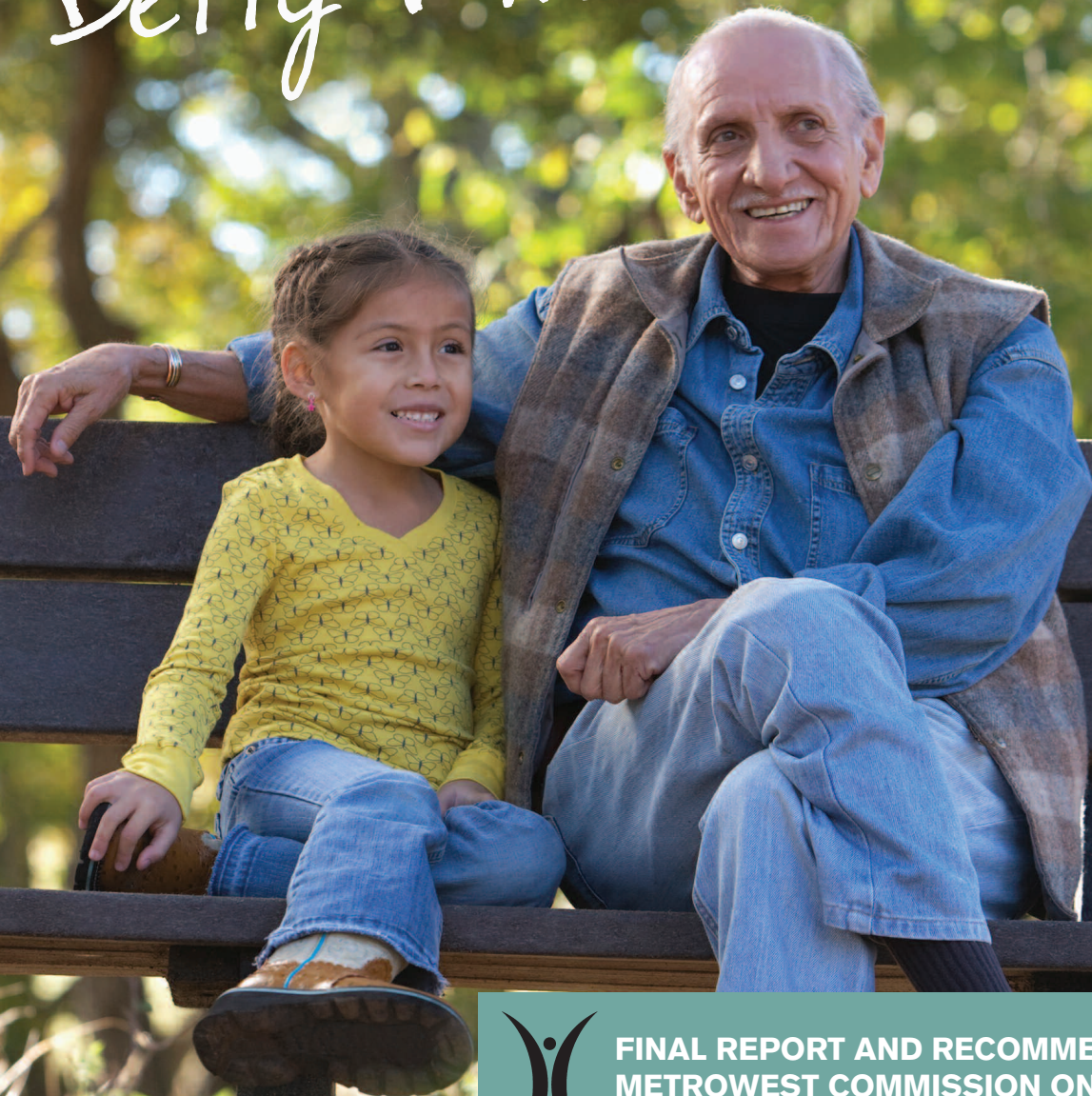


Aging is not lost youth
but a new stage of
opportunity and strength.
- Betty Friedan



FINAL REPORT AND RECOMMENDATIONS
METROWEST COMMISSION ON HEALTHY AGING
JANUARY 2011

Introduction



The concept of healthy aging is on many peoples' minds these days. As the first group of "baby boomers" reaches retirement age, they are giving great thought as to how they want to live this next chapter in their lives. They are better educated than their parents' generation, they are computer literate, and they are used to questioning authority—including medical practitioners. Whether they call themselves "seniors," "aging boomers," "elders" or "older adults" as we have done in this report, this next generation of older adults is enjoying the benefits of life in a time of unparalleled technological development. They are not willing to accept the same options that their parents had to choose from in the final decades of their lives. They are also the ones who are often the primary caregivers to their parents, so they know firsthand how difficult it can be to access needed services, coordinate care or make difficult end-of-life decisions.

