THE UNIVERSITY OF GEORGIA PRESENTS:
Knowledge is Power!

Continuing the Momentum of the
White House Conference on Aging:
Developing an Academic-Practice Partnership
Co-sponsored by:
The University of Georgia Institute of Gerontology
The University of Georgia College of Public Health
The University of Georgia College of Family and Consumer Sciences
Georgia Department of Human Services Division of Aging Services
Georgia Gerontology Society
Georgia Institute on Aging
Georgia Associate of Homes and Services for the Aging
Georgia Council on Aging
Georgia Health Care Association

Key Organizers:
• Academics (UGA):
  – Leonard W. Poon
  – Douglas C. Bachtel
  – Anna Dudziak

• Practice
  – Maria Green
    • Georgia Division of Aging Service
  – Kathryn Fowler
    • Athens Community Council on Aging

Realizing the Academic-Practice Partnership
• Selection of 6 key aging issues/activities
  – Life-long planning
  – Livable community
  – Health & wellness
  – Care-giving
  – Risk & protective factors
  – Roundtable Discussion

• Formats
  – Joint presentations
  – Presentation/Discussion

Note:
The final report from the White House Conference on Aging is now available for download at http://www.WHCoA.gov/about/about.asp#report.
# Table of Contents

Conference Program.................................................................................................................................2

Preface........................................................................................................................................................3
  Leonard W. Poon, Douglas C. Bachtel

Welcome: Policy Advisor, Office of the Governor.................................4
  Abel Ortiz

Knowledge is Power Introduction: How To Find and Use Information................................................................5
  Leonard W. Poon, Douglas C. Bachtel

Pre-Conference Summary: Continuing the Momentum of the White House Conference on Aging....................6
  Maria Greene, Kathryn D. Fowler, Doris Clanton

## Conference Presentations

Life Long Planning........................................................................................................................................14
  Lance Palmer, Abby Griffs

Older Americans and Residential Stability: Maintaining Livable Communities.............................................17
  Andrew Carswell

There’s No Place Like Home: Aging-In-Place Among Older Homeowners.................................................22
  Joseph J. Sabia

Continuing the Momentum of the 2005 WHCoA: A Few Thoughts............................................................32
  Michael H. McLendon

Health and Wellness for Older Georgians and their Families..................................................................35
  Mary Ann Johnson, Sudha Reddy, Gwenyth Johnson

Professional and Nonprofessional Caregivers.........................................................................................41
  Becky A. Kurtz, Anne Glass

Using Risk and Protective Factors and Georgraphic Information System to Profile Older Adults....................49
  Douglas C. Bachtel

Data About Older Adults.........................................................................................................................53
  John Prechtel

Continuing the Momentum of the White House Conference on Aging with Action Here at Home................55
  Kathryn D. Fowler

White Conference Remarks....................................................................................................................55
  Bob Blancato

Roundtable Discussion............................................................................................................................57
  Anna Dudziak

Conference Survey Results.......................................................................................................................59
Conference Program

8:30-9:00 a.m.  Check-In and Coffee

9:00-9:30 a.m.  Welcome and Keynote
Leonard W. Poon, Ph.D., Professor of Public Health and Psychology
Director of the UGA Institute of Gerontology, lpoon@geron.uga.edu (706)425-3222
Maria Greene, Director of Aging Services, magreene@dhr.state.ga.us (404) 657-5255
Abel Ortiz, Policy Advisor, Office of the Governor

9:30-10:00 a.m.  Lifelong Planning
Lance Palmer, Ph.D., Assistant Professor, UGA Department of Housing & Consumer Economics
lpalmer@fcs.uga.edu (706) 542-4916
with Abby Griffis, GaCares

10:15-11:45 a.m.  Liveable Community
Andrew Carswell, Ph.D., Assistant Professor, UGA Department of Housing & Consumer Economics
carswell@fcs.uga.edu (706) 542-4867
with Kathryn Lawler, Project Director for Aging Atlanta

11:00-11:30 a.m.  Liveable Community
Joe Sabia, Ph.D., Assistant Professor, UGA Department of Housing & Consumer Economics
jsabia@fcs.uga.edu (706) 542-4722
with Kathryn Lawler, Project Director for Aging Atlanta

11:45-12:45 p.m.  Lunch
Mike McLendon, Deputy Assistant Secretary for Policy, Department of Veteran Affairs

1:00-1:30 p.m.  Health and Wellness
Mary Ann Johnson, Ph.D., Professor, UGA Department of Food & Nutrition
mjohnson@fcs.uga.edu (706) 542-2292
with Sudha Reddy, Chief Nutritionist of Wellness, Georgia Division of Aging Services
and Gwyneth Johnson, Aging Services Coordinator, Georgia Division of Aging Services

1:45-2:15 p.m.  Professional and Non-Professional Caregivers
Anne Glass, Ph.D., Assistant Professor of Public Health, Assistant Director of the UGA Institute of Gerontology. aglass@geron.uga.edu (706) 425-3222
with Becky Kurtz, JD, State Long-Term Care Ombudsman

2:30-2:45 p.m.  Coffee Break  Sponsored by Georgia Nursing Home Association

2:45-3:20 p.m.  Risk and Protective Factors
Douglas C. Bachtel, Ph.D., Professor, UGA Department of Housing & Consumer Economics
dbachtel@fcs.uga.edu (706) 542-4894

3:20-3:30 p.m.  Sources and Data
John Prechtel, UGA Librarian, prechtel@uga.edu (706) 542-3472

3:45-4:30 p.m.  White House Roundtable
Kathryn Fowler, Executive Director, Athens Community Council on Aging, kfowler@acaging.org (706) 549-4850

4:30-4:50 p.m.  Wrap Up
Bob Blancato, President, Martz, Blancato and Associates, Inc.

4:50-5:00 p.m.  Wrap Up
Douglas C. Bachtel, Ph.D., Professor, UGA Department of Housing & Consumer Economics
On May 15, 2006, about 150 gerontologists and service providers for older Georgians came together to exchange information that can continue the momentum of the primary resolutions set by the 2005 White House Conference on Aging (WHCoA). WHCoA resolutions are priorities set by people from all corners of the United States to address much needed issues that are pertinent to maintain and improve the quality of life of all older Americans. Our Georgia delegation to the WHCoA contributed significantly to the identification and shaping of the resolutions. The title of this workshop was Knowledge is Power! Continuing the Momentum of the White House Conference on Aging: Developing an Academic-Practice Partnership.

Among the presenters and attendees are members of the Georgia delegation to the WHCoA, key staff persons at the WHCoA, gerontological researchers from The University of Georgia, key staff members from the Georgia Division of Aging Services, older Georgians, as well as practitioners and academicians across Georgia.

Based on the program evaluation from the participants, it was a general consensus that the information presented by teams of researchers and practitioners on the same topics were useful and informative. The participants also formed groups to further identified issues and potential solutions from their practices. Hence, the organizers have summarized the information for dissemination through this brochure as well as through the web. Our intent was to share the information with all who could improve the quality of life of older Georgians.

This publication begins with a welcome from Mr. Abel Ortiz, Governor Sonny Perdue’s policy advisor. It is followed by how information and knowledge could be translated from research to best practices. Next, a status report of the WHCoA is provided on what has happened since 2005. A review of the missions of the Veterans Administration toward older veterans and WHCoA highlights is provided by Mr. Michael H. McLendon, Deputy Assistant Secretary for Policy of the Department of Veterans Affairs. Mr. McLendon is also the Chairman of the 2005 WHCoA Advisory Committee. Joint presentations from The University of Georgia faculty and practitioners are summarized first by an overall abstract, followed by an annotative summary from their presentation materials. Finally, summaries of participants’ discussion groups on pertinent practice issues relating to older Georgians conclude this publication.

Based on the success and enthusiasm of the participants for this first conference, we would like to convene an annual conference to keep the momentum of the WHCoA vibrant and active. This is an important mandate for all who are charged with improving the quality of life of our older Georgians.

Leonard W. Poon and Douglas C. Bachtel, The University of Georgia
Maria Greene, Georgia Division of Aging Services
Kathryn Fowler, Athens Community Council on Aging
Governor Perdue’s Administrative Priorities are consistent with the recommendations from the WHCoA. They involve the following:

I. Support Comprehensive Long-Term Planning

- Long-Term Care Partnership
- Outreach and training on financial planning and personal responsibility and independence
- Aging in Place (support of CCSP, SOURCE and community-based-services)
- Collaborative providers’ relations that promote community-based options as a first priority

II. Caregiver Supports

- Respite Services
- Adult Day Care
- Kinship Resource Networks

III. Promoting Healthy Lifestyles

- Preventative Health Care and Screenings
- Good Nutrition
- Physical Activity
- Depression Screening

IV. New Areas to Examine Based Upon WHCoA Recommendations

- Emergency and Disaster Preparedness (currently in a statewide planning process)
- Transportation
- Seniors in the Workforce
- Critical Information Needed for these New Areas
  - What is our current status?
  - What are our needs/scope of change needed?
  - What are the best practices?
  - What is are the priorities for getting started?
Introduction

Knowledge is Power:

*How To Find and Use the State-of-the-Art Information to Improve Quality of Life of Older Georgians*

The term “from research to practice” or “the translation of research to practice” is an ultimate goal in which efficacious research can be converted into best practices to benefit society and improve the quality of life of its citizens. In reality, researchers and practitioners tended to have limited interactions. In spite of encouragement from federal funding agencies, there are few programs that actively translate research to practice on the one hand and the use of practice to inform research on the other hand.

A major goal of this conference is to foster closer ties between those who are in the forefront of gerontology and geriatric research and those who are front-line practitioners serving older adults in Georgia. In this manner, we are building win-win opportunities for both groups.

