appealing.
- Age-Friendly DC is a citywide planning effort in Washington, DC, that is part of a pilot project with WHO.
- New York City's CityBench program aims to increase the amount of available seating in areas that are densely populated by older adults.
- Tufts Health Plan Foundation funded a study, the Massachusetts Healthy Aging Data Report, that assessed 367 Massachusetts cities and towns according to over 100 indicators of healthy aging.
- Nurses at Johns Hopkins University in Baltimore developed the Community Aging in Place – Advancing Better Living for Elders (CAPABLE) study to provide holistic services to low-income older adults.

The Impact of Isolation: The Impact of Products, Space, Services, and Isolation on Aging Americans

Products, spaces, and services can be adapted for older adults to reduce their isolation and improve self-esteem. Below is more information about perspectives on isolation discussed in the session:

- The Consumer Protection Safety Commission (CPSC) noted that consumer products and household environments can be dangerous for older adults – each year, nearly 2.5 million unintentional injuries to older adults are caused by loss of balance, tripping over obstacles, and missteps.
- According to AARP, a decrease in social networks has increased the potential for isolation among older adults. Negative outcomes of isolation include decline, depression, high blood pressure, hunger, breast cancer, coronary attack, and suicide.
- Using the concept of Universal Design to modify environments (both indoor and outdoor) can reduce the barriers to mobility and engagement.

- A study from the University of St. Augustine showed that improving physical health and social engagement not only impacts the quality of life for older adults, but can also improve overall self-esteem.

Caregivers/Workforce Development: Using Diverse Workforces and Tools to Support Independent Living at Home

Caregivers provide critical support that allows older adults to live independently at home. Presentations in this session provided background about the stressors and difficulties that both family members and professional caregivers face. Below are some details of studies referenced in this session:

- A qualitative analysis of the University of Iowa of faculty and staff revealed that more were taking care of parents than were taking care of children. The study also found that caregivers needed to alter their work roles to accommodate their caregiving responsibilities.
- A project in Pennsylvania used photovoice as a tool to allow home care providers to share their experiences visually through photographs. This helped them share the difficulties of their profession with other home care professionals – as well as with those outside the home care community.
- HomeMeds is an evidence-based program in Los Angeles that supports home care screening for potential adverse events, such as looking for signs of confusion and inquiring about falls. As a result of the program, one hospital showed a 13 percent lower rate of emergency department (ED) use.

Health-in-All-Policies: Thinking, Surfing, Walking, and Driving – Leveraging Information and Partnerships to Change the Environment as We Age

Multisector collaborations and partnerships can identify needs and address gaps that improve neighborhoods and built environments for older adults. Presenters provided the following examples of local innovations, proposed approaches, and tools:

- The Alzheimer's Association has been assisting states with developing plans to improve and support services for people with dementia. Today, 40 states have such plans.
- NIA has developed the Talking With Your Doctor toolkit for empowering people to take an active role in their health care.

- As already noted earlier, the CityBench program in New York City — part of Age Friendly NYC — aims to increase the amount of seating on city streets in areas with high populations of older adults.
- The American Automobile Association (AAA) noted that stereotypes about older drivers do not match the data. Most states have some type of driver medical review program, and using these programs is the best approach to identifying at-risk drivers of any age.

Quality of Life in Aging Track

The Quality of Life in Aging track featured sessions that explored how injury prevention, health literacy, cultural practices, and cognitive and mental health impact quality of life for older adults.

Aging Issues for Specialized Populations

Economic, cultural, medical, health care, and mental health factors can affect various subsets of the aging population in distinct ways. Presenters shared the following insights about specific populations:

- **Immigrants:** Data from the National Epidemiological Survey on Alcohol and Related Conditions show that immigrant populations face a number of stressors that correlate to poor health, including language barriers, limited financial resources, and limited access to the health care system.
- **Black lesbians:** Researchers from the Johns Hopkins University interviewed the membership of ZAMI NOBLA (National Organization of Black Lesbians on Aging), an organization of Black lesbians, to better understand their views on traditional providers in terms of meeting their specific needs. Results indicated that Black lesbians tend to mistrust mainstream health care, delay care-seeking, and rely on spiritual and natural healing methods.
- **Inmates:** The University of Connecticut Center on Aging conducted a study to examine suicidal concerns for the aging inmate population. People in prison tend to age faster physiologically, fear victimization, and experience greater difficulty with functions such as climbing into a bunk bed or walking while wearing handcuffs.

From Active Duty to Veteran: Defense Health Agency and Veterans Affairs Initiatives to Ensure Healthy Aging

Physical conditioning and other physical demands of military service create stressors for the aging Veteran population. Below are details about some of the programs mentioned to assist the military and Veteran populations:

- Operation Live Well helps those in the military with nutrition, tobacco cessation, and other wellness services.
- The U.S. Department of Veterans Affairs (VA) has been using community support systems, telemedicine, and mobile units to help bridge the distance for Veterans living in rural areas.
- Shared Decision Making for Aging Veterans is a collaborative decision-making process designed to help Veterans plan for long-term services and support.

Health Literacy – Supporting Quality of Life and Quality of Care

Improving health literacy can support better care management and health outcomes to enhance quality of life for older adults. Below is information about specific health literacy programs and research discussed in the session:

- Living Well is a chronic disease self-management program developed by Stanford University and implemented through the University of Maryland. Through the 6-week program, older adults and their caregivers learn strategies to take charge of their health.
- AIDS Arms, Inc., has identified a framework for improving the health literacy of products. Most older adults have literacy barriers, and even simple modifications of text such as changing the size and style of font or choosing certain colors can improve health communication.
- Care at Hand is a mobile technology that uses surveys conducted by nonclinical coaches, which can be accessed remotely by nurses in real time for alerts. The program has reduced hospital readmissions.
- Fostering Literacy for Good Health Today and Vive Desarrollando Amplia Salud are the English and Spanish versions of a new computer-administered program that allows clinicians and researchers to develop a scored measure of health literacy.

Do Falls Prevention Programs Work?

One in three older adults falls each year, but fewer than half talk to their health care providers about it. During the presentations, speakers identified a number of programs and approaches to help reduce fall risk, including:

- The National Falls Prevention Resource Center educates consumers and professionals on how to reduce modifiable fall risks and provides a clearinghouse of helpful resources.
- LifePlans is a demonstration grant looking into the impact of wellness programs in reducing fall risk for long-term care insurance policyholders.
- The San Diego Fall Prevention Task Force implemented a community-based program using the STEADI (Stopping Elderly Accidents, Deaths, and Injuries) Toolkit. The initiative created motivation for older adults to go to their physicians and become more engaged in addressing fall risk.
- Asian Health Services in Oakland, CA, has worked on providing culturally and linguistically appropriate screening for fall intervention programs.

Maintaining Cognitive Health: Research, Policy, and Practice

Programs designed to improve cognitive health through “brain training” and other innovations can reduce depression and balance issues, as well as other risk factors that influence quality of life. Examples of programs that can help with maintaining cognitive health include:

- The Brain Health Resource, supported by the National Alzheimer’s Plan, CDC, National Institutes of Health (NIH), and Administration on Aging (AOA), provides a repository of resources and toolkits for both consumers and providers.
- The Synapse Project compares memory enhancement from active learning activities such as quilting and photography to more passive activities such as watching TV and playing games (e.g., Yahtzee). Researchers found that participation in mentally challenging activities for 3 months enhanced memory and that the effect lasted for at least a year.
- Brain HQ from Posit Science is a computerized game that, according to Easter Seals, has been shown to significantly reduce depressive symptoms and provide some improvement in cognitive outcomes and balance.

- Are You Smarter Than a Tennessee Senior?, organized by the Tennessee Commission on Aging and Disability (TCAD), is a team trivia, tournament-style statewide competition designed to promote brain health through practice, education, and public visibility.

Social and Community Context Track

The sessions in the Social and Community Context track explored how social support and engagement affect quality of life and health outcomes for older adults. Specific sessions are detailed below.

Benefits of Social Engagement

Evidence-based tools that incorporate family and community-level approaches contribute to an increased sense of well-being and improved quality of life among older adults and improve access to social and support services. The information below details efforts discussed during the session to provide more social engagement among older adults:

- The University of Connecticut, along with the Gerontological Society of America (GSA), designed a 4-step system called KAER to detect cognitive impairment and early diagnosis of dementia.
- The People Awakening Project studied factors that help contribute to sobriety and maintain sobriety in indigenous populations.
- The U.S. National Park Service (NPS) has designed the program "Getting Seniors Outdoors" to engage older adults in outdoor activities using a multigenerational approach.
- Although sometimes viewed as intangibles, a study conducted by Ono College in Israel showed that playfulness and hope are highly correlated with independent elderly well-being and participation in the community.

Live Well, Be Well: Promoting Older Adults' Health and Wellness Through Lifestyle

Nutrition status offers critical information about the existence of acute health problems and acts as a marker of chronic disease. Presenters shared research about the importance of nutrition on healthy aging. For example:

- The Nutritional Screening Initiative developed a report to determine why there are gaps in routine malnutrition screening and identify opportunities and additional supports needed to help malnutrition screening become a vital sign.
- In a study of lifestyle behaviors and measures of cardiovascular health in older adults, researchers at the University of Maryland analyzed dietary patterns and sociodemographic and lifestyle behaviors. They found that body mass index (BMI) and abdominal visceral fat are major predictors of health.
- In a study by the University of Illinois, factors were identified that inhibit the use of evidence-based wellness programs in senior centers. Results showed that many facilities were unaware of evidence-based practices and faced funding restrictions that made implementation difficult.
- The Why WAIT (Weight Achievement and Intensive Treatment) program offers a multidisciplinary approach to weight loss and managing diabetes.

Mental Health and Older Adults: Determinants, Trends, and Treatment

National trends in mental health treatment of – and indicators for – older adults show generational and cultural variances that can affect delivery of care. The following studies have identified key findings about the mental health of older adults as well as approaches to manage and treat mental health conditions:

- The Substance Abuse and Mental Health Services Administration (SAMHSA), through its National Surveys on Drug Use and Health, finds a high prevalence of mental illness among baby boomers and an increase in the number of psychotropic medications prescribed.
- Data from the Healthy Aging Research Initiative compared 2 immigrant populations (Afro-Caribbean and Hispanic American) and found that the Hispanic American population has a higher rate of mental health problems. This may be attributable to different expectations of the host country and differing gains and losses brought on by relocation.
- The Healthy Aging Group is a psychoeducational treatment program designed to target ageism and the myths and misconceptions regarding aging.

Cultural Competency

Health programs that employ cultural competency best practices and strategies can more effectively encourage participation and address gaps in care. Examples of programs implementing these best practices and strategies include:

- The National Indigenous Elder Justice Initiative, funded by ACL, provides culturally appropriate information on elder abuse in Indian Country. Reportedly, culturally competent challenges exist in developing a website for the indigenous population.
- The OASIS Institute designed ExerStart, a beginner exercise program for older adults taught by older adults.
- e-linc is a program designed to improve the health of older lesbian, gay, bisexual, and transgender (LGBT) adults through the implementation of a culturally appropriate model of care.

Aging in Place: Care Coordination

Partnerships between health care providers and community-based organizations can lead to stronger care coordination for older adults. Presenters shared the following models of care coordination:

- The Evidence-Based Leadership Council (EBLC), a group of 11 individuals representing
- 19 evidence-based programs, is a 1-stop shop that connects physicians and their patients with evidence-based programs in the community. EBLC is person-centered, customer-driven, and aims to offer as many treatment options as possible.
- The Healthy Living Center of Excellence is an integrated provider network designed to align medical systems, community-based social services, and older adults to achieve better health outcomes and better health care at sustainable costs.
- The Partners in Care Foundation links patients, medicine, and community-based services. The Foundation's HomeMedsPlus program provides a medication inventory and an assessment for adherence.