The MetroWest area is on the verge of unprecedented growth in its older adult population. The number of MetroWest residents 65 and older is projected to grow by 49% in the next twenty years. The 75-and-older population is projected to grow by 37%.¹ This rapid growth will result in new demands for health and wellness services and will test the ability of our existing elder care system to adequately respond to those in need.

In January 2010, the MetroWest Community Health Care Foundation invited fifteen members of the community with a professional or personal interest in aging to join them in forming the MetroWest Commission on Healthy Aging (*see inside back cover for a complete list of Commission members*). The Commission's charge was to meet over the next year, explore what is known about the region's older adult population and their needs, develop a vision of what healthy aging should look like in the region over the next ten years, and identify the steps necessary to achieve this vision.

The Commission sees healthy aging as the responsibility of both the individual and the community. From the older adult's perspective, it means working to remain healthy by ensuring a well-balanced diet, regular exercise, and responsible self-care of general health issues as well as chronic conditions. It means the ability to live in safe and affordable housing, access to quality physical and behavioral health care, and connectedness to an older adult friendly community.

The community's responsibilities to its older citizens include guaranteeing that older adults have access to the tools and opportunities that allow them to preserve their independence. The community should also support facilitated mobility and enable older adults to remain engaged in their environment. The Commission views this vision as essential to facilitate and support the goals of healthy aging in MetroWest.

The findings and recommendations of the Commission are outlined below. The Foundation will use these recommendations to help craft its grant making and other program activities focused on older adults. We hope that area organizations—such as councils on aging, elder care agencies, health care providers, and even neighborhood groups—also use this report to spark local discussions and interest in redefining how we move toward a new paradigm of healthy aging in the MetroWest region.

THE WORK OF THE COMMISSION One of the Commission’s first tasks was to define the term “healthy aging.” The Commission reviewed and debated several definitions and agreed on one adopted by several organizations across the country:

Healthy aging is the development and maintenance of optimal mental, social and physical well-being and function in older adults. This will most likely be achieved when communities are safe, promote health and well-being and use health services and community programs to prevent or minimize disease.ⁱⁱ

With this definition in place, the Commission decided to concentrate its work in four key areas:

- Physical Health
- Behavioral Health (Mental Health/Substance Abuse)
- Community Building & Social Well-Being
- Transportation

At each meeting, experts involved in various aspects of aging shared their knowledge and expertise with Commission members. We are grateful to the following individuals who took time away from their busy schedules to share their thoughts and ideas with the Commission:

Lorenz Finison, PhD, Principal of Sigma Works, Presentation Topic: [The MetroWest Healthy Aging Data Book](#)

Marian Knapp, PhD, Independent Consultant, Presentation Topic: [The Meaning of Aging in Place: A Personal and Academic Perspective on Aging in Place in Suburbia](#)

Katherine Freund, Founder and President of ITN/America, Presentation Topic: [Independent Transportation Network: Dignified Transportation for Seniors](#)

Anita Albright, MA, Director of the Office of Healthy Aging and Disability, Massachusetts Department of Public Health, Presentation Topic: [Healthy Aging: Joining Forces to Build Healthier Communities](#)

Robert Schreiber, MD, Chief Medical Officer of Hebrew Senior Life, Presentation Topic: [Healthy Aging Tools and Strategies for the Medical Community: A New Opportunity for Health Care and Aging Services Network Providers](#)

Gary Moak, MD, Clinical Professor of Psychiatry at the UMASS Medical School; **William O’Brien, MSW**, Executive Director of the UMASS Memorial Behavioral Health System; and **Brenda King, Psy. D**, Program Manager for the UMASS Department of Psychiatry’s Geriatric Mental Health Project, Presentation Topic: [Management of Psychiatric Disorders of the Elderly: Emerging Models for Primary Care](#)

The number of MetroWest residents 65 and older is projected to grow by 49% in the next 20 years.

Healthy aging is defined as the development of optimal mental, social and physical well-being and function in older adults.

HEALTHY AGING - WHAT DO THE DATA TELL US?