There is no better or more ideal opportunity to foster this academic–practice relationship than to work together to continue the momentum on the top resolutions determined by the 2005 White House Conference on Aging (WHCoA). We foster this relationship in three ways. First, we asked The University of Georgia academicians and Georgia’s service providers for older adults to work together to address key top WHCoA resolutions and present their joint products at the conference. Second, we asked panels of practitioners to provide needed questions and issues within each of the top resolutions. Outcomes of their joint presentations and roundtable discussions are contained in this conference summary. Finally, contained in the conference registration packet is a CD-Rom that contains information that could be used by practitioners. Information includes:

- the *Georgia County Guide* (a compendium of all relevant demographic information for all counties in Georgia),
- information on how to market business opportunities to elders,
- nine demographic trends in Georgia,
- *Public Health and Older Georgians* (http://www.geron.uga.edu/pdfs/PublicHealth_Aging.pdf),
- Georgia elder-at-risk neighborhoods, and
- a compendium of aging/aged web resources (http://www.geron.uga.edu/about/onlineresources.php).

Readers of this proceeding can contact Professor Douglas C. Bachtel (dbachtel@fcs.uga.edu) for a free CD-Rom.

For this conference, we had chosen five top WHCoA areas to explore how to maintain and increase our momentum. These issues are:

- Life-long planning
- Livable community
- Health and wellness
- Care-giving, and
- Risk and protective factors

Our ultimate goal is to set examples among those leaders in UGA Gerontology (Dr. Leonard Poon and Dr. Doug Bachtel) and Georgia’s practitioners (Maria Greene and Kathryn Fowler) to bring the two groups together. We hope to continue this dialogue on an annual basis to exchange ideas and information.

Leonard W. Poon, Ph.D.  
Professor of Public Health & Psychology  
The University of Georgia

Douglas C. Bachtel, Ph.D.  
Professor of Housing & Consumer Economics  
The University of Georgia
Pre-Conference Summary:  
Continuing the Momentum of the White House Conference on Aging

Maria Greene  
Division Director  
Georgia Department of Human Resources  
Division of Aging Services

Kathryn Fowler  
Executive Director  
Athens Community Council on Aging

Doris M. Clanton  
Georgia Department of Human Resources  
Division of Aging Services

Abstract

This presentation highlights the Georgia input into the resolutions that emerged from the 2005 White House Conference on Aging that was held December 11-14, 2005 in Washington, D.C.

INTRODUCTION

As Georgia Delegates to the 2005 White House Conference on Aging (WHCoA), it was our responsibility to participate in the selection of the 50 resolutions that were sent to the President and Congress to focus on the needs of seniors for the next decade. While mindful of the national scope of needs, our delegation recognized that many steps can be taken at the state and local level. Therefore, while preparing for the WHCoA and during it, Georgia’s Delegates focused on ensuring that we hear from our communities to identify strategies to benefit older Georgians.

We are indebted to The University of Georgia for their foresight in convening the May 15, 2006 Continuing the Momentum of the White House Conference on Aging: Developing An Academic-Practice Partnership. Below are several WHCoA resolution areas, with barriers and strategies for our future.

HEALTH AND WELLNESS

“Healthy aging can be the rule, not the exception. Poor health and long periods of dependency and disability are not inevitable consequences of aging. Although chronic conditions such as heart disease and diabetes are common and costly, many such conditions are preventable and others can be managed to minimize complications. There are proven strategies to promote independence and prevent chronic diseases, disabilities and injuries among seniors. Strategies to prevent and manage chronic conditions can improve the health of older adults, slow the rise in medical and social service costs, and ultimately benefit people of all ages.

Chronic diseases are the leading cause of illness and disability among older Americans. They are responsible for roughly 73% of health care costs each year. Currently chronic diseases such as heart disease, stroke, cancer, diabetes, arthritis and obesity account for three out of four premature deaths in the United States. At least 80% of adults aged 65 and over have at least one chronic condition. As a result many individuals experience a limitation in activities. The prevalence of multiple chronic conditions increases with age and also dramatically increases the cost of caring for seniors.
Research has shown that healthy lifestyles are more influential than genetic factors in helping people avoid deterioration traditionally associated with aging. People who are physically active, eat a healthy diet, do not use tobacco and practice healthy behaviors reduce their risk for chronic diseases. They also have half the rate of disability of those who do not practice healthy behaviors. Proven effective strategies to reduce chronic disease and disability already exist, but have not been used widely.” -National Governors Association

During the 2005 White House Conference on Aging in Washington, D.C., many of the Top Ten and Top 50 Resolutions selected by the Delegates are vital health and wellness issues.

Support Geriatric Education and Training for All Healthcare Professionals, Paraprofessionals, Health Profession Students, and Direct Care Workers
2005 WHCoA Top Ten Resolution (Rank -#6)

Improve Recognition, Assessment, and Treatment of Mental Illness and Depression Among Older Americans
2005 WHCoA Top Ten Resolution (Rank -#8)

Attain Adequate Numbers of Healthcare Personnel in All Professions Who are Skilled, Culturally Competent, and Specialized in Geriatrics
2005 WHCoA Top Ten Resolution (Rank -#9)

Improve the Quality of Life of Older Americans Through Disease Management and Chronic Care Coordination to Ensure Appropriate Care for Seniors with Disabilities

Prevent Disease and Promote Healthier Lifestyles Through Educating Providers and Consumers on Consumer Healthcare

Improve Access to Care for Older Adults Living in Rural Areas

Improve Patient Advocacy to Assist Patients In and Across All Care Settings

Apply Evidence-Based Research to the Delivery of Health and Social Services Where Appropriate

As displayed above, many Health and Wellness resolutions reflect a priority of older adults having healthy, safe and longer lives.
**Action Steps and Strategies:**

During the Georgia implementation session, workgroups addressed health and wellness issues. Separately, these workgroups identified gaps, priorities and strategies concerning:

- Mental Health
- Nutrition
- Physical Activity
- Disability
- Safety
- Chronic Disease

They recognized gaps in Georgia concerning chronic disease reflected by high rates of smoking, obesity, lack of exercise and poor nutrition. Additionally, they recognized that persons with disabilities often face stigma, waiting lists, and homelessness.

**Action Plans and Strategies:**

- Chronic disease screening/prevention
- Best practices concerning chronic disease, including measurable goals, women’s focus, health disparities and cultural competency
- Mental Health – depression and substance abuse screening, assessment and treatment for older adults; address stigma; address gaps in rural practitioners and increased population; geriatric training for primary care and family doctors
- Mental health in older Georgians is not being adequately screened, assessed or treated; additionally there is a lack of knowledge of available resources
- Dementia and Alzheimer’s
- Encourage Community Collaborations (public and private)
- Overcoming stereotypes of the aging and individuals with mental health needs
- Change name from senior center to health and wellness center
- Focus on prevention
- Centers should have a community approach for all ages
- Address HIV/AIDS policies, screening, education and intervention
- Utilize evidence-based research to educate consumers and policy makers
- Increase consolidated effort in regards to health fairs and empowering choices for self-directions
- Increased funding for community-based wellness programs
- Develop marketing strategies to engage seniors
- Develop K-12 gerontology health and wellness
- Nutrition education for general public that is hands on and culturally focused
- Develop food voucher programs and food banks
- Increase work exercise initiatives
- Develop mind, body, spirit (holistic) approach, including having healthy sexuality
- Focus on safety as an issue, including strategies for older drivers, in-home evaluation of falls, bone density screening; exercise and nutrition education and osteoporosis awareness

**LIVEABLE COMMUNITIES**

During the 2005 White House Conference on Aging, “Livable Communities That Enable the Elderly to Age in Place” was a theme within the “Our Community” framework of resolutions. The WHCoA included several categories:
• Senior-friendly community and residential design
• Protection from neglect and physical abuse
• Senior-friendly roads designed to keep older drivers on the road, safely
• Housing affordability and availability
• Alternative modes of transportation
• Expanded use of public transportation

Additionally, in its pre-conference strategy session, Georgia delegates identified both Transportation and Aging in Place among its top nine resolutions. The pre-WHCoA briefing materials for the Georgia delegation included descriptions of Aging in Place that exemplifies Livable Communities.

“The vast majority of Americans wish to remain in their homes and their communities as they age. There is a growing acceptance of the idea that older persons do not necessarily need to relocate as their personal and physical needs change, but can modify their environment by adding supportive services and reconfiguring their residence. This revised view of the housing continuum stresses the elasticity of conventional housing in terms of accommodating a wider spectrum of older persons. It can be achieved by creating a wider variety of options for frail older persons that facilitate aging in place in physically supportive residential settings linked with services. Aging in place requires the coordination of health and housing programs to deliver a customized level of care in an individual’s home.

Aging in place promotes self sufficiency, encourages cost–saving interdependence between friends and neighbors in the community, offsets social isolation and minimizes professional support unless necessary. Rather than relocating individuals to a facility, allowing them to age in place keeps valuable social networks. Relocating can entail the loss of friendships, regular shopping and entertainment areas and familiar support personnel, resulting in significant loss in quality of life, personal control and dignity. Aging in place allows all of these powerful networks to remain intact providing qualitative and quantitative benefits.”