Health and Health Care Track

The Health and Health Care track explored patient-centered care models, the health care continuum, multiple chronic health conditions, caregiver health, and clinical preventive services.

Multiple Chronic Conditions

Approximately 25 percent of Americans have multiple co-occurring chronic conditions. For Americans age 65 and older, that percentage increases to nearly 75 percent. Presenters focused on specific comorbidities that are most likely to occur in aging adults as part of a collection of multiple chronic conditions. Specifically, speakers noted:

- COPD is the third leading cause of death in the United States. Strategies to manage COPD include increased awareness of the condition, additional funding, and better collaboration among providers.
- The EnhanceWellness program, developed at the University of Washington, uses coaches to establish goals and stimulate action. The program has had success in reducing pain and lowering the fear of falling.
- The National Eye Institute (NEI) offers a variety of educational resources for older adults to help build awareness of eye health concerns. The NEI also has resources that encourage practitioners to better educate patients about eye health.
- Care at Hand is a diabetes self-management program that uses electronic communication technology in which a lay provider surveys early risk factors and, if necessary, involves a nutritionist in real time using a cell phone or tablet.

Continuum of Care/Care Coordination

Easing transitions, developing the caregiver workforce, and reducing medication interactions can ensure a continuum of care for older adults in home and health care settings. Presenters shared some model approaches for improving the transition from an institutional to a home setting:

- The University of Connecticut's demonstration on "Healthy Aging in the Community: Outcomes Following Transition from Institutions to Community Living through the Money Follows the Person Demonstration" showed that quality of life increases when older adults are able to return from institutional care to their homes and communities. However, the number of falls and the use of health services — including ED visits — increased.

- Elder Services of the Merrimack Valley, Inc., offers a program for older adults who are transitioning to the community that features use of a standard model and new technology. The project assesses the need for long-term services and support using measures such as blood pressure screening results and transportation needs.
- The Guiding Lights Caregiver Support Center provides advice to family caregivers, particularly for care related to dementia.
- Based on interviews and focus group findings, the University of Maryland developed an educational health campaign with specific messages focused on addressing the problems caused by interactions between alcohol and other drug use by older adults.

Patient-Centered Models

Older Americans often access health care via unplanned emergencies. These ED visits tend to focus on treating the crisis in a “quick turnover” approach versus the overall holistic patient-centered model typically used during a routine office visit. As a result, geriatric EDs now proliferate across the country. Speakers in this session discussed the following efforts to improve service delivery through geriatric EDs:

- The “Geriatric emergency department innovations in care through workforce, informatics, and structural enhancements” (GEDI WISE), a multidisciplinary collaboration commissioned by the Centers for Medicare & Medicaid Services (CMS), recommends ways to improve geriatric emergency care.
- The Wisconsin Star Method for Assessing and Addressing Complexity, developed by the University of Wisconsin, found that electronic communications technology can help older adults during emergencies, reducing ED utilization by 18 percent.
- Another evaluation by the University of Wisconsin showed that the customer satisfaction level was 97 percent for older adults using telemedicine services.
- The Elder Abuse Suspicion Index, funded by the Canadian Institutes of Health Research (CIHR) and developed at McGill University, helps identify the warning signs of abuse and can also be used to train and build awareness of potential risk factors in provider settings.

Helping Older Adults Live Healthier Lives: Improving the Delivery of Clinical and Community Preventive Services for Adults

Encouraging older adults to seek clinical preventive services requires strategies for reducing barriers to care. Presenters discussed the following efforts to improve and provide older adults with vital preventive services:

- At Gannon University, employees receive physical therapist evaluations as an employee benefit. These screenings aim to prevent chronic mobility dysfunction and to track trends with older adults in order to help more live healthier lives.
- The National Adult Vaccination Program (NAVVP), a multistakeholder industry-supported collaboration, seeks to address the underutilization of vaccines, especially in older Americans, through its Immunization Champions, Advocates, and Mentors Program.
- Dentists are working to address barriers to oral health for older adults, including health literacy issues and inadequate insurance coverage.
- The Healthy Aging Partnerships in Prevention Initiative, partially funded by HHS, addresses community preventive services, including support for aging Americans.

Health of Caregivers

About 43.5 million Americans serve as caregivers. Presenters identified the following concerns that relate to the health of caregivers:

- The National Alliance for Caregiving noted that caregiving for patients with mental health issues (e.g., dementia) and caregiving that involves nursing tasks are particularly difficult. Many caregivers perform medical tasks.
- Ann Carthern, a retired nurse with extensive experience, presented a personal anecdote in her experience as a caregiver for her husband and stressed the importance of caregivers taking time to attend to their own needs.
- The National Institute of Nursing Research (NINR) provides guidance to caregivers on wellness, self-management, and palliative care.
- A study by the RAND Corporation on medical care provided to Veterans indicated that caring for Veterans may be particularly difficult because they may have issues such as brain injuries and drug abuse problems.

Appendix A: Participant Feedback

Attendees were given an opportunity to provide feedback on the overall Summit and individual sessions. Summit participants included mostly public health officials; others in attendance included clinicians, consumers, educators, caregivers, and students.

The table below reflects feedback from participants on the overall Summit.

Overall Thoughts on the 2015 Healthy Aging Summit (N=46)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I am pleased with the overall quality of the Summit.	63%	22%	13%	2%	--
The topics covered at the Summit were relevant.	63%	28%	9%	--	--
The presenters were knowledgeable experts in their fields.	69%	28%	2%	--	--
There were adequate choices for breakout sessions.	59%	30%	9%	2%	--
Sufficient time was allotted for networking and dialog with participants and faculty.	50%	34%	9%	7%	--
Sufficient time was allotted for networking and dialog with exhibitors.	52%	35%	11%	--	2%
The overall Summit goals were met.	59%	28%	13%	--	--
The Summit, overall, was free from commercial bias.	63%	28%	7%	2%	--

In the open-ended comments, some individuals indicated that they would welcome Healthy Aging Summits on an annual basis in the future. Some participants suggested topic ideas for future Summits, including oral health, nonmedical concerns for older adults, and the importance of spirituality. Some participants also commented that it was challenging to choose between concurrent sessions, suggesting that some sessions be repeated for those who missed the initial presentation.

Appendix B: Detailed Presentation Summaries

The following are more detailed summaries of the concurrent track presentations.

Neighborhood and Built Environment Track

Emergency Preparedness and Home Safety: The Physical and Social Environments—Safe Aging in Communities

Cheryl Levine, Ph.D., Office of the Assistant Secretary for Preparedness and Response (ASPR)

Jon Sanford, M.Arch., Georgia Institute of Technology (GT)

Karen Berard-Reed, M.Ed., National Fire Protection Association (NFPA)

Lindsay Goldman, L.M.S.W., New York Academy of Medicine (NYAM)

Dalton Paxman, Ph.D., Office of the Assistant Secretary for Health (ASH), U.S. Department of Health and Human Services (HHS), Region 3 (Moderator)

Cheryl Levine, Ph.D. (ASPR), noted that being prepared can help mitigate the negative outcomes of disasters. What does this mean regarding older community members? People with access and functional needs require additional help before, during, and after an emergency. Public health and emergency preparedness agencies must integrate their approaches to ensure that all community members have access to appropriate community disaster interventions. (Access refers to ensuring they can take advantage of housing, transportation, and other resources made available during emergencies.) The CMIST framework can help communities focus on preparedness in 5 realms:

- **C**ommunication
- **M**aintaining health
- **I**ndependence
- **S**ervices and support
- **T**ransportation

Resilient communities are those that have built social capital and established community-based response teams prior to emergencies.

Jon Sanford, M.Arch. (GT), began his presentation by referencing the phrase “Peter Pan paradox,” which he stated described the tendency to design our houses as if we “never grow up.” Specifically, he stated that we approach building as if we never lose any functional ability to the point of needing changes to our home environment. The home

environment can promote or hinder functionality at any age. Common designs that can impede functionality include shower curbs that pose tripping hazards and doorknobs that challenge those who have limited hand dexterity.

One approach is to modify home environments with assistive technologies designed specifically for people with functional disabilities — for example, a raised toilet seat that affixes to a household's built-in toilet. But these technologies do not blend in with household esthetics; they look institutional and unattractive, and they take up space because they tend to be add-ons to features already in the home rather than replacements for original features. More importantly, assistive technologies are designed to work well only for the individual "in need." Others need to remove the technology or make it work for them, dividing household members into those who need assistive technologies and those who do not. Universal design offers a different approach: it aims to increase anyone's ability to navigate the home environment to the greatest extent possible regardless of age or functional ability. Universal design is guided by 7 principles:

- Equitable use
- Flexibility in use
- Simple and intuitive use
- Perceptible information
- Tolerance for error
- Low physical effort
- Size and space for approach and use

Karen Berard-Reed, M.Ed. (NFPA), noted that in 2013 more than 21,600 people age 65 and older died from falls. Every year, nearly 2.5 million unintentional injuries are attributable to falls caused by loss of balance, tripping over obstacles, and missteps. Fatal fires also disproportionately affect people age 75 and older. The NFPA created Remembering When, a program to prevent injuries and deaths of older adults due to fire and falls. The program was created to give community members a set of tools to remind older adults about actions they can take to live safely at home.

Both modules have 8 messages (see below). Supporting materials, such as a home safety checklist, help residents identify hazards in their own environments and encourage audiences to think of steps they can take to prevent accidents. Each module's toolkit contains a program book, message cards, and other supporting material (such as talking points for facilitators and tip sheets to hand out). The NFPA has materials (such as ice-

breaker activities) that enhance group presentations, as well as materials designed for home visits. The Remembering When messages to prevent falls are:

1. Exercise regularly.
2. Take your time.
3. Keep stairs and walking areas free from clutter.
4. Improve the lighting inside and outside your home.
5. Use non-slip mats in the bathtub and on shower floors.
6. Be aware of uneven walking surfaces indoors and outdoors.
7. Stairways should be well lit from top to bottom.
8. Wear sturdy, well-fitting shoes.

Lindsay Goldman, L.M.S.W. (NYAM), closed out the panel presentation noting that about 17 percent of New York City residents are older adults, and many did not evacuate during the city's recent disasters. Many drowned during hurricanes, and many others were left isolated and without food or water. Nearly 60 percent of the people who died in Hurricane Sandy were age 60 or older. NYAM studied older people in communities affected by Hurricane Sandy using focus groups, canvassing, case management, mapping, and other methodologies reaching people in English, Mandarin, and Spanish. From those findings, NYAM made the following recommendations:

- Engage older people as part of the solution
- Develop emergency plans with an "aging lens"
- Build local response capacity
- Enhance social networks

Can Age-Friendly Communities Improve the Quality of Life for Older Americans?

Renee Ray, Mobility Manager, A.I.C.P., Atlanta Regional Commission (ARC)

Nick Kushner, M.U.R.P, M.P.I.A., District of Columbia Government

Caitlyn Smith, M.P.H., New York Academy of Medicine (NYAM)

Elizabeth Dugan, Ph.D., University of Massachusetts Boston (UMass Boston)

Sarah Szanton, Ph.D., Johns Hopkins University

Jon Sanford, M.Arch., Georgia Institute of Technology (GT) (Moderator)

Renee Ray, Mobility Manager, A.I.C.P. (ARC), explained that that ARC is a 10-county, intergovernmental regional planning organization that developed the Lifelong Communities model to encourage healthy lifestyles, promote housing and transportation options, and expand access to services in the greater metropolitan region. The commission launched “tactical urbanism” intervention projects that produce fast, affordable, noticeable improvement to neighborhoods. For example, in the Sweet Auburn area of Atlanta, neighbors wanted street improvements. ARC convened approximately 40 partners to focus on making the neighborhood streets safer and more attractive. The intervention included adding a physical barrier between the bike lane and the car lane, increasing bike parking, and – using no more space than a single parking space – creating a shaded rest area for pedestrians.