To begin the Commission's work, the Foundation prepared the *MetroWest Healthy Aging Data Book*, a compendium of demographic and health data about the older adult population of MetroWest (available online at www.mchcf.org).ⁱⁱⁱ

The following are key to understanding the needs of older adults in the MetroWest area:

- As the "baby boomers" age, the MetroWest area will see dramatic increases in its early older adult population (ages 65–74) through 2010, the middle older adult population (ages 75–84) starting in 2020, and in the late older adult population (ages 85 and over) starting in 2030.
- Two thirds of MetroWest older adults currently live in family households, either with their spouse or children or both.
- MetroWest older adults are more likely to own their own homes and less likely to be below the Federal poverty level than are Massachusetts older adults.
- The ratio of women to men increases markedly with age, from 1.1:1 among persons 65–69, up to 9.3:1 for centenarians.
- MetroWest hospitalization rates for all causes are 4% lower than the overall Massachusetts rates among those ages 65–74, but 7% higher among those ages 75–84, and 9% higher among those 85 and older.
- MetroWest hospitalization rates for falls are 10% lower than Massachusetts rates among 65–74 year olds, but 9% higher among 75–84 year olds, and 12% higher among those 85 and older.
- Hospital observation days for older adults are significantly higher in MetroWest than in Massachusetts as a whole.
- The MetroWest older adult population is almost entirely White and non-Hispanic (96.3%).
- Disability *counts* among older adults are high in the largest communities of Framingham, Natick and Marlborough, but disability *rates* are highest in the South West region including Mendon, Milford, Hopedale, Bellingham and Franklin.
- 4,775 MetroWest older adults received publicly supported services through the Massachusetts Executive Office of Elder Affairs' Aging Services Access Points (ASAPs) during the period of July 1, 2008–June 30, 2009:
 - MetroWest older adults received 685,418 units of homemaker service;
 - MetroWest older adults received 322,423 units of personal care;
 - MetroWest older adults received 212,284 units of home-delivered meals.
- Mortality rates in MetroWest have declined over the past two decades for each older adult five-year age group (65–69, 70–74, 75–79, and 80–84).
- MetroWest mortality rates are lower than those for Massachusetts as a whole in the age groups 65–69, 70–74, and 75–79. For age groups 80–84 and 85 and over, mortality rates are generally higher in MetroWest.

Findings & Recommendations

1. HEALTHY AGING – PHYSICAL HEALTH CARE

The most important aspect of healthy aging is to maximize good health whenever possible and to ensure patient-centered care with dignity as the end of life approaches. Yet staying healthy also requires that older adults have the right knowledge and tools to make healthy decisions and that they live in supportive environments that enable them to lead healthy lives. Understanding the importance of nutrition, exercise and the management of chronic conditions is essential.

Our health care system has become more complex and expensive. Seventeen percent of our nation's gross domestic product is now spent on health care, and it is expected to increase to 34% by the year 2030.^{iv} Seventy-nine percent of these health care dollars are spent on chronic care, and four chronic diseases—heart disease, cancer, stroke and diabetes—cause almost two-thirds of all deaths each year.^v

A 2009 survey by the National Council on Aging on the impact of chronic conditions on the health care of Americans found a bleak and broken health care system for millions of older Americans.^{vi} The survey found that:

- Older adults dealing with chronic conditions are hurting, tired, depressed and stressed.
- Older adults are relying on a health care system that is not working.
- Older adults are facing struggles and consequently delaying medical care as well as encountering barriers to self-care.
- Older adults are seeking realistic, practical, customized help.

WHAT CAN BE DONE? Healthy aging starts with personal health—reducing the risk factors for chronic disease by improving nutrition; increasing activity and exercise; and reducing or eliminating abuse of tobacco, alcohol and drugs. A growing list of effective prevention and self-management programs has been developed to assist older adults as they seek ways to control chronic conditions. These programs have proved that behaviors can be modified and that knowledge plus self-efficacy can equal behavior change. This change can lead to fewer preventable emergency room and hospital stays and lower the cost of care.^{vii}

Understanding the importance of nutrition, exercise and the management of chronic conditions is essential for healthy aging.

There are five well recognized factors for maintaining good physical health. First, the older adult should do some form of physical activity that enhances wellness—walking, low impact aerobics, tai chi, strength training and stretching. These activities can be done alone or as organized group activities. Whatever the venue, the important principle here is to keep moving.