WHCoA Top Ten and Top 50 Resolutions on this topic include the following:

Ensure that Older Americans Have Transportation Options to Retain Their Mobility and Independence
2005 WHCoA Top Ten Resolution (Rank -#3)

Promote Innovative Models of Non-Institutional Long-Term Care
2005 WHCoA Top Ten Resolution (Rank -#7)

Encourage Community Designs to Promote Livable Communities that Enable Aging in Place

Enhance the Availability of Housing for Older Americans

Enhance the Affordability of Housing for Older Americans

Expand Opportunities for Developing Innovative Housing Designs for Seniors’ Needs

Encourage Redesign of Senior Centers for Broad Appeal and Community Participation
2005 WHCoA Top 50 Resolutions

Participants at the Georgia WHCoA Continue the Momentum conference recognized significant gaps in having a variety of housing that incorporates the needs of seniors (e.g., housing that incorporates wellness clinics; accessibility to transportation, shopping, and other services). Supportive services are needed in community concept and design. Therefore, they were prepared to address priorities for Georgia.
Action Steps and Strategies:

- Increased leverage and government funding, tax credits, incentives for affordable housing
- Build incentives/hold builders/developers accountable to create social/livable communities that incorporate transportation and health care options in the communities they build
- Tax credits for builders who build in 1st floor access design
- Build sidewalks
- Address the need for housing for persons on fixed income of SSI
- Build coalitions between foundations and local partners, including developers
- Focus efforts to influence local government in support of livable community issues
- Develop a plan or outline and provide funding for transportation when developing communities
- Investigate partnerships for transportation such as a coalition with the Department of Transportation (DOT) to use vehicles for transporting seniors
- Highlight best practices
- Take urban planning back to the village neighborhood model, using planning and legislation
- Develop innovative programs for small and rural communities
- Need for intergenerational, cross blend, cross needs for housing and communities
- Advocate and educate officials and legislators on aging in place and livable communities
- Encourage self advocacy among seniors

PROFESSIONAL AND NON-PROFESSIONAL CAREGIVERS

WHCoA Top Ten and Top 50 Resolutions on this topic include the following:

Develop a Coordinated, Comprehensive Long-Term Care Strategy by Supporting Public and Private Sector Initiatives that Address Financing, Choice, Quality, Service Delivery and the Paid and Unpaid Workforce
2005 WHCoA Top Ten Resolution (Rank -#2)

Support Geriatric Education and Training For All Healthcare Professionals, Paraprofessionals, Health Profession Students and Direct Care Workers
2005 WHCoA Top Ten Resolution (Rank -#6)

Improve State and Local Based Integrated Delivery Systems to Meet 21st Century Needs of Seniors
2005 WHCoA Top Ten Resolution (Rank -#10)

Develop a National Strategy for Supporting Informal Caregivers of Seniors to Enable Adequate Quality and Supply of Services

Support Older Adult Caregivers Raising Their Relatives’ Children
2005 WHCoA Top 50 Resolutions

Family (Nonprofessional) Caregiving

Action Steps and Strategies:

- Collect more Georgia information about caregiving, caregivers, and caregivers' needs.
- Make an inclusive assessment to include those who are caring for persons of any age and for any reason.
- Request that CDC collaborate with the state of Georgia to pilot-test caregiving questions on the Behavioral Risk Factors Surveillance Survey (BRFSS). The BRFSS surveys a general-population sample in each state.
- Review the experience and results of North Carolina’s participation as the first state to draft and pilot-test BRFSS caregiving questions. What are the different cohorts?
Inventory what is being done - in Georgia and elsewhere - to address those who provide nonprofessional care. Check with all state agencies to determine whether they are providing services. Look for best practices in the California model which successfully uses a coalition known as the Family Caregiving Alliance. What is the status of Georgia's CareNets and Kinship Care Programs? Is there uniformity and do they need more resources? What lessons can be learned from the EverCare model?

Bring partners together (CDC, DHR DAS, AARP Georgia, the Rosalynn Carter Institute for Human Development, DHR Division of Mental Health, Developmental Disabilities and Addictive Diseases, AAAs, Institute of Gerontology (The University of Georgia) and other education/research resources, CareNets, BellSouth, Coca-Cola and faith based organizations, to start the list) to develop a strategic plan to address needs of Georgia caregivers. Build on the studies that DHR DAS commissioned on caregiver needs. Coordinate across formal and informal care giving.

Implement a functioning statewide coalition and any other structure needed to implement the strategic plan. Advocate for needed policy changes. Request governor convene conference on caregivers' needs in Georgia.

Work with the aging network to continue providing information about services.

LIFE-LONG PLANNING

Foster Innovations in Financing Long-Term Care Services to Increase Options Available to Consumers
2005 WHCoA Top 50 Resolutions

Age, marital status, gender, lifestyle, health, and family history affect individuals' risk for needing long-term care. In the U.S., approximately 60% of the population will require long-term care, and 43% will need to reside in a nursing home for some period of time.

As a long-term care funding source, Medicaid has significant limitations. Increases in the state's aging population will place unprecedented demands on available Medicaid funds; and consumers who do apply must meet strict, eligibility requirements based on income, resources, and health status.

In 2005, the Georgia Department of Human Resources Division of Aging Services launched the GeorgiaCares Lifelong Planning Program – a public-private partnership that promotes financial and personal independence for aging Georgians. Volunteer and paid counselors are mobilized statewide through Area Agencies on Aging (AAA) and the coalition is supported by a growing number of private and public partners.

The program's highly trained community educators and counselors:
- build consumer awareness about long-term care services and costs;
- provide tools to help individuals assess their potential needs;
- objectively present diverse options and solutions; and
- equip individuals with consumer protection techniques for making safe, well-informed decisions about lifelong planning.

The conference breakout group participants noted that traditional avenues will not be there other than long term care insurance. They brainstormed about other avenues and how to obtain reliable information, free from bias in Long Term Care products and services. Additionally, the group discussed barriers to Life Long Planning.

Action Steps and Strategies:
- Work closely with health and wellness (It is time to make a difference!)
- Encourage employers to offer tax breaks to employees to offer LTC insurance (tax credit)
- Provide counseling and education on LTC to employers
- Provide incentives for health insurance to include LTC
- Incorporate Long Term Care planning into health insurance planning
- Educate consumers that Long Term Care is just like other insurance (just in case)
• Partner with seniors in schools (high school and college) for life skills
• Educate Human Resources of companies about educating employees on financial long term care planning
• Create standards for consumers to know what to expect from long term care planning and what to look for in a person
• Standardize criteria for evaluating financial planners
• Take advantages of Older Americans Act reauthorization to publicize Area Agencies on Aging (AAAs) as sources of information
• Develop media campaign to raise awareness
• Use popular culture to feature programs to bust the “Medicare will pay for LTC” myth
• Target those who do not have ready resource or young people who have the potential to build resource including middle to low income
• Plan for retirement first
• Provide incentives for retirees to return to work (i.e., eliminate penalties for state retirees who return to work)
• Be proactive on health and wellness
• Educate regarding reverse mortgage (elders and families)
• Middle American Act like Older American Act with financial services being pushed and sold
• Mandatory life skills seminars in high schools, technical colleges, and universities
• Use faith-based groups to educate people on Long Term Care

ADDITIONAL RESOLUTIONS OF INTEREST

In the near future, we hope to provide ongoing input to the 2005 White House Conference on Aging Resolutions and Action Plan. Several additional issues must be addressed. Additionally, there are initiatives and issues, such as Long Term Care rebalancing, emergency and disaster preparedness, and Elder Justice, where Georgia has developed expertise and initiatives to benefit older Georgians.

Encourage the Development of a Coordinated Federal, State, and Local Emergency Response Plan for Seniors in the Event of Public Health Emergencies or Disasters

Create a National Strategy for Promoting Elder Justice Through the Prevention and Prosecution of Elder Abuse

2005 WHCoA Top 50 Resolutions
Conference Presentations
Life Long Planning

Lance Palmer, Ph.D.
The University of Georgia

Abby Griffis, LMSW
Georgia Department of Human Resources

Abstract

The GeorgiaCares Lifelong Planning Program, located within the Department of Human Resources Division of Aging Services is a public-private partnership that promotes financial and personal independence for aging Georgians. Its goal is to help mid-life and older consumers prepare holistically for a range of future needs and expenses – from living independently at home to maximizing choices in facility-based long-term care. Trained community educators and counselors build consumer awareness about long-term care services and costs; provide tools to help individuals assess their potential needs; objectively present diverse options and solutions; and equip individuals with consumer protection techniques for making safe, well-informed decisions about lifelong planning.

The state’s 12 Area Agencies on Aging direct activities in their regions and recruit volunteer community educators to assist staff with one-on-one education sessions, information fairs, presentations, and other activities designed to educate and empower Georgia’s consumers. The Georgia Division of Aging Services supports these regional efforts through statewide project coordination, regular staff and volunteer training, outreach tools, partnership management, Web site development, and performance tracking.

Presentation

Overview

• Perceived retirement preparedness among current workers
  – Results of the 2006 Retirement Confidence Survey
• Automated plan designs
  – Worker responses
• GeorgieCares long-term care planning initiative
• Retirement Preparedness Confidence

Sources of Retirement Income

Trends in Retirement Confidence

Very
Somewhat
Not too
Not at all

0% 10% 20% 30% 40% 50%

• From where will the money come?
  – 48% expect the largest source of retirement to be from personal savings
• How much do they think they will need?
  – 50% of workers expect to comfortably live on less than 70% of pre-retirement income
  – 55% of retirees report that they need about the same or more income during retirement

Digging Deeper Pollyanna Planning?
• Disconcerting inconsistencies
  – 61% of workers expect to receive income from defined benefit plans, only 40% of workers are currently covered by such a plan
  – Of the very confident workers:
  • 39% have less than $50,000 saved for retirement
  • 37% have not calculated how much money they need for retirement

Current and Planned Savings Pollyanna Planning?
• How much money do workers think they need for retirement
  – 30% think they will need < $250,000
  – 18% think they will need > $1 million
• Total savings of workers age 45-55
  – 31% have less than $10,000
  – 16% have more than $250,000
• The likelihood of incurring large healthcare and/or long-term care costs appear to be substantially underestimated

Current Net Worth by Age

<table>
<thead>
<tr>
<th>Age of HH Head</th>
<th>Median Net Worth</th>
</tr>
</thead>
<tbody>
<tr>
<td>All families</td>
<td>$93,100</td>
</tr>
<tr>
<td>&lt; 35 yrs old</td>
<td>$14,200</td>
</tr>
<tr>
<td>35 – 44</td>
<td>$69,400</td>
</tr>
<tr>
<td>45 – 54</td>
<td>$144,700</td>
</tr>
<tr>
<td>55 – 64</td>
<td>$248,700</td>
</tr>
<tr>
<td>65 – 74</td>
<td>$190,100</td>
</tr>
<tr>
<td>&gt; 75 yrs old</td>
<td>$163,100</td>
</tr>
</tbody>
</table>