Nick Kushner, M.U.R.P., M.P.I.A. (District of Columbia Government), described Age-Friendly DC as a citywide planning effort that is part of a WHO initiative to make communities friendlier to all residents as they age. Starting in 2012, DC joined what has become a network of more than 250 communities around the world committed to transforming their cities into urban areas that promote functionality throughout life.

The District is seeking WHO designation as an age-friendly city. To achieve this, the city has agreed to meet standards in 10 domains of city life, including social participation, housing, public spaces, and transportation. The organization began its initial assessment with a listening exercise and a review of extensive data. The team assessed 11 city plans, 415 strategies, and 72 targets. It also conducted block-by-block walks during which more than 500 volunteers walked portions of 104 districts looking for sidewalk repairs, crosswalks graffiti, vacant housing, and other areas that provided opportunities for improvement. This information informed a strategic plan for implementing and sustaining improvements. The District is now 1 of 15 cities across the world participating in a WHO pilot project to measure indicators of age-friendly cities. These indicators are:

- Neighborhood walkability
- Accessibility of public buildings and spaces
- Accessibility of public transportation stops
- Affordable housing
- Access to healthy food

Caitlyn Smith, M.P.H. (NYAM), then spoke about an effort by New York City to become part of the WHO network of global age-friendly cities. The city’s age-friendly neighborhood initiative was established in 2007 as a partnership with the Office of the

Mayor, the New York City Council, and NYAM. It is funded by the City Council to leverage neighborhood assets. The group had early success transforming a dangerous crosswalk in Queens to a much safer crossing.

Another successful initiative is the CityBench program, which aims to increase the amount of seating on city streets in areas with high density of older adults. Just a phone call from a resident requesting a bench sets the wheels in motion. Ensuring that benches are available at transit stops with no shelter is the priority. Age-Friendly NYC is currently implementing 14 “hyper-local” neighborhood-level assessments to bring even more improvements to the city.

Elizabeth Dugan, Ph.D. (UMass Boston), stated that in Massachusetts, 23 percent of the population will be age 65 or older by 2035. Well before then, nearly all regions of the state will have significant portions of older adults. Does the state offer a good quality of life for older people? The state is assessing each of its cities on this issue, quantifying the results, comparing communities, and publishing the data.

Tufts Health Plan Foundation funded the Massachusetts Healthy Aging data report, a large, yearlong study that assessed 367 Massachusetts cities and towns, including several Boston neighborhoods. Communities were assessed on 100 indicators of healthy aging, including measures for physical and mental health, access to care, walkability, and crime rates. Then they ranked the entire state and indicated where communities fell short of or exceeded state averages. Maps and other products showed comparisons among communities. The study has a public website where users can view the data and watch a tutorial about the assessment. The data have proven useful for creating change. For example, advocates used the data to win an extra \$1 million in state appropriations to make improvements. Legislators were also given their community profiles and trained on how to interpret the data.

Sarah Szanton, Ph.D. (Johns Hopkins University), closed out the panel presentation. She explained that nurses at the Johns Hopkins School of Nursing in Baltimore, MD, noticed that functionality of many low-income older adults is limited not only by medical conditions, but also by conditions in their own home. An unsafe staircase in one's home, for example, can prevent a person from taking the stairs even if no medical condition prevents them from climbing stairs in general. The **CAPABLE** (Community Aging in Place – Advancing Better Living for Elders) study examines whether providing holistic services to low-income older adults increases the likelihood that they can safely age in place. The study's 4-month intervention includes a health assessment by a nurse and a home assessment by an occupational therapist (OT), who observes study participants

as they navigate their homes and identifies elements of the home environment that may challenge functionality. In addition to a nurse and an OT, the CAPABLE response team includes a handyman with a \$1,300 home-improvement budget.

To get started, the team sits down with the participant to prioritize and develop an action plan that mitigates functional disability. On the first visit, the OT asks about what the person wants to be able to do, i.e., Activities of Daily Living /Instrumental Activities of Daily Living (ADL/AIDL). On the second visit, the OT observes how the person navigates their environment. Then the OT and the study participant make a work order for the handyman. The interventions are client directed, rather than client focused, meaning that the team helps study participants decide which functionality is most important to the individual. Cosmetic improvements are not budgeted, but because this is a client-directed intervention, safety repairs are not necessarily made first. In the final step, the nurse begins a medical assessment and medication management. The study has shown promising results so far; data show that depressive symptoms among participants were cut nearly in half. Additionally, 80 percent of participants showed marked improvement in their activities of daily living.

The Impact of Isolation: The Impact of Products, Space, Services, and Isolation on the Aging

Steven Hanway, M.S., Consumer Product Safety Commission (CPSC)

Kamili Wilson, AARP Foundation

Debra Young, M.Ed., EmpowerAbility, LLC

Lisa Chase, Ph.D., University of St. Augustine

George Borlase, Ph.D., Consumer Product Safety Commission (CPSC) (Moderator)

Steven Hanway, M.S. (CPSC), noted that consumer products and household environments can be dangerous for older adults. Falling is the most likely hazard for older adults. In 2013, more than 21,600 people age 65 and older died from falls. Every year, nearly 2.5 million unintentional injuries are attributable to falls caused by loss of balance, tripping over obstacles, and missteps. Additionally, for every 100 older adults, 4.8 medical visits are associated with harm from consumer products. Data show that the most common hazards for older adults include:

- Stairs, ramps, landings, and floors
- Beds, mattresses, and pillows
- Chairs, sofas, and sofa beds

- Bathroom structures and fixtures
- Household appliances

Kamili Wilson (AARP Foundation) explained that as social networks decrease and the number of older adults living alone continues to grow, older adults are at risk of experiencing isolation. Although isolation can be difficult to define, it includes subjective and objective aspects. Subjective aspects include feeling lonely and lacking a sense of purpose. Objective aspects include quantifiable aspects that are not dependent on an individual's perception and include the quantity and quality of supportive relationships in a person's life and their ability to access resource and information. Currently, 1 in 5 adults older than age 50 experiences isolation. Isolation is associated with negative outcomes. Consider the following:

- Prolonged isolation is equivalent to smoking 15 cigarettes a day.
- Loneliness and low social interaction are predictive of suicide.
- Isolation is associated with increased cognitive decline, depression, high blood pressure, hunger, breast cancer, coronary attack, and other negative health consequences.
- Having few social networks is associated with high rates of mortality.

Risk factors for isolation can occur at the individual, community, and societal levels. Examples of risk factors for isolation may include:

- Living alone
- Having a physical disability
- Belonging to an ethnic, racial, sexual, or religious minority group
- Experiencing a major life transition, such as retirement or loss of a spouse
- Living in a poorly designed community
- Facing linguistic and cultural barriers

In her presentation, Debra Young, M.Ed. (EmpowerAbility, LLC), stated that the vast majority of adults desire to age in place but that our car-centric communities and home designs do not consider the needs of older people. The United States has a large older adult population that is living longer with chronic disease, and they are residing in aging homes. The average home in the United States is 36 years old. Universal design suggests

ways to help older adults age in place. The 7 principles of universal design suggest ways to make home environments age-friendly. They are:

- Equitable use
- Flexibility in use
- Simple and intuitive use
- Perceptible information
- Tolerance for error
- Low physical effort
- Size and space for approach and use

Lisa Chase, Ph.D. (University of St. Augustine), closed out the panel presentation with discussions about self-esteem. As people age, self-esteem can diminish. Self-esteem is a subjective evaluation. But a healthy sense of self-esteem can enhance quality of life as people age. Generally speaking, in younger people, self-esteem is tied to physical self-esteem – how good individuals think they are at sports (particularly men) and how good individuals think they look (particularly women).

Older people also have physical self-esteem, but it is less tied to athleticism and appearance and more tied to functional capacity and health (for both women and men). For example, an older person's dependence on medications affects how they feel about themselves. Self-esteem also mediates behavior, meaning that positive experiences day after day motivate and reinforce a perception – as do negative experiences. Healthy environments that empower older people – such as environments that incorporate principles of universal design and thus increase independence and function – can improve self-esteem. To help people maintain self-esteem as they age, find out how they perceive themselves and what they value. Then help them get what they value – that will help them develop and/or maintain self-esteem.

Caregivers/Workforce Development: Using Diverse Workforces and Tools to Support Independent Living at Home

Brian Kaskie, Ph.D., University of Iowa

Amy Russo, M.S., Sarah Lawrence College

June Simmons, M.S.W., Partners in Care Foundation (PCF)

Michelle Davis, Ph.D., M.S.P.H., Office of the Assistant Secretary for Health (ASH), U.S. Department of Health and Human Services (HHS), Region 2 (Moderator)

Brian Kaskie, Ph.D. (University of Iowa), noted that in a study of the University of Iowa faculty and staff more faculty and staff were taking care of parents than taking care of children. A full 60 percent of those surveyed were, are, or soon will be providing informal care for someone age 65 or older. Informal care refers to helping adults with activities of daily living for no financial compensation. These informal caregivers reported increased stress levels, decreased psychological well-being, lower self-reported health status, and increased use of health services.

Researchers also found that caregivers alter their work roles to accommodate their caretaking responsibilities – for example, they take time off, arrive late, and take several days off in a row. About 7 percent even quit their jobs to maintain caregiving responsibilities. The University of Iowa survey found that informal caregivers who quit their jobs had unmet needs, such as leave time from their employment and education training about caregiving. Employers are passive about increasing awareness about programs and connecting caregivers to programs that would help. Most caregivers surveyed were aware of resources such as the Family and Medical Leave Act (FMLA), but may not have realized it can be used to take care of parents. Only about 1 in 3 of informal caregivers surveyed used flex time or eldercare. As Kaskie observed, “the pathways to programs and services need paving.” An array of service and resources are still not available.

Amy Russo, M.S. (Sarah Lawrence College), stated that there are nearly 2 million home health aides in the market now, and by 2022 the market will demand 1 million more. Home care is a difficult profession. Although training is required, the median annual earnings are \$13,000, and more than half the workforce relies on public assistance to make ends meet. Women make up nearly 90 percent of the workforce, and people of color make up 50 percent. Sixty percent of the workforce turns over annually, largely because they cannot afford to stay. In interviews with home care workers, 1 researcher found that caring about people is a key motivation for people entering or staying in the field. Safety is frequently an issue; their clients often live in dangerous or unsanitary conditions, and hence care workers are exposed to these conditions, as well. The low pay means that many can't afford to own or operate cars, so they often spend a lot of time taking the bus to work.

In a project utilizing Photovoice, home care providers were able to share their experiences visually through photographs to convey the difficulties of their profession with other home care professionals – as well those outside the home care community.

June Simmons, M.S.W. (PCF), closed out the panel presentation. She stated that up to 48 percent of community-dwelling older adults have medication-related problems, and more than 700,000 people visit EDs each year for adverse drug events. Drug-related morbidity and mortality cost \$200 billion annually, and 25 percent of adverse events are preventable. HomeMeds is an evidence-based program in Los Angeles that seeks to reduce adverse drug events through a cadre of home care workers and alternative workforces that already make home visits. The program trains non-licensed personal to screen for potential adverse events using methods such as looking for signs of confusion and inquiring about falls. HomeMeds service providers attempt to identify the less complex cases that can be resolved at home – for example, when a client has been prescribed a medication twice by different doctors and are taking twice the dosage prescribed. HomeMeds conducts 2-hour visits in which service providers complete a medication inventory, assess for adherence, and look for medication-related problems. A pharmacist reviews the assessment and everyone helps develop a case plan – including care coordination – that an R.N. will manage. HomeMeds has shown good results: 1 hospital showed a 13 percent lower rate of ED use and 22 percent fewer hospital readmissions after 30 days.