The second involves practicing good nutrition and diet. Older adults—especially those who may be on special diets due to diabetes, high blood pressure or high cholesterol levels—need to understand the value of preparing and eating healthy foods.

The third key factor to good physical health involves attention to fall prevention, as older adults are especially at risk for falls. Falling is often associated with considerable mortality and morbidity, reduced functioning and premature nursing home admissions. Simple measures such as strength and balance training and environmental modifications can reduce the risk of falls. According to the Centers for Disease Control and Prevention, nearly a third of all older adult falls could have been prevented if someone had paid attention to such things as the installation of grab bars in the shower area or the removal of scatter rugs.^{viii}

The fourth key factor to maintaining good physical health is the importance of screening and treatment for depression and substance abuse. The high depression rates we see among older adults need to be addressed through effective screening and intervention. Such screening and intervention is also needed to address the number of elders who have problems with substance abuse.

The last and probably the most important key factor for good physical health for those with chronic diseases, like heart disease or diabetes, is to engage in good self-management of their illness. Following doctors' orders for medication compliance, exercise and diet can make an important difference in managing diabetes, heart disease and other chronic conditions and in preventing hospitalization.

There are many “evidence based programs” that focus on self-management. The Massachusetts Department of Public Health, in conjunction with the Executive Office of Elder Affairs, has promoted the use of the Stanford University Chronic Disease Self-Management Program, which in Massachusetts is called *My Life, My Health*. It is a comprehensive program of six weekly two-and-a-half-hour workshops intended to support older adults in living successfully with chronic illnesses. Other programs such as *Healthy Eating for Successful Living*, *Fit for Your Life* and *A Matter of Balance* also promote good nutrition, physical fitness and fall prevention, respectively.^{ix}

Some systems change is also necessary so that older adults can receive good health care. Since most of the health care provided to older adults is in the primary care physician's office, it is essential that primary care physicians and their staffs understand the service systems that provide community care to older adults. They must have access to the necessary screening tools that deal specifically with older adult mental health and substance abuse issues, develop collaborative relationships with geriatric medical and service professionals in the community, and be cognizant of caregiver concerns and issues.

In 2008, the Institute of Medicine (IOM) report *Retooling for an Aging America: Building the Health Care Workforce* called for a fundamental reform in the way we care for older

According to the Centers for Disease Control & Prevention, nearly a third of all older adult falls could have been prevented.

A growing list of effective prevention and self-management programs has been developed to assist older adults as they seek ways to control chronic conditions.

adults.^x The report recommended the development of a task force with a three-pronged approach, which would:

- Enhance the competence of all individuals in the delivery of geriatric care;
- Increase the recruitment and retention of geriatric specialists and caregivers;
- Redesign models of care and broaden provider and patient roles to achieve greater flexibility.

PHYSICAL HEALTH RECOMMENDATIONS:

1. Enhance the competence of all individuals in the delivery of geriatric care.
 - Train and attract to MetroWest more primary care providers who understand the aging process and are committed to coordinating older adult care that so often involves an array of specialists and health issues.
 - Train and attract to MetroWest more geriatric specialists (i.e., geriatricians, geriatric nurse practitioners, specific disciplines with geriatric expertise).
 - Promote earlier and more effective education by providers about palliative and hospice care and the approach of death, so that families are better prepared to access those services at the earliest times they can be useful.
2. Encourage, promote and support evidence-based programs and practices including those related to disease prevention and chronic disease management.
 - Support the use of evidence-based programs in a variety of community settings including Senior Centers; older adult housing; assisted living facilities; the faith community; and other locations frequented by older adults, including hospitals and doctors' offices.
3. Promote the development of a seamless continuum of care to meet the changing needs of older adults as they age, as well as the needs of their families.
 - A continuum of care should include services in the home, assisted living outside the home, long-term residential care, and end-of-life care including palliative care and hospice services.
 - Consistent with the 2008 IOM report *A New Health System for the 21st Century*, this future system of care should be safe, effective, person-centered, timely, efficient and equitable.^{xi}
4. Encourage and promote financially affordable universal access to quality health care services.
5. Increase health care providers' awareness and responsiveness to all forms of cultural diversity among older adults.