Planned vs. Actual Retirement Age Pollyanna Planning? – cont’d
• Workers’ plans
  – 23% plan to retire before age 62
  – 32% plan to retire after age 66 or never retire
• Retirees’ experience
  – 40% retired before age 62
  – Only 17% retired after age 66 or are still working
• Many retirees who retired before 62 did not plan to retire at that age
Increasing Preparedness thru Plan Design
Most workers support having automatic plan features
• Automatic enrollment
  – 69% strongly or somewhat favor, 15% strongly oppose
• Life-cycle investment default
  – 59% strongly or somewhat favor, 19% strongly oppose
• Automatic savings increase with raise
  – 65% strongly or somewhat favor, 17% strongly oppose

Advice Worth Having
• By a 2 to 1 margin the most helpful retirement planning advice reported by workers was from financial professionals
  – 63% of workers received advice from financial professionals
  – Nearly 30% of these workers had access to financial professionals through their employer
• Next most helpful
  – Written material from employer; family, friends, and co-workers
• Least helpful advice
  – Internet; television; radio; software; seminars; and online services

GeorgiaCares Lifelong Planning Program
• The purpose of the program is to:
  – build consumer awareness about long-term care services and costs
  – help individuals assess their potential needs
  – objectively present diverse options and solutions
  – help consumers make safe, well-informed decisions about lifelong planning.
Older Americans and Residential Stability:  
*Maintaining Livable Communities through the 21st Century*

Andrew Carswell, Ph.D.  
The University of Georgia

**Abstract**

In keeping with the rest of the American population, older adults are constantly confronted with issues related to community that affect the overall residential housing situation, perhaps even adversely. The intent of this presentation is to inform members of this vulnerable target population about the dangers that today’s communities face. These include such issues as housing affordability and residential lending for older Americans; eminent domain and its effects on mature neighborhoods; mortgage fraud and its effect on vulnerable neighborhoods; and the evolution of neighborhood associations and the implications for service delivery in older neighborhoods. The presentation concludes with specific examples of the types of projects that a local non-profit agency, Aging Atlanta, has implemented for older adults living within the Atlanta metropolitan area.

**Presentation**

**Issues to Be Covered…**

- Housing Affordability/Lending Issues
- Eminent Domain
- Mortgage Fraud
- Neighborhood Associations
- Home/Residential Design
- Transportation Issues/Proximity to Services

**Housing Affordability for Older Americans**

*The Renter Population*

- Older homeless could be as high as 80,000 (Burt et al, 2001)
- Rental cost burden prohibitive for older populations
- Additional concerns for MF operators as well
Housing Affordability

Rental Cost Burdens
Number of jobs (40 hours per week, 52 weeks a year) per household at prevailing minimum wage needed to afford the Fair Market Rent for a two-bedroom unit at 30% of income.

Housing Affordability for Older Americans

The Homeownership Option
- >80% of older persons are considered HOs (Golant, 2003)
- Most HO’s reluctant to “cash out” on existing home (Venti & Wise, 2001)
- Still, a lot of “cash poor, house poor” HO’s (Golant, 2003)
- Growth of RAMs as a housing finance vehicle

Targeting Older Americans

Predatory Lenders
- Contrasted with “subprime” industry
- Examples of abuses
- Implications for older adults
- Methods of addressing predatory lenders
Panacea for Elderly Housing Cost Concerns

*The Housing Counselor*

- RAM/HECM counseling
- Predatory lending
- Fair housing
- Default/delinquency
- Other types

**Housing Costs for Americans 50+**

- Housing, 32%
- Food, 13%
- Other, 19%
- Health Care, 7%
- Transport, 19%
- Personal Insurance & Pensions, 10%

**Areas 50+ pay 30%+ of income for housing**

*Paying more than 30 percent of income toward housing expenses. Source: AARP analysis of the Census Bureau’s 2002 and 2003 American Communities Survey*
Eminent Domain – Implications for the Elderly?

Eminent Domain Concerns Regarding Older Americans

• *Kelo* decision – Summer 2005
• AARP files *amicus* brief supporting limitations on eminent domain
• Increasing number of cases involving older communities

Economic Consequences of Mortgage Fraud

**Mortgage Fraud Example Flowchart**

Neighborhood Consequences of Mortgage Fraud
The Importance and Evolution of Community Organizations…
• Devolution of government services
• Strengthening of neighborhood organizations
• Becomes all the more important over time
• Still concerns for older neighborhoods

...To Counter a Decline in Neighboring Nationwide
• Membership in social organizations declining over time
• These organizations are less grass roots in nature
• Activities of neighborhood organizations have evolved
• These organizations helpful, but not entirely necessary for building social capital

<table>
<thead>
<tr>
<th>Percent who “Strongly agree”</th>
<th>High Engagement</th>
<th>Moderate Engagement</th>
<th>Low Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am satisfied with my life the majority of the time</td>
<td>87%</td>
<td>79%</td>
<td>56%</td>
</tr>
<tr>
<td>I am able to make choices about things that affect how I age</td>
<td>80%</td>
<td>70%</td>
<td>56%</td>
</tr>
<tr>
<td>I have been able to influence others’ lives in positive ways</td>
<td>81%</td>
<td>60%</td>
<td>41%</td>
</tr>
<tr>
<td>I have a high quality of life</td>
<td>85%</td>
<td>69%</td>
<td>46%</td>
</tr>
<tr>
<td>I am able to meet all of my needs and some of my wants</td>
<td>78%</td>
<td>71%</td>
<td>48%</td>
</tr>
</tbody>
</table>

The Tie-In Between Community Strength and Personal Satisfaction
There’s No Place Like Home:  
Aging-in-Place Among Older Homeowners

Joseph J. Sabia, Ph.D.  
The University of Georgia

Abstract

Elderly housing surveys consistently report that older Americans prefer to remain living in their homes for as long as they are physically able. This presentation examines individual-level, family-level, housing-level, and community-level characteristics associated with aging-in-place behavior of older homeowners. Using data from the Panel Study of Income Dynamics (PSID), hazard models are estimated to examine the relationship between family composition changes, income shocks, housing traits, and local community characteristics on aging-in-place decisions during the period 1972-1992. The empirical results suggest consistent evidence that diminishing health and functionality, negative income shocks, higher user costs of homeownership, widowhood, and divorce are significantly negatively associated with aging-in-place. Greater home equity, more assets, and greater access to local public transportation services are positively associated with aging-in-place. Taken together, these findings suggest that products and services designed to enhance functionality could facilitate aging-in-place.

BACKGROUND

One of the most consistent findings of elderly housing surveys over the past several decades is the preference that older Americans have for living independently (Pynoos, 1995). A May 2000 survey conducted by the American Association of Retired Persons (AARP) found that more than 8 in 10 respondents aged 45 and over preferred to remain living in their homes for as long as possible. 90 percent of respondents 65 and older expressed a preference to continue aging-in-place. In fact, 82 percent of older Americans would prefer to avoid moving from their current homes even if personal care services were necessary (AARP, 2000). Most of these individuals are homeowners. The 2000 Census reported that 78 percent of the non-institutionalized elderly population owned their own homes. The 1995 American Housing Survey reflects that 85 percent of elderly homeowners owned their homes “free and clear” of mortgages.

The issue of elderly housing alternatives is becoming increasingly important as the American population grays and as the oldest-old population grows. Demographic changes, increasing health care costs for nursing home care, and elderly preferences to age-in-place make facilitating aging-in-place an important objective for policymakers.

This presentation examines the factors associated with aging-in-place behavior among older homeowners during a 20-year period from 1972-1992. Using longitudinal data from the Panel Study of Income Dynamics (PSID), Cox non-proportional hazard models are estimated to examine the relationship between individual-level, family-level, housing-level, and community-level characteristics and aging-in-place behavior among older homeowners. Separate analyses are done for each of two cohorts — homeowners aged 50 to 60 at baseline (younger-old cohort) and those aged 70 to 80 at baseline (older-old cohort) — to capture mobility decisions of older Americans at different stages of life.

MEANINGS OF HOMEOWNERSHIP

Research on older homeowners in the sociological and gerontological literature suggests that older homeowners attach three meanings to homeownership: security, family, and legacy. First, homeownership is viewed as a means by which to insure against micro and macro insecurities (Dupuis and Thorns, 1996; Mason, 1989; Wright, 1991). Many seniors’ views of homeownership were shaped in the context of The Great Depression, the greatest macroeconomic downturn of the 20th century. The sociological and psychological effects of the Depression...
translated into preferences for long-term ownership, as many elderly individuals view homeownership as one means by which to insure themselves against the risks of macroeconomic downturns.

In addition to protection from macroeconomic insecurities, Dupuis and Thorns (1996) find that the elderly view homeownership as a means of protection from micro insecurities. They conclude that seniors are uncomfortable with the insecurities associated with the rental market, specifically the control that landlords could have over their housing, and the limitations that may be placed on their ability to alter their surroundings. The authors also find that many seniors view their owned home as economic security to pay for future health care costs or losses in income. This finding is consistent with economists' “precautionary wealth hypothesis,” which posits that older homeowners will only liquidate housing wealth as a last resort (Jones, 1997).

The second major meaning of homeownership to seniors involves the connection between home and family (Allen and Crow, 1989). A home is believed to be “a physical building, a house, transformed over time into a home by the presence of the occupants, the family” (Roberts, 1989). Ninety percent of those surveyed in the 1996 study by Dupuis and Thorns stated that they associated home with bringing up children or being surrounded by family. The inextricable connection between the home, familial memories, and intergenerational support makes the prospect of selling their owned home rather unpalatable for many seniors. Finally, seniors associate their home is their legacy to their children. Bequest motives lead many older Americans to hold onto their homes for as long as possible. Taken together, the meanings of home to the elderly create strong preferences for aging-in-place.

STAGES OF ELDERLY MOBILITY

When do older homeowners move? Litwak and Longino (1987) assert that elderly migration can be classified in three stages. First-stage migration occurs around the time of retirement and is motivated primarily by the amenities of alternative housing (Wiseman and Roseman, 1979). These moves are generally to retirement communities in the Sunbelt or to non-metropolitan small towns. Many of these first-stage moves result in seniors living further away from family (Clark and Wolf, 1992).