Health in All Policies: Thinking, Surfing, Walking and Driving—Leveraging Information and Partnerships To Change the Environment as We Age

Randi Chapman, J.D., Alzheimer's Association

Megan Homer, M.A., National Institute on Aging (NIA), National Institutes of Health (NIH) Caitlyn Smith, M.P.H., New York Academy of Medicine (NYAM)

Nathan Warren-Kigenyi, M.P.H., American Automobile Association National Office (AAA)

CAPT Jim Lando, M.D., M.P.H., Office of the Assistant Secretary for Health (ASH), U.S. Department of Health and Human Services (HHS), Region 5 (Moderator)

Randi Chapman, J.D. (Alzheimer's Association), explained that Alzheimer's is a progressive brain disease that destroys brain cells, causing problems with memory, thinking, and behavior. It is the most common form of dementia – about 70 percent of people with dementia have Alzheimer's disease. More than 84,000 people in the United States die every year from Alzheimer's, and that number is increasing. There is no effective treatment. The cost of Alzheimer's is as follows:

- Total cost to the United States: \$226 billion
- Costs to Medicare and Medicaid: \$153 billion
- Share of Medicare: \$1 of every \$5
- Projected costs, 2050: \$1.1 trillion

To address this growing issue, the Alzheimer's Association encourages each state to develop a plan. A state plan is a set of state-specific recommendations about how to improve and support services for people with dementia. The plan should be based on a comprehensive report developed by a variety of stakeholders, and ideally mandated through gubernatorial or legislative action. Good state plans will provide a blueprint for solutions. In the 1980s and 1990s only a few states had plans. But in the 2000s, the Alzheimer's Association began working with states to create state-specific plans. Now, 40 states have plans, and several others have plans in the works. About 8 states are in the process of implementing their plans. Most plans address the issues of workforce development, increasing public awareness, and improving services. Some plans address policy issues, such as safety, brain health, caregivers, legal issues, and early detection, and diagnosis. State plans should be living documents that are reviewed and updated regularly.

Megan Homer, M.A. (NIA), shared details of the NIA's Talking with Your Doctor, a toolkit to help people take an active role in their health care. Toolkit users are provided with everything they need to deliver a presentation, down to the cues for clicking through the presentation. The toolkit includes:

- A PowerPoint presentation of 18 slides that can be tailored to audiences
- Speaker script and notes that allow non-experts to deliver the training with little or no preparation (notes include the purpose of activity, how long it should take, a script, questions to stimulate discussion, and more)
- Presentation handouts
- Tips for presenting

NIA developed this resource to meet the demand for training on this issue. Because caregivers have little time, the toolkit was designed for use with little or no preparation.

Caitlyn Smith, M.P.H. (NYAM)², explained that New York City is a part of the WHO network of global age-friendly cities. The city's age-friendly neighborhood initiative was established in 2007 as a partnership with the Office of the Mayor, the New York City Council, and the New York Academy of Medicine. It is funded by the City Council to leverage neighborhood assets. The group had early success with transforming a dangerous crosswalk in Queens to a much safer crossing. It added a wider, more visible crosswalk and a median that provided a safe place to wait if people could not safely

² Caitlyn Smith also presented as part of "Can Age-Friendly Communities Improve the Quality of Life for Older Americans?" described on page 19.

cross all the lanes of traffic before signals changed. Extending crossing times, repainting pedestrian lanes, improving ramps, building bulb-outs on curbs, and adding medians and countdown clocks on wide roads are just some of the ways to make intersections safer for older adults.

Another successful initiative is the CityBench program, which aims to increase the amount of seating on city streets in areas with high density of older adults. Just a phone call from a resident requesting a bench sets the wheels in motion. Ensuring that benches are available at transit stops with no shelter is the priority. Age-Friendly NYC is currently implementing 14 “hyper-local” neighborhood-level assessments to bring even more improvements to the city.

Nathan Warren-Kigenyi, M.P.H. (AAA), closed out the panel presentation by noting that stereotypes about older drivers do not match the data. In fact, older drivers are some of the safest drivers. Only when drivers get to be in their 80s do their records mirror teenage drivers. An individual's fitness to drive is the only thing that should the legal right to drive – not advanced age or medical conditions. Yet people with decreased function have increased risk of crashing. A Driver Medical Review is the best approach to identifying at-risk drivers because it applies to drivers of any age.

AAA makes 9 policy recommendations to identify at-risk drivers:

1. In-person license renewals every 5 years beginning no later than age 75
2. A vision test for all drivers at in-person renewals
3. Observation by trained Department of Motor Vehicles (DMV) staff
4. A form for easy referral from physicians
5. A form for easy referral from law enforcement
6. Health care provider immunity for good-faith referral
7. DMV access to medical expertise for assessment of at-risk drivers
8. Restricted licensing for at-risk drivers
9. Driver remediation for at-risk drivers

Quality of Aging Track

Aging Issues for Specialized Populations

Gavin Hougham, Ph.D., Battelle Health and Analytics

Tonia Poteat, Ph.D., M.P.H., P.A.-C., Johns Hopkins University Bloomberg School of Public Health

Lisa Barry, Ph.D., M.P.H., University of Connecticut (UConn) Center on Aging

RADM Epifanio (Epi) Elizondo, Ph.D., Office of the Assistant Secretary for Health (ASH), U.S. Department of Health and Human Services (HHS), Region 6 (Moderator)

Gavin Hougham, Ph.D. (Battelle Health and Analytics), began by talking about aging specific to immigrants. He noted that there are 40 million immigrants and that 4.5 million of them are older than 65 years of age – a percentage that will double soon. Dr. Hougham noted that his research looked at whether their health needs were being met. Although language and cultural barriers can be obstacles, there are other concerns, as well – for example, a person's ability to acculturate (which is stressful) or trauma that the person may have experienced in his or her home country. He referenced the "healthy immigrant paradox:" the longer a person lives in this country, the worse his or her health. This may be attributable to a sedentary lifestyle, lack of exercise, and processed foods. Legal issues, such as fear of losing one's status, also cause stress. Additionally, lack of access to health care affects overall health. Using data from the National Epidemiological Survey on Alcohol and Related Conditions (along with U.S. Census Data), Dr. Hougham examined the following key research questions:

- What are the driving factors impacting the quality of life for older immigrants (both physical and mental health)?
- Do immigrants age differently?

The study also looked at different immigrant communities (Hispanics versus Asians), which helped determine whether different life experiences (e.g., traumatic events in one's home country) could be a factor. Results showed that marriage, a college education, and a strong support network served as protective factors. The factors that most adversely impacted health were feelings of discrimination, stress, and traumatic lifetime events, which had impacts on both physical and mental health. In terms of policy implications, Dr. Hougham recommended the following:

- Reduce fears of legal status issues
- Reduce confusion of accessing health care

- Educate health professionals on the unique issues of immigrants
- Intervene early during traumatic events
- Promote social networks of support

Tonia Poteat, Ph.D., M.P.H., PA-C (Johns Hopkins University Bloomberg School of Public Health), started her presentation by sharing the following quote from a participant in her qualitative study about the aging of Black lesbians: "I just don't do doctors." She stated that this community has 3 unique characteristics: race, gender, and sexual orientation. It is hard to find a health care provider who understands all those characteristics. Dr. Poteat added that this study had to use an intersectionality lens because just looking at 1 factor does not capture the complexity of the issue. She conducted qualitative interviews with members of a Black lesbian organization in Atlanta called ZAMI NOBLA (National Organization of Black Lesbians on Aging) who were older than 40 years of age. Specifically, this included surveys and focus groups. Findings of the 100 participants included:

- 20 percent were uninsured compared to approximately 13% of the general American population.
- 36 percent had a disability compared to approximately 13% of the general American population.
- Of those with a disability, half had mobility problems and 25 percent had mental illness.

Some of the recurring themes identified by Dr. Poteat included:

- An increased need for "competent" mental health services. There is a persona of the strong black women, but stresses have impact.
- A general mistrust of mainstream providers and a desire for more holistic approaches.
- Resiliency factors include supportive partners, spirituality, sex, dance, and laughter.

Lisa Barry, Ph.D., M.P.H. (UConn Center on Aging), concluded the panel presentation noting that there are 2.2 million incarcerated Americans in the United States, representing 25 percent of the world's incarcerated population. Because of longer sentences and the 3-strike rule, older prisoners (older than 50 years of age) are the fastest growing inmate population. By 2030, it is expected that 1 in 3 inmates will be older than 50 years of age. Older inmates face a number of unique factors:

- Inmates experience accelerated aging – because of hardships and nutrition issues, the physiological age of inmates is 10 to 15 years greater than their chronological age.
- Older inmates face increased victimization.
- Older inmates face environmental concerns that can make activities of daily living particularly hard – for example, hearing orders from staff, climbing into a top bunk, or walking with handcuffs.

Older inmates have the highest suicide rate of adult inmates. The objective of Dr. Barry's study was to determine factors associated with suicidal ideation (SI) severity in older inmates, with a focus on disability in activities necessary for managing prison life.

This study was an examination of 125 older inmates in 3 Connecticut facilities.

They did chart reviews and conducted interviews about suicide ideation. The instrument used was the geriatric suicide ideation scale. The scale was cross-referenced with the Prison Activities of Daily Living (PADL) scale. Findings showed that demographics and reasons for incarceration were less important factors in older inmates but that PADL limitations were a factor in suicidal ideation. PADL also was correlated with depression. Dr. Barry suggested that, as a result, suicide prevention strategies should start with the onset of disabilities that impact PADL.

From Active Duty to Veteran: Defense Health Agency and Veterans Affairs Initiatives to Ensure Healthy Aging

RADM Raquel Bono, M.D., Defense Health Agency (DHA)

Bret Hicken, Ph.D., M.S.P.H., U.S. Department of Veterans Affairs (VA)

Sheri Reder, Ph.D., M.S.P.H., VA Puget Sound Health Care System

RADM Sharon Ricks, M.A., Office of the Assistant Secretary for Health (ASH), U.S. Department of Health and Human Services (HHS), Region 4 (Moderator)

RADM Bono, M.D., (DHA), noted that The Defense Health Agency (DHA) has a tremendous amount of data to share since many of the DHA community have been covered from cradle to grave. One unique aspect of military personnel is the physical requirements of their work. In their training, they are conditioned for all types of scenarios: being in a submarine for long periods, working in deserts or mountains, and dealing with issues (e.g., toothaches) in remote locations. They also face sleep deprivation and other physical hardships.

Military members are also affected by some of the same health challenges as the overall American population: as the general American public faces increased rates of obesity and other unhealthy conditions, so do military candidates. As a result, fewer military candidates can meet the minimal physical requirements for service. Also like the general population, military personnel face hereditary factors related to aging. Other factors that are more prevalent in military personnel include stress, use of tobacco, hearing loss, and sleep deprivation. Operation Live Well is a program aimed at encouraging the military population to live a healthier lifestyle. The program uses tools and apps to help individuals with nutrition, exercise, and sleep habits. Cafeterias are being stocked with better food choices. The initiative started in 14 test sites. Some initiatives included adding farmers' markets to military bases and establishing walking routes. For children of military personnel, study personnel did a recess-before-lunch campaign; it resulted in children eating healthier and even doing better in class. Operation Live Well also has a tobacco cessation program.

One quarter of all U.S. Veterans live in rural locations. In his presentation, Bret Hicken, Ph.D., M.S.P.H. (VA), noted that the VA has been working on ensuring that rural veterans can "age in place" as long as possible. Some of the obstacles relate to the fact that a rural location might not have a veterans facility nearby. Rural veterans are:

- In poorer physical health
- More likely to live alone
- Have higher incidence of mental health issues
- More likely to commit suicide
- More likely to have a surgical wound

To address these concerns, the VA has in some instances provided better transportation to veterans facilities and also "virtual" health options. But more importantly, the VA has formulated partnerships and collaborations with non-veteran health providers to help provide services locally with VA oversight.