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- Cultural diversity may encompass racial, ethnic, linguistic, sexual orientation, physical ability, and a myriad of other differences among older adults.
 - Stimulate ongoing conversations and education among older adults regarding culturally sensitive topics for maintaining the quality of life throughout the course of life and in the face of life-limiting illness.
6. Expand and build upon existing caregiver support and education programs and services including respite care.
 - Develop and disseminate materials that will assist caregivers and promote their self-identification as caregivers.
 - Support the development of caregiver programs that will promote awareness of the caregivers' need to address their own physical and emotional issues, including stress reduction programs.
 - Continue to develop respite programs that will meet the needs of caregivers, especially at "off-peak" hours when respite programs are not generally offered.
 7. Establish a pilot "Healthy Aging Wellness Center," in a community-based central location, accessible and attractive to older adults.
 - Such a center should offer a variety of professional supports such as a geriatric nurse practitioner, dietician, physical therapist and pharmacist on a rotating basis, and offer evidence-based prevention programs and opportunities for support groups.^{xii}
 8. Provide "Home Safety Audit" services similar to Home Energy Audits, designed to promote safe mobility and function, fall prevention, medication use, storage and labeling, etc.
 - The audit, using a team approach of a nurse and physical or occupational therapist, could evaluate kitchen, bath, living areas, outside and basement safety and provide teaching/prevention services directed at those older adults who are currently healthy and not directly under routine, frequent care of a health care provider.
 - Where the audit identifies issues, encourage affordable programs to make necessary adaptations.
 9. Encourage greater use of technology to promote health and wellness.
 - Explore the use of automatic health messages that can serve as reminders of medication guidelines, warm lines for chatting to preserve connectedness, regular contact systems to assure the continued safety of at-risk older adults, and simplified e-mail systems to encourage Internet use.
 10. Create a comprehensive and organized database of local older adult health care resources, including end-of-life care but not limited to hospice services.

2. HEALTHY AGING – BEHAVIORAL HEALTH

Some estimates predict that by 2030 there will be 70 million older Americans. Of these, 15 million will have some kind of mental disorder: 5–10% will have a major depressive disorder or dysthymia; and 5–16% will have subsyndromal depression. These behavioral health issues can lead to functional impairment, poor health outcomes, increased total health care costs, and increased mortality.^{xiii}

By 2030 there will be 70 million older Americans, of these 15 million will have some kind of mental disorder.

For many older adults, the treatment of depression occurs mainly during a visit to their primary care physician. It is a primary care physician who prescribes the majority of psychoactive medications to older adult patients, including antidepressants, and geriatric depression frequently remains inadequately treated in primary care settings. No antidepressant medications are given to 41% of depressed older adults treated by their primary care physician; when antidepressants are prescribed, they are often prescribed in too low a dose and for too short a time. A sobering statistic about completed suicides among older adults indicates that 70% of suicide completers visited their primary care doctor within one month, 40% of suicide completers visited their primary care doctor within one week, and 20% of suicide completers visited their primary care doctor that day.^{xiv}

Unfortunately, primary care practices are poorly designed and inadequately resourced to provide comprehensive management of late-life mental disorders. Depression is discussed in only 7% of primary care visits,^{xv} and the median duration of mental health discussion is two minutes.^{xvi}

The solution may be to have more mental health and substance abuse providers who are specifically trained to treat older adults. Currently there are only 1,596 certified geriatric psychiatrists, but 7,000 will be needed by 2030. There is one geriatric psychiatrist per 11,372 older adult patients; by 2030 there will be 1 geriatric psychiatrist per 20,195 older adult patients. Less than 1% of nurses, pharmacists, and physician assistants specialize in geriatrics, and only 4% of social workers currently specialize in geriatrics.^{xvii}

Adding to the concerns about behavioral health needs are cognitive diseases such as dementia and Alzheimer's disease. These conditions take a tremendous toll on the older adult who is experiencing them, the caregivers who are trying to support the individual, the community which has to plan for their care, or the health care system which needs to develop appropriate services and funding mechanisms to treat these devastating conditions.

Cognitive disabilities affect not only a person's memories, which can be such a large part of self-definition, but they also interfere with an individual's ability to self-care. When forgetting how to prepare meals, turn off appliances and take medications becomes a regular occurrence, a person faces serious risks in personal safety, increased hospitalizations and financial distress. The ability to enjoy relationships, be creative, and in general realize an acceptable quality of life is threatened.

The community also loses when cognitive health is absent. Older adults with cognitive disabilities are less able to contribute to family care, civic activities, spiritual growth and the economic well-being of neighborhoods. Workforce productivity is also lost as caregivers quit their jobs or cut back on hours to care for their family member. This affects a family's income and potential retirement contributions to Social Security.^{xviii}

Mental health and substance abuse services need to be part of a larger menu of generic health services.