Second-stage migration occurs when homeowners are in their mid-70s and results primarily because homeowners wish to be closer to family for health and financial support (Silverstein, 1995; Choi, 1996; Litwak, 1985; Siegel, 1985). Meyer et al. (1985) explore factors that affect first-stage and second-stage migration and find results consistent with Litwak and Longino’s theory. The authors find that assistance mobility increases with age, while amenity mobility decreases with age.

Third-stage migration occurs when the health and functionality of older individuals deteriorates sufficiently such that institutional care is necessary. At this stage, personal care services provided by kin are insufficient or too time consuming to continue to support non-institutional living arrangements for the elderly. Moves into institutions tend to be local moves, and children may still provide complementary personal care services to their parents (Dobrof, 1976; Litwak, 1985).

RESULTS: YOUNGER-OLD COHORT

*Family Composition Changes.* Family composition changes emerge as significant factors associated with aging-in-place among older homeowners. The hazard of moving for older homeowners who experience a spousal death is 69 percent higher than the hazard of moving for married homeowners who do not become widowers or widows. This finding supports the theory of second-stage moves (Litwak and Longino, 1987). Widowhood may trigger increases in housing maintenance costs due to the loss of a household laborer and may also decrease the availability of personal care services used to compensate for declining functionality of the living spouse (Chevan, 1995; Feinstein and MacFadden, 1987). The onset of divorce is also negatively associated with aging-in-place. The hazard of moving for married older homeowners who become divorced is 52 percent higher than the hazard for those who do not divorce.
Health and Functionality-Related Amenities. Changing health conditions are also significantly associated with aging-in-place behavior. Homeowners that develop physical limitations that limit their abilities to perform activities of daily living have an 8 percent higher hazard of moving than those who do not develop such limitations. Similarly, homeowners that develop health problems that result in over 24 hours of illness per year have a 29 percent higher hazard of moving than their consistently healthier counterparts.

Homeowners who live in dwellings with public transportation within walking distance of the dwelling have an 11 percent lower hazard of moving than homeowners without such transportation nearby. This is consistent with the hypothesis that local public transportation services may provide older homeowners a means by which to compensate for declining functionality.

Income, Assets, and User Costs. The findings on income and assets yield results consistent with theory. Higher home equity is associated with a marginally significant lower hazard of moving, consistent with Reschovsky (1990). Moreover, higher liquid assets are associated with a lower hazard of moving, consistent with the precautionary wealth hypothesis. Homeowners will only wish to liquidate housing wealth as a last resort and will first use liquid assets to insure against future health, functionality, and wealth shocks. Finally, if a homeowner’s annual income — including social security, labor market wages, and other government transfers — falls below the poverty line, the hazard of moving is 87 percent higher than for a homeowner whose income does not fall below the poverty line. This suggests that aging-in-place is a normal good.

Jones (1997) finds that older homeowners may hold onto home equity not only as insurance against health and wealth shocks, but also to bequeath housing assets to dependents. The estimation results provide some evidence to suggest that to the extent that homeowners age-in-place so as to bequeath those assets, cash transfers to outside dependants may be inter-vivo substitutes for such bequests. Homeowners who give cash transfers to outside dependants have a 66 percent higher hazard of moving relative to those who do not offer cash transfers.

User costs of homeownership also emerge as significant correlated of aging-in-place in the hazard models. A $500 increase in annual utility costs (in 1999 dollars) is associated with a 7 percent higher hazard of moving. Similarly, a $500 increase in annual mortgage payments is associated with a 2 percent higher hazard of moving.

Preference for Mobility. Moving behavior may also be influenced by preferences for risk-taking and new life experiences. Homeowners who had at least a college education had a 10 percent higher hazard of moving than those with less schooling. The most powerful variable in the model, judged by the hazard ratio, is whether the homeowner had ever moved in the previous ten years. Those who had moved in the decade prior to 1972 had a 265 percent higher hazard of moving than those who did not move.

RESULTS: OLDER-OLD COHORT

Most homeowners aged [50,60] have not yet retired; thus, many of the correlates observed in the previous models are for first-stage migration decisions. The following results correspond to a cohort of older homeowners — those aged [70,80] in 1972. In this group, a greater share of homeowners will make second or third-stage migration decisions.

While the results for the older-old cohort are generally similar to those for the younger-old cohort described above, there are some important differences. First, homeowners with family within walking distance of the dwelling have a 31 percent lower hazard of moving than those without family nearby. This result is consistent with results in Meyer and Cromley (1989), Silverstein (1995), and Choi (1996), each of whom find that migration among individuals in their mid-70s is motivated, in large part, to be closer to children. This may be due to declining functionality and health, and the need for low-cost personal care services.
Second, the relationship between the onset of health problems and physical limitations the hazard of moving is larger in magnitude for the older-old cohort than for the younger-old cohort. Homeowners who develop physical limitations that limit their abilities to perform activities of daily living have an 84 percent higher hazard of moving, relative to the 8 percent estimate for the younger-old cohort. Similarly, homeowners in the older-old cohort that develop illnesses that last for more than 24 hours per year have a 211 percent higher hazard of moving, compared to the 29 percent estimate for the younger-old cohort. These findings on health and functionality are consistent with second-stage mobility, which is theorized to occur, in part, due to declining health.

The final important difference between estimates in the younger-old and older-old cohorts is the estimated relationships between community amenities and aging-in-place behavior. In the younger-old cohort, indicators of poor quality neighborhoods are negatively associated with the probability of aging-in-place, consistent with first-stage migration, which suggests moves to improve local amenities. However, for the older-old cohort, there is little evidence that living in communities with frequent break-ins, noise, crowding and traffic problems results in an increased propensity for moves. In fact, those living in dwellings with heat and plumbing problems have lower hazards of moving. Taken together, this may suggest some evidence that older homeowners may become trapped in poor quality communities, and find it difficult to escape these circumstances, consistent with the findings of Burkhauser et al. (1995).

PUBLIC POLICIES

Home modifications and reverse annuity mortgages are two products that may facilitate aging-in-place among older homeowners. Home modifications, such as bathroom bars, wheelchair ramps, and shower seats, can enhance the functionality of older homeowners, thereby allowing them to age-in-place. Reverse annuity mortgages are a mechanism by which “house rich, cash poor” can draw down home equity to increase cash income, which may facilitate aging-in-place. The challenges to the adoption of these products include (1) informational asymmetries between sellers and buyers, (2) fear of fraud, (3) a thin (but growing) markets, (4) a reluctance of older Americans to trust new products, and (5) bequest motives. Federal, state, and local governments have recently taken steps to increase the acceptance of these products through favorable tax policies, publicly provided counseling, and greater local outreach.

Presentation

Preference to Age-in-Place

- Consistent survey findings among elderly
  - Live independently
  - Age-in-place

- National AARP Survey (2000)
  - 89 percent of those aged 55 and older expressed a preference to age-in-place
  - 63 percent aged 45 and older believe they will age-in-place
  - 82 percent prefer to “remain in their homes” even if develop physical ailment

Elderly Homeownership Rates

- 1970: 68 percent of household heads 65 and older owned homes
- 2000: 78 percent of elderly owned homes
  - Highest rates in Utah (87%), West Virginia (85%), and South Carolina (84%)
- 80 percent of elderly homeowners live in one-unit detached homes
  - 5% in one-unit attached, 8% mobile homes
- Median home value ~ $82,000 in 1995$
  - “House rich, cash poor”

Stability in Housing Arrangements

- AARP Survey (2000)
  - 36% of household heads aged 45+ have lived in homes over 20 years
– 47% aged 55+ have lived in homes over 20 years
– 25% of 55+ have lived in homes for over 30 years
– Mobility most common among younger cohorts due to job changes

Meaning of Homeownership

• Security
  – “Precautionary wealth hypothesis”
    • Great Depression (macroeconomic trends)
    • Health shocks
• Home and Family
  – “Site where intergenerational relations of help, support and succor took place”
    (Dupuis and Thorns, 1996)
• Bequests
  – Altruism a strong motivation
• Control
=> Generational changes in meaning

Elderly Health and Functionality

• Chronic Health Conditions
  – 50% report arthritis; 36% hypertension; 32 percent heart disease; and 29% hearing impairments
    (1994)
  – As life expectancy rises, and oldest old population grows, health care expenditures soar
• Functionality Problems
  – 54 percent of elderly population had a limitation that prevented them from performing ADLs or IADLs
  – Individuals over 65 comprised 38 percent of all hospital stays; 58 percent of all days of care in hospital
  – 25% of those aged 45+ reported it is “very or somewhat likely” will have difficulty getting around the house in next five years

Stages of Migration

• Litwak and Longino (1987) posited three classes of migration by elderly
  – “First-stage migration”
• Retirement (sunbelt or non-metro small towns)
  – “Second-stage migration”
• Health and functionality deteriorate sufficiently such that
• Disabilities impede ADLs
  – Spouse can compensate
  – Death of spouse often triggers move nearer children
  – “Third-stage migration”
    • Further deterioration of health and functionality
    • Move into institutional care

Determinants of Elderly Mobility

• “Economic” and “Non-Economic” Factors
  – User costs of homeownership
  – Widowhood
  – Marital Status
  – Bequest Motives (Children)
  – Physical Limitations and Poor Health
  – Income and Assets
  – Retirement
  – Community Amenities
  – Housing Characteristics
Panel Study of Income Dynamics

- Dataset used to examine determinants of mobility among older homeowners
  - 1972-1992: longitudinal survey of individuals and families from early 1970s to mid-1990s
  - Information on:
    - Family composition changes
    - Labor force participation
    - Income
    - User costs of homeownership
    - Community amenities
    - Housing characteristics

Descriptive Statistics
(measured at baseline)