Dr. Hicken noted that the "warrior class" has greater access to some of the most extensive health services than any other population. One of the problems is that many veterans are not fully aware of the services available to them. There is an effort to create a "no wrong door" policy so that whomever a veteran calls, he or she can get access to needed services. The Utah Aging and Disability Resource Center (ADRC) conducted a pilot training of counselors to improve efforts to connect veterans with available services and benefits.

Sheri Reder, Ph.D., M.S.P.H. (VA Puget Sound Health Care System), concluded the panel discussion by introducing a program that focused on shared decision-making for aging veterans. The focus is on long-term care. It is a tool for providers, veterans, and their families and includes a section on general well-being as well as home and community-based services. One component has decision-making worksheets and a personal health inventory, which also had the benefit of building relationships between home, community, and institutional caregivers. The program has been implemented in a number of demonstration projects across the country. The website for the program can be found at www.va.gov/geriatrics/.

Health Literacy—Supporting Quality of Life and Quality of Care

Manisha Maskay, Ph.D., AIDS Arms, Inc.

Lisa McCoy, M.S., University of Maryland

Carol Marsiglia, M.S., R.N., C.C.M., The Coordinating Center

Raymond Ownby, M.D., Ph.D., Nova Southeastern University (NSU)

Karen Matsuda, M.N., R.N., Office of the Assistant Secretary for Health (ASH),

U.S. Department of Health and Human Services (HHS), Region 10 (Moderator)

Manisha Maskay, Ph.D. (AIDS Arms, Inc.), noted that clear communication is an essential component for ensuring effective health care and applies to both written and oral communications. It impacts a patient's access to health care, their understanding of patient rights, and overall navigation of care. Health literacy is the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Dr. Maskay noted that nearly half of adults (47 percent) perform at the lowest level of literacy, and that health professionals often forget this. Materials need to be written for audiences of all literacy levels. Even those with high literacy may struggle when words have multiple meanings and interpretations. Health literacy decreases with age due to factors such as vision/hearing impairment and cognitive issues. The following strategies for effective communication are:

- Identify goals
- Identify key messages
- Determine mode of communication (e.g., written, oral)
- Assess your audience (e.g., culture, etc.)
- Pilot-test the message

Some general recommendations by Dr. Maskay in terms of communicating with older adults include:

- Do not use color backgrounds or fancy fonts because of potential vision impairment.
- Keep language at a 6th-grade level and jargon-free.
- Be active and specific (e.g., say, "The nurse will call you tomorrow morning" not "You might want to call the nurse").

Dr. Maskay also referenced a number of tools that can be used to assess a product's readability, including the Flesch-Kincaid Grade Level and Flesch Reading Ease Score, FOG, Fry Readability Formula, SMOG, SAM, and PMOSE/IKIRSCH Document Readability Formula.

Lisa McCoy, M.S. (University of Maryland), is part of a team that has developed Living Well in Maryland, a self-management tool for individuals with chronic diseases. Approximately 80 percent of older adults have 1 chronic condition. The 6-week workshops are led by non-health care peers. However, the program has a standardized manual to ensure fidelity. Participants must have 1 chronic condition. The program is offered in 4 languages (Spanish, English, Korean, and Chinese). Workshop topics include nutrition, exercise, medication management, pain management, and fall prevention. The program is very action oriented to help a person plan based on their unique needs. Outcomes for participants attending these workshops include improved health status and improved communication with health care providers.

Carol Marsiglia, M.S., R.N., C.C.M. (The Coordinating Center), shared information about Care at Hand, an app designed to help with transitions from hospital to home. The pilot was done with 5,400 individuals in 2 communities in Baltimore, MD. The participants had high-risk conditions such as congestive heart failure, diabetes, COPD, depression, and pneumonia. Non-health workers conduct home visits 3 days after discharge, and the information collected is shared with a nurse-coach in real time for follow-up if needed. The program reduced overall hospital readmissions and became an opportunity for using health extenders. The approach of using a hub model for service delivery also shows promise.

According to Raymond Ownby, M.D., Ph.D. (NSU), computer literacy in older adults is linked to improved quality of life. Fostering Literacy for Good Health Today (FLIGHT) and its Spanish counterpart Vive Desarrollando Amplia Salud (VIDAS) are computer-administered measures of health literacy. The questionnaire focused on the participant's

use of computers, cell phones, and other technologies (e.g., microwave, remote control). The sample included 235 participants. It also had some sample applications such as using a computerized map at a hospital. The findings indicated that a substantial number of older adults do not use computers. Findings also indicated that more frequent computer use was positively related to health literacy, better quality of life, and other health-related variables.

Do Falls Prevention Programs Work?

Kathleen Cameron, M.P.H., National Council on Aging (NCOA)

Jessica Miller, M.S., LifePlans, Inc.

Kari Carmody, M.P.H., County of San Diego

Susan Huang, M.D., M.S., Asian Health Services (AHS)

*Laurie Konsella, M.P.A., Office of the Assistant Secretary for Health (ASH),
U.S. Department of Health and Human Services (HHS), Region 8 (Moderator)*

According to Kathleen Cameron, M.P.H. (NCOA), the National Council on Aging's mission is to improve the life of aging adults, especially those who are struggling. Falls are a major problem in the United States; they are the leading cause of fatal and nonfatal injuries in older Americans. The fear of falls also affects the quality of life of older adults by restricting their daily activities and social engagement. This can result in depression and social isolation. She noted that every 13 seconds, an older adult goes to an ED for a fall-related injury. Additionally, every 20 minutes, an older adult will die as a result of a fall. Ms. Cameron compared the many risk factors to a tower of tilted bricks: each new factor builds upon other factors to increase risk. It is important to note which factors are modifiable.

NCOA operates a National Falls Prevention Resource Center, which serves as a clearinghouse of tools, best practices, and other information on falls and falls prevention for consumers and health providers. In addition, NCOA has a National Falls Free Initiative, which is a growing network of organizations committed to falls prevention. Based on the Healthy People 2020 objective, the aim is to reduce older adult fall-related Emergency Department visits by 10 percent. The program has facilitated state and local coalitions. National Fall Prevention Awareness Day events take place on September 23 (the first day of fall) and include proclamations, contests, and events. Last year, the program was implemented by 43 state coalitions and reached 12 million older adults and caregivers. Ms. Cameron also detailed the collaborative work with the Administration for Community Living (ACL) for providing fall prevention grants to evidence-based programs. Some

examples include implementation of CDC's STEADI toolkit, Tai Chi, and Yak Trax (a device for winter shoes used by a tribal grantee).

Jessica Miller, M.S. (LifePlans, Inc.), explained that Lifeplans has worked with HHS to develop a comprehensive Fall Prevention and Wellness Program based on the evaluation of literature, best practices, and existing protocols and instruments. The pilot study was divided into 3 groups, including 2 control groups and 1 intervention group. The intervention group received an individualized action plan, wellness toolkit, fall and exercise journals, and follow-up calls. Findings showed that members of the intervention group were more compliant with fall prevention activities, were less fearful of falling, and also had fewer actual falls. The program also reduced long-term care insurance claim costs. She noted that the 3 greatest risk factors for falls are balance problems, medical conditions, and environment.

Kari Carmody, M.P.H. (County of San Diego), discussed the work of the San Diego Fall Prevention Task Force, which aims to reduce falls and their devastating consequences in San Diego County. The Task Force conducted a needs assessment for both older adults and physicians to determine whether older adults were having conversations about fall prevention during their office visits. This needs assessment found that conversations between older adults and physicians about falls prevention was lacking. The Fall Prevention Task Force did a study of 375,000 adults using CDC's STEADI (Stopping Elderly Accidents, Deaths, and Injuries) toolkit. The toolkit was presented in non-medical settings, such as mall events. Those individuals who were found to be at high risk for falls were instructed to contact their physician, and physicians recommended primary fall prevention recommendations as necessary, including exercise or physical therapy recommendations. Then there was a follow-up to determine whether attendees followed up with their doctors. Results showed that 39 percent did. Unfortunately, in 20 percent of those physician-patient discussions, the physician offered no suggestions.

Susan Huang, M.D., M.S. (AHS), is a physician at a federally qualified health center in Oakland, CA, that serves a large Asian American Pacific Islander population. She noted that the center had to modify falls prevention efforts both for language and cultural sensitivity. There is also a gap in data for falls and effective best practices within community health settings for this population. For example, Chinese older adults tend to have lower fall rates than other races, but there is a paucity of data to explain why. Through a culturally and linguistically competent falls risk assessment, Asian Health Services aimed to 1. address the paucity of data on falls incidence among racial/ethnic groups, and 2. promote prevention through routine screening in a primary care, community health setting.

The center developed and administered an instrument that looked at general screening, staff risk assessments, and interventions suggested. Findings included:

- Falls in Chinese populations may be underreported.
- There are linguistic and cultural barriers to addressing fall risk and fall injuries.
- Older adults who receive intervention have lower rates of hospitalization.

Dr. Huang emphasized that more follow-up is needed, including:

- Training for health care professionals and multi-disciplinary primary care teams
- More studies on this population
- Development of more linguistic and culturally appropriate risk screening tools

Maintaining Cognitive Health: Research Policy and Practice

Jane Tilly, Dr.PH., Administration for Community Living (ACL)

Denise Park, Ph.D., University of Texas at Dallas (UTD)

Cheryl Irmiter, Ph.D., L.C.S.W., C.A.D.C., Easter Seals National Headquarters

Anna Lea Cothron, Tennessee Commission on Aging and Disability (TCAD)

Allison Thigpen, M.P.H., Tennessee Commission on Aging and Disability (TCAD)

Betsy Rosenfeld, J.D., Office of the Assistant Secretary for Health (ASH), U.S. Department of Health and Human Services (HHS), Region 1 (Moderator)

Jane Tilly, Dr.P.H. (ACL), noted that the **Brain Health as You Age** resource is a collaboration between ACL, the Centers for Disease Control and Prevention, and the National Institute on Aging. This brain health resource is evidence-based and free, and seeks to educate the public on brain health and dementia. It focuses on reducing risk factors associated with threats to brain health , including:

- Diet and exercise
- Medication
- Chronic disease
- Social isolation

Brain Health as You Age is a four-part set of materials: a PowerPoint presentation designed to help older adults and their caregivers learn how to reduce risks that may be related to brain health, along with educator guide, fact sheets for health professionals

and older adults, and key facts and resources. It has been presented in webinars, at community health events, at Meals on Wheels programs, and by organizations such as AARP and hospitals.

Denise Park, Ph.D. (UTD), presented a study called the Synapse Project. The program was designed to isolate a specific mechanism that could slow the rate of cognitive aging, including whether learning new things (mental effort) improved cognitive health. In the 3-month project, study participants were divided into six groups including intervention groups that learned and participated in quilting, learned and participated in photography, or participated in a combination of quilting and photography. Follow-up included both interviewing and brain scans. Results showed that even after a year, the highly challenged groups had enhanced memory. Additionally, those in the highly challenged groups who spent more hours in the project saw a larger effect on brain activity, including attention and object recognition. She noted there are some theories that people build neuroscaffolding as they learn, which improves cognitive health.

Cheryl Irmiter, Ph.D., L.C.S.W., C.A.D.C. (Easter Seals National Headquarters), presented a study that examined the change in depressive symptoms, global cognition, and balance following a 10-week cognitive training intervention among cognitively impaired older adults. The intervention included cognitive training using a computer-generated learning program from Posit Science called Brain HQ along with weekly balance training. Study results showed improvements in balance, cognitive outcomes, and depression. However, only the improvement in depressive symptoms was statistically significant.