WHAT CAN BE DONE? The 2008 IOM report, *Retooling for an Aging America: Building the Health Care Workforce*, states that systems of care that dealt with older adults needed to improve competencies of all clinicians to provide geriatric care; increase numbers of geriatric specialists; redesign models of care; significantly shift the ways services are organized, financed and delivered; and develop models of service that will be reimbursed by Medicare.^{xix}

A possible answer is the model of “Collaborative Care,” which is defined as providers from different specialties, disciplines or sectors working together to offer complementary services and mutual support, to ensure that individuals receive the most appropriate service from the most appropriate provider in the most suitable location, as quickly as necessary, with a minimum of obstacles. Collaboration can involve better communication, closer personal contacts, sharing of clinical care, joint educational programs, and/or joint program and system planning.^{xx}

The UMASS Geriatric Psychiatry Consulting Program is one locally-based program providing assistance to primary care physicians and caregiver families. Its goals are to improve primary care physicians’ comfort with late-life mental disorders, increase case finding and evaluation, and support treatment and management in primary care.

After a year in operation, the program has found that the Central Mass primary care physicians are highly motivated to improve the mental health of their older adult patients. They feel prepared to handle milder late-life mental disorders but feel ill equipped for complex or more severe problems. They identify the lack of geriatric mental health services as a problem. The UMASS Geriatric Psychiatry Consultation Program provides real-time access to telephone consultation for primary care physicians and provides direct access to a psychiatrist or care manager. They are also able to provide limited, short-term care management services and limited clinical assessment of selected cases.^{xxi}

The ability of our health care system to respond to cognitive impairments is affected by the etiology of the issue and the severity of the illness. While 40–50% of all individuals over the age of 85 suffer from Alzheimer’s disease—which is not curable—and 1.8 million Americans are affected by severe dementia, 1–5 million older Americans experience much more treatable mild-to-moderate cognitive impairments which are often not caused by dementia.^{xxii}

These cognitive problems, usually preventable or treatable, include symptoms of depression, poor health habits or minor strokes. The National Institute on Aging has specified more than 100 conditions that mimic serious cognitive impairment and are reversible. It is therefore important that early screening is in place to differentiate these conditions and that families and caregivers are supported as they care for their affected family member.

BEHAVIORAL HEALTH RECOMMENDATIONS:

1. Mental health and substance abuse services need to be part of a larger menu of generic health care services.
 - Since primary care physicians provide the majority of care to older adults, his or her involvement in the assessment and delivery of mental health services is essential.

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- Primary care physicians need to be educated about the benefits of mental health and substance abuse screenings and provided with specific information about tools that are valid and easy to administer.
 - A continuum of care for physical and behavioral issues in the older adult population needs to be developed.
 - The costs/benefits of developing a geriatric consultation service in MetroWest aimed at assisting primary care physicians in their efforts to provide informed care in the area of behavioral health should be explored.
2. Family members and nonprofessional caregivers must be educated about issues of mental health and substance abuse in older adults so that problems can be identified, referrals made, and appropriate services provided.
 3. The MetroWest area needs more mental health professionals who focus specifically on the older adult population.
 4. The MetroWest area needs better local screening and treatment resources for cognitive impairments.
 5. Easily accessible education and supports for caregivers who are dealing with a family member with cognitive disabilities are needed and must be available at the earliest signs of cognitive impairment.

3. HEALTHY AGING – COMMUNITY BUILDING & SOCIAL WELL BEING

A MacArthur Foundation Study of Aging in America found that maintaining a high level of engagement with one's community is a key ingredient for preserving a high quality of life for older adults. This includes opportunities for socialization; group activities; and social, civic and community engagement activities as a means of remaining active in their communities.^{xxiii}

With growing suburbs and geographic mobility, the traditional notion of neighborhood support has diminished. Family, friends and neighbors can no longer be counted on to be there to support an older adult in need. New methods of community building are needed to assure the integration and social well-being of older adults and to help them remain independent and safe in their community. Such communities should also engage older adults and promote community inclusion on a number of levels, from municipal planning to intergenerational volunteerism.

Just as we seek to support older adults in their own homes, we need to increase support and education to caregivers who are the backbone of the long-term care system. Unpaid caregivers, who often have elder family members living with them, may be so overwhelmed with caregiving responsibilities that they cannot navigate the maze of resources that may be available. Caregivers are often so exhausted that they have no "extra" to invest in seeking out help. It is too much work.