<table>
<thead>
<tr>
<th>Variable</th>
<th>AIP (20 years)</th>
<th>No AIP (&lt; 20 yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Taxable Income of Household</td>
<td>$45,324</td>
<td>$41,389</td>
</tr>
<tr>
<td>House Value</td>
<td>$81,608</td>
<td>$81,112</td>
</tr>
<tr>
<td>Average Annual Mortgage Payment</td>
<td>$2,653</td>
<td>$3,348</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>AIP</th>
<th>No AIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Annual Utility Bill</td>
<td>$1,468</td>
<td>$1,617</td>
</tr>
<tr>
<td>Annual Food Expenditures</td>
<td>$7,208</td>
<td>$7,838</td>
</tr>
<tr>
<td>Mean Annual Property Tax</td>
<td>$1,224</td>
<td>$1,240</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>AIP</th>
<th>No AIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>% With Physical Limitation</td>
<td>18%</td>
<td>24%</td>
</tr>
<tr>
<td>% With Worsening Limitation</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>% With Family Within Walking Distance</td>
<td>58%</td>
<td>52%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>AIP</th>
<th>No AIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>% With Public Transportation Nearby</td>
<td>51%</td>
<td>55%</td>
</tr>
<tr>
<td>% That Spend Income on Cigarette</td>
<td>45%</td>
<td>57%</td>
</tr>
<tr>
<td>% Attending At Least College</td>
<td>19%</td>
<td>20%</td>
</tr>
</tbody>
</table>
Descriptive Statistics

<table>
<thead>
<tr>
<th>Variable</th>
<th>AIP</th>
<th>No AIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Known &gt;20 People in Neighborhood By Name</td>
<td>65%</td>
<td>57%</td>
</tr>
<tr>
<td>% of Homeowners that Expect to Move</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>% Living in More Than One State</td>
<td>52%</td>
<td>58%</td>
</tr>
</tbody>
</table>

Descriptive Statistics

<table>
<thead>
<tr>
<th>Variable</th>
<th>AIP</th>
<th>No AIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Married</td>
<td>87%</td>
<td>80%</td>
</tr>
<tr>
<td>% Widowed</td>
<td>6%</td>
<td>14%</td>
</tr>
<tr>
<td>% Make Transfers to Outside Dependents</td>
<td>7%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Samples and Model

- Younger-Old Cohort
  - 3949 homeowners aged 50-60 in 1972
  - 2889 moved at least once from 1972-1992
- Older-Old Cohort
  - 588 homeowners aged 70-80 in 1972
  - 304 moved at least once from 1972-1992
- Estimate Hazard Model
  - What are the effects of family composition changes, economic conditions, and declining functionality on time until move for older homeowners?
  - Models include wide set of individual-level, family-level, and community-level characteristics

Results: Younger-Old Cohort

- Family Composition Changes
  - Widowhood is a trigger for mobility
  - Older homeowners who experience death of a spouse have a 69% higher hazard of moving than those who do not experience widowhood
  - Divorce induces mobility
  - Homeowners who experience divorce have a 52% higher hazard of moving
  - Exit of a child from household triggers mobility
  - Homeowners who experience exit of child have 54% higher hazard of moving

Results: Younger-Old Cohort

- Health and Functionality Changes
  - Physical limitations impede aging-in-place
  - Development of physical limitations that impede performance of ADLs associated with an 8.1% higher hazard of moving
  - Health problems impede aging-in-place
Results: Younger-Old Cohort

- User Costs of Homeownership
  - A $500 increase in annual mortgage costs results in a 2% higher hazard of moving
  - A $500 increase in annual utility costs results in a 7% higher hazard of moving

- Income, Assets, and Bequests
  - If household income falls below poverty line, the hazard of moving is 87% higher
  - A $10,000 increase in taxable assets associated with 6% lower hazard of moving
  - Giving positive cash transfers to dependents is associated with a 66% higher hazard of moving

Results: Younger-Old Cohort

- Community Characteristics
  - Homeowners living in neighborhoods with a lack of security and frequent break-ins are less likely to age-in-place
  - Homeowners in crowded, noisy, traffic-filled environments are less likely to age-in-place
  - Homeowners with public transportation within walking distance are more likely to age-in-place

Results: Older-Old Cohort

- Functionality impairments and declining health impede aging-in-place even more among oldest-old
- Widowhood has a similar effect
- Individuals with relatives living within walking distance of the home more likely to age-in-place
- More likely to be trapped in bad neighborhoods
- Higher home equity increases likelihood of aging-in-place

Summary

- Most important impediments to aging-in-place among older Americans:
  - Diminishing health and functionality
  - Decline in income
  - Family structure changes
  - Community amenities
  - Home equity

Policies Designed to Promote Aging-in-Place

- Home Modifications
  - Technology that allows individuals to cope with physical limitations
  - AHEAD data (1994)
    - 27% of elderly homes (70+) had grab bars or shower seat in bathroom (1994)
    - 12% had modifications to deal with wheelchair movement
    - 47% of 80 to 89 year-olds had some modifications
    - Among those residences with modifications, 58% are single-family units

Home Modifications

- Kutty (1999) studied elderly demand for home modifications
  - Results suggest that the following characteristics are associated with presence of home modifications:
    - Living alone
    - Higher education
    - Falls in the last year
    - Formal personal care services in the home
    - Use of other assistive devices (walking equipment)
    - Newer dwellings (technology)
    - Apartments (economies of scale)
Home Modifications

- Recent Legislative Action (2006)
  - Maryland Income Tax Credit for Aging-In-Place Home Modifications bill (House Bill 1498)
    * Tax credit up to $1,000 a year to a homeowner who modifies his home via:
      - installing grab bars
      - no step entrances
      - lever door handles
      - raises the height of light switches and electrical outlets to 27 - 44 inches off the floor
      - creates wider interior passage doors

Why Don’t More Homeowners Modify Homes?

- Source: AARP (1997)
- Three Policy Suggestions from Pynoos (2000)
  - “Reform Medicare and Medicaid to pay for home environmental assessments by occupational therapists or other health care professionals and allow broader coverage for home modifications.”
  - “Change IRS and state income tax rules to more easily allow home modifications as a deductible expense and/or provide a tax credit.”
  - “Encourage states and localities to use revolving loan programs, grants and housing trust funds for home modification and retrofitting of multi-unit housing.”

Home Modification Assistance

- Community Housing Resource Center (Atlanta, GA)
  - Serves several hundred older adults each year with home repairs and modifications
  - Housing Counselors conduct a site visit to interview the homeowner, go over the program, and inspect the home
  - Repair needs assessed; work is carried out by licensed, professional, city-approved contractors
  - Counselors guide them through the process
  - Search out opportunities to strengthen connections to resources and long-term supports in their communities
  => Comprehensive strategy

Reverse Mortgages

- Loan against home equity owned by borrower
  - Not require monthly payment
  - Repayable when borrower ceases to use home as primary residence (moving or death)
  - Homeowner increases indebtedness by drawing down equity in home
• Payment forms
  – Lump-sum
  – Term plan
  – Tenure plan
  – Credit line

Reverse Mortgages
• Attractive for several reasons
  – Facilitate aging-in-place
  – May alleviate poverty (Kutty, 1998) among “house rich, cash poor” seniors
• Kutty simulates poverty alleviation among poor elderly homeowners using American Housing Survey
  – Simulates tenure plan of Home Equity Conversion Mortgage (HECM), sponsored by HUD
  – Finds that over 620,000 elderly homeowners could be raised above poverty line if obtained HECM reverse mortgage
  – Reduce elderly poverty rate by 2 to 3 percentage points (19 percent decline in poverty rate)

Reverse Mortgages
• Challenges
  – Document literacy
    – 1992 National Adult Literacy Survey: 47 percent of Americans over the age of 60 are functionally illiterate in comprehending documents
  – Thin (But Growing) Reverse Mortgage Market
    • Lender risk: tenure, home-value, interest rate (for fixed rate mortgages)
      – Some have suggested pooling life insurance with reverse mortgages (Mayer et al. 1994; Chinloy et al., 1994)
      – Kutty (1998) suggests greater government involvement in creating secondary market
  – Overcoming information barriers, lack of trust, fraud
    • Longlife Planning Program (GA)
Continuing the Momentum of the 2005 WHCoA: A Few Thoughts

Michael H. McLendon
Deputy Assistant Secretary for Policy
Department of Veterans Affairs
Chairman, 2005 WHCoA Advisory Committee

Thoughts for Today
• Snapshot of Department of Veterans Affairs
• Overview of WHCoA Highlights
• Future Considerations
• Critical Success Factors

Our Mission
• “To care for him who shall have borne the battle and honor his widow, and his orphan.”
  Abraham Lincoln
• By providing benefits and services to veterans and their dependents

VA Snapshot
• 235,000 employees
• FY 07 Budget $81 Billion
• 7 Million vets enrolled for HC; treat about 5.9M/Year
• Infrastructure
  o 21 Veterans Integrated Service Networks (VISNs)
    – 162 Hospitals
    – 850 Hospital, Community-Based and Independent Clinics
    – 135 Nursing Homes
    – 206 Readjustment Counseling Centers (Vet Centers)
    – 43 Domiciliaries
  o 57 Regional Offices for Benefits
    – 139 Benefits Delivery Sites
    – 138 Vocational Rehabilitation Offices
  o 120 National Cemeteries + State Veteran Cemetery Grant Program

VA's Dollar Impact in Georgia – FY2005
• 758,963 veterans (FY 2005)
• About 200,000 treated by VA (FY 2005)
• Dollars
  o Salaries for 5900+ Staff $301M
  o Disability/Pension Payments $1080M
  o Medical Services $714M
  o Education/Voc Rehab $154M
  o Insurance Payments/Dividends $41M
  o Nursing Home/Domiciliary Care $14M
  o Other $60M
  o Total $2.3B
2005 WHCoA Conference Paradigm
THE BOOMING DYNAMICS OF AGING: From Awareness to Action

- Future
- Solutions
- Actions
  - Federal
  - State
  - Tribal
  - Local
  - Community
  - Individual
  - Private Sector
  - Business/Industry
  - Nonprofit

WHCoA Highlights
- 400 events (August 04 – December 05)
- 150,000 participants
- 1200 Appointed Delegates
- Top 50 resolutions voted out of 73
- About 75% of possible votes that could have cast were
- Over 3000 implementation strategies identified in working groups and by individuals at December conference
- On track to complete final report June 05

2005 Conference Perhaps the Most Important One…
- Conference of Firsts
  - Of the 21st Century
  - Mandated focus on 78 million Boomers
- Comes at a time of future labor force availability and program funding concerns
- Accelerating old and new trends

“The future is disorder. A door like this has opened up only five or six times since we got up on our hind legs. It's the best possible time to be alive, when almost everything you thought you knew is wrong.”
- Valentine in Arcadia, a play by Tom Stoppard

“When I was young I was amazed at Plutarch's statement that the elder Cato began at the age of 80 to learn Greek.
I am amazed no longer. Old age is ready to undertake tasks that youth shirked because they would take it no longer.”
- W. Somerset Maugham

“Politically, we have become a Nation of red and blue states, but the FACTS are purple.”
- David Walker, Comptroller General of the U.S.