Anna Lea Cothron and Allison Thigpen, M.P.H. (TCAD), closed out the session by sharing a program by TCAD to engage older adults in cognitive training. Senior Brain Games is modeled after March Madness and is a statewide team trivia competition designed as a platform to promote brain health through practice, education, and public visibility. Participants can socialize, eat healthy meals, exercise, and learn more about cognitive health through trivia games. The competition also garners media attention, which further promotes cognitive health to the public.

Social and Community Context Track

The Benefits of Social Engagement

Richard H. Fortinsky, Ph.D., University of Connecticut (UConn) School of Medicine, UConn Center on Aging and Department of Medicine

Amiya Waldman-Levi, Ph.D., O.T.R., Research Institute for Health and Medical Professions, Ono Academic College, Israel

Jordan Lewis, Ph.D., M.S.W., C.P.G., Indigenous Wellness Research Institute, University of Washington (UW) School of Social Work

Randy Thoreson, National Park Service (NPS)

Martina Taylor, M.T., National Cancer Institute (NCI), National Institutes of Health (NIH) (Moderator)

Richard H. Fortinsky, Ph.D. (UConn), discussed his work with the GSA in identifying evidence-based assessment tools for detecting cognitive impairment and increasing the use of evidence-based cognitive assessment tools among primary care providers. Dr. Fortinsky and the GSA workgroup designed a 4-step system called the KAER Process to point patients and physicians in the right direction. The KAER Process is as follows:

- **K**ickstart conversation about current cognition condition
- **A**ssess if patient is symptomatic
- **E**valuate patient with a full diagnostic workgroup if cognitive impairment detected and achieve a full diagnostic evaluation
- **R**efer patient to community resources and activities

Amiya Waldman-Levi, Ph.D., O.T.R. (Ono Academic College, Israel), shared her research on the associations between playfulness, hope, well-being, and participation beyond cognitive and emotional factors. Using a variety of questionnaires and assessments designed to measure sociodemographic and medical status, participation, well-being, hope, and cognitive status, the study showed that "hope, emotional status, and playfulness were highly correlated with independent elderly participation within the community" and that "emotional status, hope, and playfulness highly correlated with the well-being of independent elderly persons."

Jordan Lewis, Ph.D., M.S.W., C.P.G. (UW School of Social Work), presented his research on sobriety among American Indians and Alaska Natives (ANs). The study, People Awakening (PA) Project, aimed to investigate what motivational factors contribute to sobriety in indigenous populations and what has helped to maintain sobriety among AN elders. The PA Project found that AN elders abstained from drinking alcohol or quit drinking alcohol for 4 reasons: i) influence from family members and the desire to care for their family, ii) the desire to serve as a role model for others, iii) wanting to pass on their knowledge to the younger generations, and iv) spirituality.

Randy Thoreson (NPS) spoke – as a living representative – of how healthy aging and the outdoors go hand in hand. He designed a program that brought older adults into the

outdoors at the local and national levels to get them involved in outdoor activities and promote healthy aging and quality of life. Mr. Thoreson concluded the panel on a high note with the inspirational message, "You're never too old, and it is never too late."

Live Well, Be Well: Promoting Older Adults' Health and Wellness Through Lifestyle

Johanna Dwyer, D.Sc., R.D., National Institutes for Health (NIH), Tufts University

Amy Anderson, Ph.D., University of Maryland

Julie Bobitt, A.B.D., University of Illinois at Urbana-Champaign

Osama Hamdy, M.D., Ph.D., FACE, Joslin Diabetes Center/Harvard Medical School

Dalton Paxman, Ph.D., Office of the Assistant Secretary for Health (ASH), U.S. Department of Health and Human Services (HHS), Region 3 (Moderator)

Johanna Dwyer D.Sc., RD. (Tufts University), began her discussion by explaining that nursing plays a critical role in taking vital signs and is also on the front line for monitoring and working to improve intake in collaboration with dietitians and other providers.

Johanna noted that nutrition should be considered a vital sign because it provides critical information regarding existence of an acute health problem, magnitude of illness or coping, and marker of chronic disease process. In collaboration with the Nutritional Screening Initiative, she worked on a report to determine why malnutrition screening is not routinely performed and how to secure malnutrition screening as a vital sign. Although there are many assessment tools used today to screen for malnutrition, Dr. Dwyer notes that challenges still remain including research gaps, standardization, and lack of health care provider training in nutrition.

Amy Anderson, Ph.D. (University of Maryland), provided an overview of the relationships between lifestyle behaviors and cardiovascular health in older adults. Dr. Anderson noted that "Lifestyle behaviors tend to be strongly correlated with each other and react together with health." After analyzing dietary patterns and sociodemographic and lifestyle behaviors in 3,075 adults ages 70 to 79 from Pittsburgh, PA, and Memphis, TN, Dr. Anderson found that "BMI and abdominal visceral fat emerged as major predictors of health."

Julie Bobitt, A.B.D. (University of Illinois at Urbana-Champaign), noted the factors that inhibit the use of evidence-based wellness programs in Illinois senior centers. The growing older adult population has brought with it an increase in chronic diseases and, thus, a need for prevention and intervention programs that are proven to be effective through research and practice. However, there is a lack of these evidence-based

programs in Illinois senior centers. After a series of interviews and surveys investigating 4 Area Agencies on Aging (AAAs), Ms. Bobitt concluded that multiple factors may affect the implementation of evidence-based programs in senior centers and AAAs, such as limited knowledge and funding. Senior centers are more concerned with client-based programs, there is a decreasing number of participants in senior centers, and there is doubt about the effectiveness of evidence-based programs. To move forward, senior centers will need a better understanding about the evidence behind these programs.

Osama Hamdy M.D., Ph.D., FACE (Joslin Diabetes Center/Harvard Medical School), provided an overview of a comprehensive lifestyle intervention and spoke about the role of medical nutrition therapy in lifestyle intervention and long-term weight reduction. He noted that, since 1152 B.C., there has been a quest for the perfect diet for people with diabetes. For a very long time, doctors' understanding of the recommended proportions of carbohydrates and proteins in a diabetic's diet was limited. Dr. Hamdy's solution to this problem is his Why WAIT program, which offers a multidisciplinary approach to weight loss and managing diabetes. The program starts by restructuring the patient's diet (specifically by lowering calorie intake and glycemic index, and increasing protein intake). It goes on to introduce an individualized physical activity program that incorporates flexibility, aerobics, and strength-building exercises. Patients also receive cognitive behavioral modification and a 12-week group diabetes education class.

Mental Health and Older Adults: Determinants, Trends, Treatments

Beth Han, M.D., Ph.D., Substance Abuse and Mental Health Services Administration (SAMHSA)

Ruth Tappen, Ed.D., R.N., F.A.A.N., Florida Atlantic University (FAU)

Ashley Stripling, Ph.D., Nova Southeastern University (NSU) Center for Psychological Studies

Hugh Tilson, M.D., Dr.P.H., M.P.H., University of North Carolina (UNC) Gillings School of Global Public Health (Moderator)

Beth Han M.D., Ph.D. (SAMHSA), presented on mental health treatment policies impacting trends in mental health treatments among baby boomers with mental illness. There is a high prevalence of mental illness among baby boomers; Dr. Han's study aimed to examine this high prevalence as well as the kinds of services (traditional or alternative) that baby boomers were seeking for treatment. Using the data from the 2008-2013 National Surveys on Drug Use and Health, Dr. Han found an increase in the number of psychotropic medications prescribed without inpatient or outpatient mental health treatment but no changes in the prevalence of inpatient or outpatient treatment.

Ruth Tappen Ed.D., R.N., F.A.A.N. (FAU), discussed the underlying factors that lead to significant differences in depressive and anxiety symptoms among two immigrant groups, Afro-Caribbean and Hispanic American (HA) adults. Data were taken from the Healthy Aging Research Initiative, a sample of more than 600 men and women age 60 and older. Dr. Tappen found that the HA group seemed to have a higher rate of mental health problems and proposed that the differences in these 2 immigrant groups may be due to different expectations of the host country and differing gains and losses brought on by relocation. Isolation after the relocation also could be a factor, as well as differing mental and emotional resilience among the 2 immigrant groups.

Ashley Stripling, Ph.D. (NSU Center for Psychological Studies), discussed a mental health treatment model for older adults and its benefits to mental health care delivery and quality in late life. Dr. Stripling also noted some of the negative effects of ageism and how to spot it. Her proposed solution to combat the negative effects of ageism is the Healthy Aging Group, a 12-week psychoeducational treatment program designed to “target the myths and misconceptions regarding aging in order to improve quality of life, decrease depressive symptoms, and empower older adults and their caregivers.” A unique feature of this program is its focus on the behaviors of the caregivers as well as those of the participants. Dr. Stripling advised audience members to watch how they speak and avoid labeling groups in order to avoid falling victim to stereotype threats brought on by ageism.

Cultural Competency

Jacqueline S. Gray, Ph.D., Principal Investigator and Director, National Indigenous Elder Justice Initiative (NIEJI)

Trevor Chiasson, Web Developer, National Indigenous Elder Justice Initiative (NIEJI)

Kathy Smart, Ed.D., University of North Dakota (UND)/National Indigenous Elder Justice Initiative (NIEJI)

Sara Lovegreen, M.P.H., M.C.H.E.S., OASIS Institute

Jeffrey Kwong, D.N.P., M.P.H., A.N.P.-B.C., Columbia University School of Nursing

Alexis Bakos, Ph.D., M.P.H., R.N., Office of Minority Health (OMH), U.S. Department of Health and Human Services (HHS) (Moderator)

The first 3 speakers on the panel were members of the NIEJI team. The first presenter was the NIEJI Director, Jacqueline S. Gray, Ph.D. The purpose of NIEJI is to provide clear and culturally appropriate information on elder abuse in Indian Country and resources on how to address this abuse. According to Dr. Gray, only 1.1 percent of Native elders report they use Elder Abuse Prevention Services, but 12.7 percent report they would use

these services if they were more available. One of the goals of NIEJI is to make sure the information is being presented in ways that older adults can easily connect with. One of the ways in which NIEJI does this is by using familiar and respected symbols of Native American culture, such as feathers and the medicine wheel, on its website.

Kathy Smart Ed.D. (UND), of the NIEJI education team, spoke on the challenges of creating a website that would be user friendly and contain information that would be easily understood by diverse audiences . The NIEJI website needs to be easy to navigate, have a clean and simple appearance, and be self-paced.

Sara Lovegreen M.P.H., M.C.H.E.S. (OASIS Institute), spoke about an evidence-based physical activity program, ExerStart, designed for older adults. ExerStart (currently available only in St. Louis, MO) was created in response to the large subgroups of the older adult population who did not fit into the traditional exercise program model. What makes ExerStart unique is that it is an entirely mobile program (the only materials that are used are resistance bands and a music player) designed to assist community leaders with leading physical activity exercises. ExerStart uses community leaders instead of fitness trainers to facilitate the activity because they are familiar and easily relatable figures who know the strengths and weaknesses of the community.

Jeffrey Kwong D.N.P., M.P.H., A.N.P.-B.C. (Columbia University School of Nursing), presented on a special program designed to help LGBT adults with the unique challenges as they age. Thirteen percent of older LGBT adults have reported being denied health care or have received inferior care, and more than 20 percent do not disclose their sexual orientation to their primary care physician for fear of being unfairly judged or denied care. In collaboration with the American Geriatrics Society (AGS), Dr. Kwong developed E-LINC, a novel program designed to "improve the health of older LGBT adults through the implementation of a culturally appropriate, high-quality, interprofessional collaborative practice model of care." One of the objectives of E-LINC is to provide cultural competency-based training opportunities for health professional students working with older LGBT adults via interprofessional education (IPE) Student Seminars. In the future, Dr. Kwong hopes to increase and expand the client base, IPE Student Seminars, and health and wellness programs.