Just as we seek to support older adults in their own home, we need to increase support and education to caregivers.

In addition, there is a significant dearth of information available to caregivers, and that which is available often comes from the perspective of the professional as opposed to the family's or older adult's perspective. Caregivers need a rapid, ready resource of pertinent information that will support them in continuing their role. They also need help navigating the community connections that can play a significant part in helping them provide care and avoid the isolation that comes from caregiving.

While many older adults are intellectually competent, physically active and desire independence from their children, inaccurate assumptions are often made about their capacities and capabilities, and there is often inadequate respect for the experience of older adults. They live complex lives in complex environments and can and should continue to learn both formally and informally and have valuable life experiences. These add to the sense of community and the sense of attachment and belonging.^{xxiv}

Those individuals who are independent enough to take care of themselves face the possibility of increasing isolation and functional decline if they lack easy, friendly, family-like access to social and helping networks. Much of the existing network of help for older adults comes in professionalized and often eligibility based forms, principally from health care providers, various community-based organizations, and state or federal benefit programs. The result can be compartmentalized services, without the creation of any lasting social connections.

The statewide network of Aging Services Access Points (ASAPs) and Councils on Aging (COAs) works in tandem to provide extensive support services for older adults and a venue for social connections, intergenerational programs and volunteer opportunities. Both ASAPs and COAs offer many of the services needed to enhance independence for older adults, but consumers are often unaware of the existence of these organizations and the services they offer. In addition, COAs are often stereotyped as primarily serving only the neediest and most impaired older adults.

What is called for is a cultural reorientation that engages elder care organizations, public sector agencies, and other community organizations to work in new arrangements to promote the healthy aging of older adults.

WHAT CAN BE DONE? Across the United States, a growing program model that promotes independence and mutual cooperation for older adults has its roots here in Boston. Beacon Hill Village was started in 2001, and there are now more than forty Village programs across the country. Beacon Hill Village is a membership organization created by a group of long-time Beacon Hill residents as an alternative to moving from their houses to retirement or assisted living communities. Beacon Hill Village organizes and delivers needed programs and services that allow older adults to lead safe, healthy and productive lives in their own homes. Several MetroWest communities, including Wellesley, Wayland and Needham, are already working on establishing similar "Village" programs.

Older adults have great skills and experience that can be put to work after retirement.

As older adults reach retirement age, their talents and expertise should be engaged. Older adults have great skills and experience that can be put to work after retirement. There are many model programs, such as Project Able or Discovering What's Next that assist older adults as they seek to transition to new activities. There are also many programs that focus

on intergenerational learning, using the experience of older adults to assist youth. All of these programs can help older adults avoid the social isolation that often occurs after retirement.

Education and support is needed for those that provide care to older adults. Most caregivers will tell you that they learned everything they know about caring for an older adult on the job and had little assistance through the journey of supporting a spouse, parent or friend. Such caregivers are essential to healthy aging and they must be supported. New programs such as Chronic Care Community Corps offer education and training that proactively support caregiving.

COMMUNITY BUILDING & SOCIAL WELL BEING RECOMMENDATIONS:

1. Support an ecology that encourages interaction within the neighborhood—walking paths, gardens and outdoor spaces friendly for older adults, parents and children.
2. Diminish age segregation through such intergenerational activities as service learning and volunteerism by teens from schools and youth groups and parent associations and by older adult volunteering in the schools and other service organizations. Identify “talent pools” among active older adults.
3. Recognize that teens and older adults share developmental needs for meaning and connection, and seek creative ways to bring together these groups for their mutual benefit.
 - Seek ways for public agencies, COAs and related community organizations to be catalysts for development of neighborhood networks for helping older adults.
 - Create collaborative new partnerships among community organizations, schools and faith-based institutions to support enrichment and services at the neighborhood level as well as develop new uses of existing neighborhood facilities.
4. Create experiments to spur townwide interagency cooperation (schools, houses of worship, women’s clubs, Rotary) led by Councils on Aging and/or an appropriate community agency.
5. Encourage consumer-driven, neighborhood-based activities of enrichment and social support that combine activity with social connections.
 - Possibilities might include the creation of a clearinghouse for matching volunteers with service opportunities for older adults, young adults and students; or older adults teaching crafts, tutoring, helping to walk children to school, mentoring and serving as virtual “grandparents.”
 - Invite proposals from COAs, schools or other community entities to broaden their outreach and encourage informal social and helping networks.
6. Seek technological innovation and the extension of Web-based technologies that can link up social support networks and volunteers with persons who need help. A number of Web-based programs of this kind already exist, such as www.lotsahelpinghands.com, www.caringbridge.org, www.myhometownlink.com, and www.volunteermatch.org.