Critical Point in Time…
- In 2004...41% of Federal spending was for Medicare, Medicaid, and Social Security
- By 2015, total HC costs > $4 T
- Within a decade, aging America will spend 1 out of every 5 dollars for HC...
- But only about 26% think they have enough money to finance LTC needs
- To balance the budget by 2040 we would need to cut Federal spending by 60% and increase taxes by a factor of 2.5.
Strategic View

Critical Success Factors
- On critical path to success
- Essential to dealing with three major management challenges
  - Improve programs for current seniors
  - Create programs and networks for the future
  - Manage the transition and concurrency
- Institutional will power

Realign Programs
- New structures should follow new strategies
- Pushing 21st Century needs and solutions thru dated programs not efficient and effective
- Opportunity savings to apply to unmet needs

21st Century Service Delivery
- Beyond coordination and collaboration
- Beyond tinkering with stove pipes
- True Integration

Accountability
- Personal
- Institutional
- Follow Through
Health and Wellness for Older Georgians and Their Families

Mary Ann Johnson, Ph.D.
The University of Georgia
and
Sudha Reddy, MS, RD, LD
Gwenyth Johnson, RD, LD
Georgia Division of Aging Services

Abstract

Georgia has a rapidly growing older adult population and nearly 2 million people will be 65 and older by 2030 (AARP, 2005; Georgia Department of Human Resources, Division of Aging Services, 2005; Glass, 2005). Although most older Georgians live independently in the community, many are at especially high risk for age-related problems. Risk factors include being in a minority/ethnic group, living in a rural area, low education, low income, and poverty. Families face difficult choices including nursing home placement, which can cost more than $50,000 annually. Caregiving, heart disease, stroke, diabetes, hypertension, falls and fractures are among the many issues older people may face and these are discussed briefly below.

Heart disease is the number one killer in Georgia (Georgia Department of Human Resources, Division of Public Health, 2005; Georgia Department of Human Resources, Diabetes Prevention and Control Program, 2005). The prevalence of diabetes, heart disease, and stroke is higher in Georgia than the national average. In Georgia, 67%, 76%, and 81% of those who die from diabetes, heart disease, or stroke, respectively, are aged 65 and older. Health care costs for people with diabetes are $13,243 annually compared to $2,560 for those without diabetes. Improved management of diabetes saves markedly on health care costs. Cardiovascular diseases, including stroke and congestive heart failure, cost $3.34 billion annually in Georgia – and at least $2.5 billion of these costs are incurred by older adults. Nutrition and physical activity are essential for preventing and managing these conditions. Modifiable risk factors include smoking, inadequate physical activity, poor diet, obesity, high blood pressure, high blood cholesterol, and diabetes. In Georgia, 94% of adults have at least one of these modifiable risk factors for heart disease. People who have all seven of these risk factors are 38 times more likely to have a history of heart disease or stroke compared to those who have none of these risk factors – even having five risk factors increases the risk by eleven fold.

Osteoporosis related fractures are costly – but preventable (Burge et al., 2000; CDC, 2005; Georgia Academy of Family Physicians, undated; Georgia Division of Public Health, Injury Prevention, 2005; NIH, 2002). Between 2000 and 2009 in Georgia, there will be 304,000 osteoporosis related fractures and $3.5 billion total medical costs, with over two-thirds of the costs in people aged 75 and older. About 95% of hip fractures are caused by falls and 60% of fatal falls occur in the home. Osteoporosis-related fractures send about 10,000 older people to long-term care annually. Up to 25% of community-dwelling older adults who sustain hip fractures remain in long-term care for at least one year. Healthy eating and regular physical activity, improvements in home safety and medication management, and regular check-ups can reduce osteoporosis, bone fractures, and falls.

Many people will spend more time caring for parents than caring for their children. Nearly one in five adults in Georgia has primary responsibility for caring for someone other than a child who cannot take care of themselves. Caregiving can be rewarding, but can lead to stress, depression, and health problems and even to elder abuse or neglect.

Partnerships

Older adults, their families and communities face a complex and interacting set of physical, emotional, mental, and social challenges. Linking the public health and the aging services network is ongoing. Also, private and public partnerships can address the needs of older adults and their families in culturally sensitive and innovative ways.
Planning our Pathways to Success

Successfully meeting the many challenges Georgia faces with its growing older adult population will involve many pathways. Networking across all sectors of society and the aging services network is critical. Public health campaigns that promote key messages are essential. One such public health campaign is Live Healthy Georgia – Seniors Taking Charge. The goal of this program is to reduce the risk and improve the management of chronic disease in older adults by promoting five key messages: eat healthy, stay active, get checked, stay smoke free, and be positive. The website Live Well Age Well provides practical information about these and other health promoting behaviors (www.livewellagewell.info).

Major activities include promoting the campaign messages, creating partnerships and a statewide public relations media campaign to promote nutrition, physical activity and wellness, maintaining a website for older adults, their families, and caregivers, expanding chronic disease prevention, and conducting a community intervention study to increase fruit and vegetable intake and physical activity and improve self-management of diabetes. Key partnerships include the Department of Human Resources, Division of Aging Service (DHR-DAS); Department of Foods and Nutrition, University of Georgia; Area Agencies on Aging; Diabetes Association of Atlanta; Division of Public Health; local health departments; and Cooperative Extension Service.

Another part of Live Healthy Georgia – Seniors Taking Charge is a statewide community intervention study to improve dietary choices, physical activity and self-management of diabetes in more than 40 senior centers. The initial results show that physical activity and nutrition need improvement (Figure 1) and the prevalence of lifestyle-related chronic diseases is high (Figure 2).

Live Healthy Georgia – Seniors Taking Charge is just one example of how partners can work together to improve the health and well being of older adults. Additional initiatives from the public and private sector are necessary to address the many needs of older Georgians and their families and communities.

Resources

General Information

Centers for Disease Control and Prevention, Healthy Aging for Older Adults, http://www.cdc.gov/aging/.


Heart Disease, Stroke, Diabetes


Falls, Fractures, Osteoporosis


Presentations

Health and Wellness Resolutions

- Mental health (2 resolutions)
- Evidence-based geriatrics, health, and wellness; research into practice (8)
- Informed healthcare consumers and consumer choice (1)
- Innovative models of non-institutional long-term care (1)
- Long-term care (2)
- Patient access to quality care (3)

CDC: How to Improve Older Adults Health and Quality of Life

... The prevention of disease and injury is one of the few tools available to reduce the expected growth of health care and long-term care costs ... http://www.cdc.gov/aging/

Georgia Aging Challenges

- Age 50-64: 1.4 M
- Age 65+: ~ 850,000 (9.6%)
  95% community
  Nursing Homes: > $50,000/yr
- 1995 to 2005
  18.8% inc. 65+
    >2X national rate (9.2%)
- 65+ nearly 2 million by 2030
Glass, A.P. Institute of Gerontology, UGA, 2005; Reforming the Health Care System, State Profiles, AARP Public Policy Institute, 13th Edition, 2005

Georgia Aging Challenges

40% are < 200% poverty level
> 30% rural
> 22% minority/ethnic
< 15% BA/BS degree+
> 90,000 grandparents raising grandchildren
Glass, A.P. Institute of Gerontology, UGA, 2005; Reforming the Health Care System, State Profiles, AARP Public Policy Institute, 13th Edition, 2005
Georgia Aging Challenges
• Age 50+ mental health not good for >1 week in month: 11.9% (11th)
• Age 50+ fair/poor health: 29.3% (10th)
• Age 50+ high blood pressure: 50.6% (7th)
• Age 50+ overweight or obesity: 63.9% (34th)

Reforming the Health Care System, State Profiles, AARP Public Policy Institute, 13th Edition, 2005

Georgia Aging Challenges
• Age 50+ diabetes: 16.2% (7th)
• Age 65+ smoke: 11.2% (6th)
• Age 65+ self-care limitation: 11.1% (9th)
• Age 65+ 6+ teeth lost to decay/gum disease: 52.5% (12th)
• Age 65+ exercise to maintain/lose weight: 46.4% (46th)

Reforming the Health Care System, State Profiles, AARP Public Policy Institute, 13th Edition, 2005

CDC: How to Improve Older Adults Health and Quality of Life
• Healthy lifestyles
  – Foods, exercise, not smoking
• Early detection of diseases
  – While most treatable
• Immunizations
  – 36,000 65+ die yearly from influenza and invasive pneumococcal disease
• Injury prevention
  – > 1/3 older adults fall yearly -> injury
• Self-management techniques
  – Arthritis, diabetes, other chronic conditions

CDC, 2006

What can Georgia do about these health and wellness problems?
• Examples
  – Governor’s Live Healthy Georgia Campaign
  – Community Intervention Study
  – Website: Live Well Age Well

Governor’s Live Healthy Georgia Campaign
- Seniors Taking Charge!