Aging in Place: Care Coordination

Susan Snyder, M.S., Evidence-Based Leadership Council (EBLC)

Jennifer Raymond, Healthy Living Center of Excellence (HLCE)

June Simmons, M.S.W., CEO, Partners in Care Foundation (PCF)

Edwin Walker, J.D., Administration for Community Living (Moderator)

Susan Snyder, M.S. (EBLC), began the panel by discussing the mission and goals of EBLC, a 1-stop shop that connects physicians and their patients with evidence-based programs in the community. In addition, the EBLC is person centered and customer driven and aims to offer as many treatment choices as possible.

Jennifer Raymond (HLCE) was next on the panel. HLCE is an integrated provider network whose goal is to align “medical systems, community-based social services, and older adults” together “to achieve better health outcomes and better health care — both at sustainable costs.” HLCE offers a large provider network of community-based organizations that provide evidence-based programs and works closely with health care providers to determine the most prevalent issues needed to create a defined delivery service package that meets the needs of health care in a community.

The final speaker of the day was June Simmons M.S.W. (PCF). The goal of PCF is to link patients, medicine, and community-based services. HomeMedsPlus, a PCF program, provides a “medication inventory [and] assessment for adherence and other medication-related problems” as well as psychosocial and functional assessments. This program has reduced ED use by 13 percent and lowered the 30-day readmission rate by 22 percent. PCF uses technology to find out where most of its members are and to determine the best location to reach the most members. As more people express an interest in community-based workshops, the greater the need becomes for partnering with health care organizations that can expand and grow evidence-based services for older adults, such as EBLC, HLCE, and PCF.

Health and Health Care Track

Multiple Chronic Conditions

Winston Liao, North Carolina COPD Taskforce

Ivan Molton, Ph.D., University of Washington (UW)

Neyal Ammary-Risch, M.P.H., M.C.H.E.S., National Eye Institute (NEI), National Institutes of Health (NIH)

Joan Hatem-Roy, M.S.W., L.I.C.S.W., Elder Services of the Merrimack Valley, Inc.

Andrey Ostrovsky, M.D., Care at Hand

Hugh Tilson, M.D., Dr.P.H., M.P.H, University of North Carolina (UNC) Gillings School of Global Public Health (Moderator)

Winston Liao (North Carolina COPD Task Force) started the first panel of the day in the Health and Health Care Track by describing a multiple chronic conditions initiative in

North Carolina. One in 4 Americans have multiple concurring chronic conditions (e.g., arthritis, asthma, and many others). For Americans age 65 and older, as many as 3 in 4 have multiple chronic conditions. COPD features a number of progressive lung diseases, including chronic bronchitis, emphysema, refractory asthma, bronchiectasis, and more. In all cases, the airways are partially blocked. COPD is the third leading cause of death in the United States. The Healthy People 2020 objectives call for a reduction in its prevalence, which was about 6.5 percent of the U.S. population in 2013. All states report COPD prevalence, and there are geographic differences. Rates for females are higher than rates for males. The highest rates are in Native Americans.

COPD leads to a large number of ED visits. The overall cost of COPD to the nation is about \$36 billion annually, with \$32 billion of that attributable to medical costs. About \$3.9 billion is attributed to absenteeism. COPD features multiple comorbidities, which lead to additional comorbidities such as bone-risk falls. About 2 in 3 adults with COPD report disability. COPD is due primarily to smoking. Exposure to secondhand smoke is related to about 26.7 percent of people with COPD. Strategies for addressing the problem of COPD include the following:

- Increase awareness of the disease.
- Educate patients, health care providers, caregivers, and policy makers.
- Increase funding for outreach and community-based programs.
- Promote collaborative efforts.

Ivan Molton, Ph.D. (UW), presented next noting that by 2030, 1 in 5 Americans will be older than 65 years of age. Aging is a primary risk factor for a long list of disabilities, including osteoarthritis, osteoporosis, COPD, coronary heart disease, peripheral vascular disease, dementia, diabetic complications, and bone frailty. More Americans are “aging with disability.” The goals of gerontologists include identifying the key health conditions, ameliorating them, and maximizing function. Barriers to progress are the presence of multiple funding and policy streams, a lack of capacity building, and the use of unhelpful jargon in discussions of aging and disability. People with multiple chronic conditions age more quickly and suffer from additional conditions, such as sleep disorders and depression. Such additional factors tend to peak in the middle years of life. The risk of falls is another common factor, the prevalence and impact of which increases throughout the lifespan.

Dr. Molton cited a need for community- and evidence-based health promotion programs. People with disabilities are often missing from research cohorts. Intervention is needed in

middle age, when pain severity is greatest. One example is the EnhanceWellness program developed at UW, which features the use of coaches to establish goals and stimulate action. The program has had success in reducing pain, reducing the fear of falling, and more. People with long-term disability represent a unique population in need of access to care. Much of what is needed for middle-age people already exists for older adults with disabilities.

Neyal Ammary-Risch, M.P.H. (NEI), described an eye health program developed through NEI. Common vision problems with aging include losing focus, declining sensitivity, and requiring more light. Vision loss and blindness are not normal aspects of aging, but older adults are at higher risk for disorders such as macular degeneration, cataracts, diabetic eye disease, and dry eye. The incidence of vision loss will increase during the next 35 years. Early detection and treatment are important. According to 1 study, only 10 percent of older adults knew that glaucoma has no early symptoms. Additionally, only 58 percent of persons with diabetes knew that vision loss can be prevented – and only 8 percent knew that there are no early symptoms. People think, incorrectly, that vision loss is a natural part of aging. In fact, it can be avoided by eating healthy balanced diets, maintaining a normal body weight, avoiding smoking, wearing sunglasses and brimmed hats, and knowing the eye health history of one's family. NEI offers many documents and tools for maintaining eye health.

Andrey Ostrovsky, M.D. (Care at Hand), closed the panel by describing the Diabetes Self-Management Program (DSMP), which features the use of technology to improve diabetes management. He described the program's workflow, during which lay leaders sign in patients, staff members make phone calls, and pre- and post-testing are conducted. Using electronic communication technology, lay leaders are prompted to pose questions, seek to detect early risk factors, and involve a nutritionist when necessary. An app on a cell phone or tablet is used ("care-at-hand" technology). The goal is to prevent the need for acute care of participants. Results of testing of the program included a 95 percent alert rate and a 70 percent program completion rate. Twenty-three percent of alerts led to an intervention by a nutritionist. Factors leading to alerts included weight changes and poorly controlled blood sugar levels. The data were preliminary and cannot point to cause and effect. The program suggests opportunities to better coordinate care, save time, measure patient engagement, prevent program attrition, and avoid hospitalizations.

Continuum of Care/Care Coordination

Julie Robison, Ph.D., University of Connecticut (UConn) Health Center

Andrey Ostrovsky, M.D., Care at Hand

Joan Hatem-Roy, Elder Services of the Merrimack Valley, Inc.

Nicole Bruno, Guiding Lights Caregiver Support Center

Cooper Linton, Transitions Lifecare

Faika Zanjani, Ph.D., University of Maryland

CAPT Betsy Thompson, M.D., Dr. P.H., M.S.P.H., Office of the Assistant Secretary for Health (ASH), U.S. Department of Health and Human Services (HHS), Region 9 (Moderator)

Julie Robison, Ph.D. (UConn Health Center), described a program to reduce the reliance of people on institutional care by developing community-based long-term care opportunities and allowing people with disabilities to participate fully in their communities. The program in Connecticut seeks to transition 5,200 people by 2018 (2,500 so far). At any given time, about 19,000 people are institutionalized in Connecticut. The transition program is voluntary and addresses all ages (many are older adults) and all abilities. It features the use of transition teams. About 44 percent of participants transition to living alone. The program applies quality-of-life surveys at baseline, pre-transition, and then follows up at 6, 12, and 24 months post-transition. The program looks at changes in quality of life, life satisfaction, and use of health services. Results of the survey showed that the reported happiness of participants increased and was sustained. Unmet needs diminished over time. A sense of autonomy developed, and community involvement increased. However, the number of falls and the use of health services — including ED visits—increased.

In the next panel presentation, Andrey Ostrovsky, M.D. (Care at Hand), and Joan Hatem-Roy (Elder Services of the Merrimack Valley, Inc.) described a program for transitioning to the community featuring the use of a standard model and new technology. The project assesses a need for long-term services and supports using measures such as blood pressure screening results and transportation needs. These factors are measured before and after the technology is applied. The program features an electronic communication prompt for coaches, who are nonmedical staff members. The prompt sends alert messages to nurse coordinators when necessary, and the nurse coordinator then acts appropriately. The program also features a survey. Goals are to achieve risk predictions and reduce hospital readmissions. Results included an increased need for using blood pressure cuffs and transportation (participants required rides). The electronic technology was able to recognize undetected needs for long-term services and supports and pointed to significant Medicare cost savings.

Nicole Bruno (Guiding Lights Caregiver Support Center) and Cooper Linton (Transitions LifeCare) presented on programs to support family caregivers in time of need. Ms. Bruno explained that Guiding Lights follows family caregivers closely, offering advice and strategies for crisis prevention. It features training in handling dementia, how to run support groups, and how to use the teach-back method. The Guiding Lights organization provides access to a library, videos, and radio shows – and presents community events. Mr. Linton talked about his group's efforts to find a social model, offer access to resources to caregivers, and develop a sustainable business model. There is a need to monetize the programs. Mr. Linton's group is working with Ms. Bruno's group in the Transitions Guiding Lights project in North Carolina. He discussed issues faced by accountable care organizations, managed care organizations, integrated health systems, and large hospitals – especially current disincentives. In response to a question, Ms. Bruno and Mr. Linton stated that the program is still young and has not yet been evaluated to determine whether burden is reduced. Some of the work (e.g., dementia training) is evidence-based.

Closing out the panel presentation, Faika Zanjani, Ph.D. (University of Maryland), described a program designed to address the problems caused by interactions between alcohol and other drugs at the community level. Her group spoke with pharmacists and sized up the problem of ignorance about the effects of such interactions. Many people end up in the hospital. Older people are at greater risk, partly because drugs remain in their bodies for longer periods. Older adults also take multiple medications (polypharmacy), and many of those can interact with alcohol. Dr. Zanjani's group performed interviews to determine how to conduct a campaign to raise awareness about this problem. Respondents suggested that an important action is to advertise the potential harmful effects of combining alcohol and drugs. Another step to take is highlighting the health improvement achieved by avoiding interactions. The group developed a health campaign with specific messages, created a brochure and a public service announcement for pharmacists, and went into senior centers and spoke with older adults to describe the campaign. The older adults involved showed improvements in understanding.

Patient-Centered Models

Michael Malone, M.D., Aurora Health Care, University of Wisconsin

Ula Hwang, M.D., M.P.H., Icahn School of Medicine at Mount Sinai

Manish Shah, M.D., University of Wisconsin

Carol Zernial, M.A., WellMed Charitable Foundation

Brendan Carr, M.D., M.A., M.S., Office of the Assistant Secretary for Preparedness and Response (ASPR) (Moderator)

Michael Malone, M.D. (Aurora Health Care), began the panel presentation noting some of the unique needs of the aging population. Of the more than 40 million older Americans today, more than 1 in 5 live in rural settings, and more than 1 in 4 live alone. Low educational levels and low-income levels can shape the context of their acute illnesses. There were more than 10 million Medicare hospitalizations in 2012. Dr. Malone described Wisconsin Star Method, which assesses people by recording personal factors, medications, medical conditions, behavioral factors, and social needs (functional status). To prepare for care of older adults, we must consider the following:

- Geriatric guidelines
- Workforce education
- Transitions to EDs
- Access to care (to prevent ED use)
- Linkage to community services
- Best practice models
- Patient goals and preferences
- Use of advance directives
- Identification of people at greater risk
- Management of medications

According to Dr. Malone, geriatric models must:

- Define patients' goals and preferences (e.g., about when and whom to contact)
- Provide 24-hour service for advising
- Assess function and cognition
- Provide care coordination
- Provide access to community resources
- Review and reconcile medications
- Provide access to electronic health records
- Provide self-management of chronic disease
- Support family caregivers
- Employ an interdisciplinary team
- Hold weekly team discussions

Dr. Malone emphasized that older Americans often access health care via unplanned emergencies. ED care must be provided in the context of the older person's social and behavioral health needs, and the workforce must be trained.