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7. Strengthen ASAPs and COAs by providing support to enhance innovative services such as caregiver support, chronic disease self-management, and fall prevention, and promote the role of ASAPs and COAs in the community as focal points for programs and services that advance healthy aging.
 8. Enlarge the circle of cooperating agencies who serve older adults to include privately sponsored organizations such as the new “Villages” that make it their purpose to provide individualized and customized follow-up and social opportunities.
 9. Create mechanisms for older adults who do not meet financial eligibility criteria to “financially buy in” to services they want to access through a membership status that would charge according to ability to pay.

4. HEALTHY AGING – TRANSPORTATION & MOBILITY

The ability to shop, go to medical appointments, worship or even visit with friends and family is often dependent on an older adult’s ability to drive.

Women live on average 10 years longer than they can drive, men 6.5 years.

One of the most difficult issues older adults face is how to remain mobile as they age. For older adults, the automobile has become an essential part of remaining active and engaged in various aspects of community. The ability to shop, go to medical appointments, worship or even visit with friends and family is often dependent on one’s ability to drive there. Katherine Freund, the founder and president of Independent Transportation Network® (ITNAmerica) noted the following statistics about safety and mobility for older people:^{xxv}

- Older adults have the highest fatal crash risk;
- Women live on average 10 years longer than they can drive;
- Men live on average 6.5 years longer than they can drive;
- 90% of trips taken by older adults are in private automobiles;
- Fewer than 2% of trips by older adults are taken on public transportation;
- 8% of trips taken by older adults occur through walking;
- 54% of older adults live in communities without public transit.

Few older adults want to voluntarily give up their cars. Others may not be able to know when they should stop driving. Recent tragedies involving older adult drivers led the Massachusetts Legislature to enact new laws requiring mandatory license retesting after age seventy-five. This will undoubtedly create more older adult drivers who have little choice but to give up their cars. But what is the alternative?

For the MetroWest region, there are limited alternatives to the private automobile. Most of the area’s senior centers provide some transportation for medical appointments, but these are often limited and dependent on volunteer drivers being available. Regional transit organizations, such as the MetroWest Regional Transit Authority, which serves 11 of the MetroWest communities, also provide limited fixed-route minibus system, as well as paratransit systems (The Ride) for those that are disabled. Taxi service is available in some communities but can also be expensive when traveling outside one’s community.

WHAT CAN BE DONE? Many communities have developed programs to expand volunteer transportation systems. One such model is ITNAmerica, a unique community-based, flexible approach to elder transportation that allows older adults to convert their assets into mobility portfolios. The ITN program started in Portland, Maine and is now provided in 15 cities across the country. The program uses cars to provide rides 24 hours a day, seven days a week, for any purpose, without restriction to its members (adults 60 years of age or older and people with visual impairments). The rides are sustainable through fares from those who use the service and through voluntary community support, without the use of taxpayer dollars.

Key elements of the ITNAmerica program include:

- Provision of 24/7 “door-to-door, arm-through-arm” service;
- Empowerment of older adults by enabling them to maintain independence and dignity;
- Donation of unwanted cars to pay for rides;
- Support from corporations, businesses and health care providers;
- Use of technology to create efficiency;
- Reliance on volunteer drivers.^{xxvi}

TRANSPORTATION & MOBILITY RECOMMENDATIONS:

1. Seek ways to develop and support the replication of successful regional older adult transportation approaches, such as ITN, in the MetroWest region.
2. Seek ways to encourage more volunteer drivers in towns throughout MetroWest.
3. Encourage municipalities to address sidewalks, bicycle and pedestrian issues (e.g., crosswalks and walk signals, snow removal) in their community planning and development efforts, and raise consciousness about issues such as the importance of an environmentally friendly landscape and streetscape for encouraging walking and social interaction.
4. Encourage the creation of catalogues (printed and/or Web-based) of existing transportation services and options for users of transportation services and for towns and agencies.
5. Encourage the continued development of regional transit authority (Greater Attleboro & Taunton Regional Transit Authority, MetroWest Regional Transit Authority, and the Massachusetts Bay Transportation Authority) efforts to address the transportation needs of older adults and those with disabilities.

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