Ula Hwang, M.D. (Icahn School of Medicine at Mount Sinai), followed by presenting issues regarding ED efforts related to elderly patients. Patients arrive in the ED from various sites. There are opportunities for care coordination and prevention, yet there is a disconnect between ED care and older adults. For example, EDs are designed for quick turnover. Dr. Hwang wrote an article describing a "geriatric ED" that provides different care needs, different processes, and attention to functional limitations and polypharmacy. A number of these departments exist today. She described a Centers for Medicare & Medicaid Services (CMS) grant-funded project to work in 3 hospitals (New York, New Jersey, Chicago) to provide better care, produce better health, and lower costs. The project has managed to reduce admission rates over a 1.5-year period. A study of geriatric EDs in general found great heterogeneity and discovered that many were not exactly "geriatric EDs." As a result, guidelines for geriatric EDs were developed. There is a continuing need to recognize differences in aging populations to produce better care and reduce costs. We need more evidence.

Manish Shah, M.D. (University of Wisconsin), then described a project designed to apply technology to address acute reports without sending patients to the ED. The strategy loosens the bounds of time and space, using electronic communications technology to forward patient records and send technicians to a patient's side within an hour. The result, for example, might be a decision to increase a medication dosage. Dr. Shah and his colleagues performed a study of the program in senior living communities and found that it was able to address 90 percent of patient needs. ED utilization by the prevention group showed an 18 percent drop. He concluded that this use of telemedicine can reduce ED use and enhance access to care, but that it will face legal and regulatory issues — as well as remain expensive due to industry outpacing the science.

Carol Zernial, M.A. (WellMed Charitable Foundation), closed out the panel by describing her foundation's work to help elderly patients avoid elder abuse in Texas and Florida. The group offers grants to study elder abuse prevention in primary care settings. The funded projects feature trained clinical staff members and educational materials. They use the Elder Abuse Suspicion Index (EASI), featuring questions for staff members to ask older adults. For example, the first question is "Have you relied on people for any of the following: bathing, dressing, shopping, banking, meals?" Results of the index survey rank in either the red, yellow, or green category, with red indicating the greatest potential

for abuse. Ms. Zernial and colleagues have tested and implemented the program in 63 clinics. They have trained 744 staff members and have referred patients. About 400 patients were referred in absence of the survey – that is, staff members reported abuse directly. The program also features training of staff members and has reported improvements in their knowledge about recognizing abuse, neglect, and exploitation. Ms. Zernial stated in conclusion that elder abuse occurs every day – it is a factor in coordinated care, and we must involve the medical community in preventing and addressing it.

Helping Older Adults Lead Healthier Lives: Improving Delivery of Clinical and Community Preventive Services for Older Adults

Kristine Legters, P.T., D.Sc., Gannon University (GU)

R. Gordon Douglas, Jr., M.D., Weill Cornell Medical College

Dushanka V. Kleinman, D.D.S., M.Sc.D., School of Public Health, University of Maryland

Kathryn G. Kietzman, Ph.D., M.S.W., University of California, Los Angeles (UCLA) Center for Health Policy Research

CAPT Jose Belardo, J.D., M.S.W., M.S., Office of the Assistant Secretary for Health (ASH), U.S. Department of Health and Human Services (HHS), Region 7 (Moderator)

Kristine Legters, P.T., D.Sc. (GU), described a model in use at GU that features annual assessments of physical health and the training of health professionals. The American Physical Therapy Association (APTA) has said that there is a role for physical therapists in preventive services, health promotion, and wellness. This may help prevent negative physical changes in older adults. The GU program involves use of a physical therapist evaluation annually, with an emphasis on employees at work. The evaluations are an employee benefit. The group adapted a template from APTA, along with validated tools (measuring BMI, vital signs, etc.) to collect data. Participants filled out forms about medical and family histories, completed assessments and a report card, and discussed the results. They also learned about educational and community resources and filled out a satisfaction survey. Student staff members who conducted the surveys were surprised by the fitness of the older adults and their awareness of the role of physical therapy in wellness. Annual comparisons were provided to the participants. The study investigators noted a lack of preventive knowledge about osteoporosis and a lack of evidence for screening for depression, hearing impairment, and dental appointments. The program plans to offer a *pro bono* physical therapy clinic for clients.

R. Gordon Douglas, Jr., M.D. (Weill Cornell Medical College), was up next and described the GSA's National Adult Vaccination Program (NAVVP). The program seeks to address

underutilization of vaccines, especially in older Americans. Such vaccines include the influenza vaccine, pneumococcal vaccine, and herpes zoster vaccine. GSA held a summit meeting in 2013 and selected key drivers that the group might “own” as it works to push vaccination rates upward. The group considered drivers for mobilizing providers and the public. It considered key policy changes and improvements needed to drive adult immunizations. Dr. Douglas provided a list of ideas that the group created. At the end of the group’s discussion, it chose a single driver that might be addressed — using “champions” to alter the utilization of vaccine interventions. GSA then created the Immunization Champions, Advocates, and Mentors Program (ICAMP), which identifies incentives for provider champions, creates toolkits, develops targets, and encourages training. It is recruiting for a fall program, seeking 40 people in provider settings to serve as champions.

In her presentation, Dushanka Kleinman, D.D.S., M.Sc.D. (University of Maryland), noted that the 2000 Oral Health in America: A Report of the Surgeon General states that “oral diseases and disorders in and of themselves affect health and well-being throughout life” and that lifestyle behaviors affect both oral and general health. She noted that we have safe and effective methods to address oral health issues. She also explained that although the U.S. Preventive Services Task Force (USPSTF) found insufficient evidence to recommend dental screening in asymptomatic people, dental groups disagree and feel it is important. Population groups at higher risk for oral health problems include chronically ill patients, older adults, people with special care needs, and people who are institutionalized. Barriers to oral health include the following:

- Lack of physical and social capacity
- Lack of health literacy
- Weak perceptions of oral health
- Lack of knowledge about preventive measures
- Inadequate insurance coverage, insufficient provider availability and capacity
- Limited community health support

Many health care providers are not aware of oral health issues. Dr. Kleinman referred to a report that identified oral health as within the top 10 unmet needs of people who are aging and have disabilities.

Kathryn Kietzman, Ph.D. (UCLA Center for Health Policy Research), closed out the presentation with a description of the local Healthy Aging Partnerships in Prevention

Initiative (HAPPI) in Los Angeles that addresses the need for community preventive services, including support for the aging population. The project builds on work on healthy aging supported by CDC and features services such as flu shots and breast cancer screenings. After conducting a systematic review of existing programs, the initiative developed a core set of services that can help reduce health disparities. It determined how to create links between organizations and the community to develop capacity. Departments of aging served to offer referrals. The program offers small grants to assess capacity, provide training, and help organizations work with community health centers. Dr. Kietzman presented a map of the many participating sites in south Los Angeles. In 3 of 8 clinics, the project has completed interviews with CEOs, CMOs, CFOs, QI leadership, referral coordinators, and community outreach specialists. It is working to determine the factors that help and hinder clinic staff. Dr. Kietzman noted that many clinics already provide community preventive services, and older adults are seen as an emerging market. However, there is a lack of capacity in clinics to support older adults with multiple chronic conditions, high workforce turnover, and limitations in scope of programs because of dependence on time-limited funding. Many clinics operate in reactive environments.

Health of Caregivers

Gail Gibson Hunt, National Alliance for Caregiving

Ann Ellis Carthern, L.P.N., Personal Caregiver

Karen Huss, Ph.D., M.S.N., R.N., National Institute of Nursing Research (NINR), National Institutes of Health (NIH)

Margaret (Meg) Kabat, M.S.W., Department of Veterans Affairs (VA)

Nancy Lee, M.D., Office on Women's Health (OWH), U.S. Department of Health and Human Services (HHS) (Moderator)

Gail Gibson Hunt (National Alliance for Caregiving) described a study that evaluated family caregiving in the United States, resulting in an overall national picture and a resource for caregivers. Today, about 43.5 million Americans serve as caregivers for elderly persons, children with disabilities, spouses, and others. The study defined the caregiver, identifying daily living aspects and emphasizing caregivers who perform medical nursing work (e.g., injections, colostomy care). She noted that most caregivers also have jobs. In the study, most caregivers reported having only fair or poor health themselves. Some indicated that their health had worsened since they became caregivers. Caregiving for patients with mental health issues (e.g., dementia) and caregiving involving nursing tasks are particularly difficult. Having no choice but to

be a caregiver appears to be a significant stressor. About 1 in 3 caregivers reported experiencing physical strain. Many people performing medical tasks do so without training – this includes regular tasks such as wound and colostomy care, as well as responding to incipient events such as strokes. Caregivers need respite care and a support system. We need to address advanced care planning – when the caregivers cannot be of aid.

Ann Carthern, L.P.N., a retired nurse with extensive experience, presented a personal anecdote in her experience as a caregiver for her husband. She stressed the importance of caregivers attending to their own needs. She noted that safety must be the first priority, and that the caregiver must have a personal plan – for sleeping, maintaining a good diet, engaging in physical exercise, maintaining social and family contacts, relaxing, and activities such as attending church. Ms. Carthern stated that she keeps track of time spent in caregiving activities to ensure that she is organizing her life well. She gave an example of a difficult experience with her husband, who had become incapacitated while bathing. It took a significant amount of time to get her husband to a better position, during which she was careful to pace herself and ensure her own well-being.

Karen Huss, R.N., Ph.D. (NINR), presented next on the Institute's efforts to improve the health of individuals, families, and communities. Supported nursing science addresses health and quality of life, engages people as participants in their health, applies interdisciplinary approaches, and promotes equity and reduced disparities. Areas of focus include symptom science, wellness, self-management, and end-of-life and palliative care. For caregivers, NINR covers areas such as caregiver-patient relationships and communication between clinicians and caregivers. Issues in current studies supported by NINR include the unique characteristics of caregiving, levels of care in the final 6 months of life, basic science (e.g., inflammation, anxiety), cancer-family caregivers, and reducing nighttime events for people with dementia. Dr. Huss listed funding opportunities at NIH/NINR. She referred to a workshop held in May about caring for caregivers that presented the state of science, knowledge gaps, and proposals for research. It revealed a lack of information to support high-quality care. We need to raise awareness, understand better the roles, and develop a prevention model to keep caregivers healthy.

Margaret Kabat, M.S.W. (VA), closed out the panel session by describing a study by the RAND Corporation on health care for Veterans. There are about 5.5 million caregivers for Veterans, and their experiences differ from the experiences of those caring for non-Veterans. Caring for young Veterans differs markedly from caring for older Veterans.

Post-9/11 care features dealing with brain injuries and drug abuse problems. A 2010 federal law expanded supports for caregivers of Veterans. They can now receive direct services, training, and support. There are services to help caregivers care for themselves, link to other people, and to get help (e.g., a phone number). There is also a website found at www.caregiver.va.gov. The VA has placed clinicians at health centers to support caregivers. A post-9/11 program provides stipends for caregivers and offers health care. Ms. Kabat cited a need to focus on the health of caregivers and to assess caregivers and the role of families.