Key Messages
• Get checked
• Be smoke free
• Be active
• Eat healthy
• Be positive
  • http://www.livehealthygeorgia.org/
  http://www.livewellagewell.info
  http://www.livewellagewell.info/study/materials.htm

Partners
Seniors Taking Charge!
• Division of Aging Services
• Aging services network
• Senior centers
• Diabetes Association of Atlanta
• Diabetes Technologies, Inc.
• Division of Public Health
• Local public health departments
• The University of Georgia, Department of Foods and Nutrition & Cooperative Extension Service

Live Healthy Georgia - Seniors Taking Charge
Statewide Community Intervention Study

Senior centers/congregate meals programs
• 8 lessons “Seniors Taking Charge of Diabetes!”
• 8 lessons “Serving Up Fruits, Vegetables and Physical Activity Everyday!”
• Reviewed by experts
• Menus, recipes, handouts, games
• All lessons include physical activity
  – Step counter
  – Walking
  – Chair exercises (NIA)

Live Healthy Georgia - Seniors Taking Charge
Statewide Community Intervention Study

Findings Before Intervention:

![Figure 1. Physical Activity and Nutrition Need Improvement](image)
Website for Live Healthy Georgia- Seniors Taking Charge!

**Target Audience:**
- Consumers: Georgians age 50+
- Families and caretakers/caregivers
- Health professionals working with older adults

**Benefits:**
- Translates “Live Healthy Georgia” messages for older adults and their families
- Information on healthy living, disease risk management, and links to community resources

**Georgia Health and Wellness Challenges**
- Physical and mental health
- Translate research into practice in community and geriatric settings
- Access information: www.livewellagewell.info
- Use evidence-based methods

**Georgia Health and Wellness Resources**
- Centers for Disease Control and Prevention, Healthy Aging for Older Adults, [http://www.cdc.gov/aging/](http://www.cdc.gov/aging/)
Abstract

Becky A. Kurtz, Georgia State Long-Term Care Ombudsman

The WHCoA delegates recognized caregiving as a critical issue for an aging population. Several of the top ten resolutions (plus others in the top 50) directly addressed caregiving issues and the need for innovative approaches in providing long term care.

Factors causing a crisis in caregiving include:

- the dramatically increasing aging population (as well as younger individuals with disabilities needing the same or similar services);
- the stagnant growth of the traditional caregiver population (females aged 25-44);
- women providing less informal caregiving than historically; and
- fewer working women who choose caregiving jobs in the workplace.

According to a May 14, 2006 article in the Atlanta Journal Constitution, Georgia will need more than 140,000 new and replacement health care professionals, including formal caregivers, by 2010.

Most caregiving of seniors is provided informally, by unpaid family and friends. Georgia caregivers have identified access to “coordinated information on services and providers” as their most pressing need (see www.aging.dhr.georgia.gov for 2002 and 2003 reports). Informal caregivers continue to need support even when the care recipient is living in residential or facility settings. The Long-Term Care Ombudsman Program plays a significant role in working to resolve their complaints, providing information, and supporting family councils. Many of the complaints received by the Ombudsman Program are likely the result of insufficient or poorly managed or trained staffing in long-term care facilities.
Abstract
Anne P. Glass, Ph.D.

Caregiving is a growing challenge. Most of us will need some care before we die. Where will it be provided, by whom, and how well?

Statewide Snapshot: Currently, Medicaid is the primary payer for long term care and there has historically been a bias toward institutionalization. Georgia has a higher percentage of the 65+ population in nursing homes (4.4%), a higher percentage with Medicaid as the primary payer (77.6%), and a higher occupancy rate (90.9%), compared to the nation as a whole (4.0%, 66.3%, and 82.6%, respectively) (Gibson, Gregory, Houser, & Fox-Grage, 2004). Georgia also had the lowest percent in the country of Medicaid spending going to long term care, and was among the lowest in Medicaid long term care spending per capita, as well as the spending on home and community-based services (HCBS) per capita.

Innovative Models of Long-Term Care: Four innovations in long term care are highlighted in this presentation: improving the institutional/home care balance, culture change in nursing homes, mutual support, and PACE.

Improving the Institutional/Home Care Balance: The rate of nursing home residence has been declining for several years. One reason is the rise of assisted living as an alternative. Another reason is the national movement toward improving the balance between nursing home care and home care. This movement gained impetus with the Supreme Court’s landmark Olmstead decision in 1999. This decision requires state and local governments to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities, and prohibits unnecessary institutionalization. In response, the Centers for Medicare and Medicaid Services (CMS) offered “Real Choice Systems Change” grants to states to examine and improve their services and help move individuals out of nursing homes and back into the community when possible. A movement toward consumer-directed care is also being supported.

Nationally, about 70% of the Medicaid long term care budget is still going to institutional care. However, as Medicaid is a federal/state program, the services vary greatly between states. Medicaid programs can offer home and community-based services under waiver programs, and beginning January 1, 2007 (CMS, 2006), they can be offered as a State plan optional benefit without waivers. Oregon is the leader in the percent of Medicaid going to HCBS at 73%, Louisiana is the lowest at 10%, and Georgia comes in at 25% (Sumner, Friedland, Mack, & Mathieu, 2004).

Culture Change in Nursing Homes: A movement has been taking shape over the past 15 years within the nursing home world. One of the early leaders was William Thomas, who was himself a physician in a nursing home and thought they could be better. In 1991, he started the “Eden Alternative.” Nursing homes that have adopted the principles of the Eden Alternative strive to make the environment more home-like, with more pets, children, plants, and light, and more supportive of autonomy and dignity for the residents. The approach is more supportive of staff as well.

Four stages of culture change in nursing homes have been suggested (MyInnerView, 2006). Most nursing homes start in the “institutional” phase, which is the traditional hierarchal medical model with no permanent staff assignments. In the “transformational” stage, the nursing home administration begins to make mostly symbolic changes, but may also begin to assign staff permanently to units. The organization may change to focus on smaller functional areas in the third stage or “neighborhood model,” while the “household model” looks quite different altogether. In this model, less then 25 residents reside in their own self-contained area, with cross-functionally trained staff permanently assigned.
A further outgrowth of Thomas’ work is the Green House Project, which typifies the household model. The first ones – four ten-person homes – have been built in Tupelo, Mississippi. Residents have private rooms with private bathrooms, and share the living area including a kitchen and dining space.

**Mutual Support:** Another new movement is the development of communities of mutual support. One of the first – ElderSpirit Community – is opening right now in Abingdon, Virginia. It is unique in many ways. It is one of the first co-housing projects to be developed specifically for elders, and it integrates an element of spirituality and mutual support. It is exceptional in that a group of elders came together to design and develop it themselves, and it is also unusual as it can accommodate individuals of moderate to low income. As noted above, the growth in traditional (younger) caregivers will remain relatively flat as the aging population expands, so encouraging elders to be able to help care for each other may be an important part of the puzzle of care provision.

**Program for All-Inclusive Care for the Elderly (PACE):** In contrast, PACE is not a new program – it started in 1973 at On-Lok in San Francisco – but it is still not widely known. PACE is an integrated system designed to provide comprehensive and coordinated care to frail elders who meet nursing home criteria and who are dually-eligible (i.e. Medicare and Medicaid). A typical PACE center serves about 100 clients and receives a capitated payment from Medicare and Medicaid per member per month. An interdisciplinary team works together with the goal of keeping the members in the community. PACE received permanent provider status in 1997 and as of 2004, there are 32 programs in 18 states.

**How Well?** In an effort to improve the care provided to elders, Geriatric Education Centers (GECs) have been funded throughout the country since 1984. Last year, for the first time, Georgia received funding for a GEC, proposed as a partnership through the UGA Institute of Gerontology, Emory’s Division of Geriatric Medicine, and the College of Health Professions at Armstrong Atlantic State University. Unfortunately, although geriatric education ended up in the top ten of the WHCoA resolutions, Congress zeroed out the budget for GECs for this year, affecting GECs all over the country.

*Presentation*

**Why is Caregiving Such a Critical Issue?**
What do Georgia’s Caregivers Say They Need?
Both formal and informal caregivers in Georgia say they need:
- more coordinated information on services and providers;
- more services, especially respite care in the home, financial assistance and emergency services for caregivers;
- more adequate training for providers at all levels;
- more financial and backup support for families and nursing assistants;
- education of the faith community;
- social support for the caregiver;
- contingency planning.

2002, 2003 For copies of reports go to: www.aging.dhr.georgia.gov and select “publications”
- Area Agencies on Aging are a great resource

What are Ways to Support Informal Caregivers?
When care is provided in residential or facility setting, informal caregivers still need support:
- Long-Term Care Ombudsman Program:
  - Worked to resolve complaints reported by 834 relatives or friends of residents (21% of complainants) last year; and
  - Provided service to another 6,756 relatives or friends, primarily through information on long-term care and involvement with family councils.
  - State fiscal year 2005 data.
What are Ways to Support Professional Caregivers?

• Advocate for more adequate staffing in facilities (GA licensure regulations only require 2.0 nursing hours per resident per day; compare to 4.1 recommendation)

• Ombudsmen work to resolve problems for residents likely related to inadequate staffing:
  o Dignity, respect, staff attitudes (382 NHs, 57 personal care homes)
  o Call lights, response to requests for assistance (297 in NHs, 8 in personal care homes)
  o Staff unresponsive, unavailable (94 NHs, 23 personal care homes)
  o Shortage of staff (68 NHs, 15 personal care homes)

Caregiving is a Growing Challenge

• Most of us will need some care before we die
• Where?
• Who will provide it?
• How well?

Nursing Home Use (2003)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>GA</th>
<th>Rank</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Nursing Facility (NF) Residents (#)</td>
<td>36,372</td>
<td>15</td>
<td>1,451,672</td>
</tr>
<tr>
<td>NF Residents (% Age 65+)</td>
<td>4.4</td>
<td>24</td>
<td>4.0</td>
</tr>
<tr>
<td>NF Residents with Medicaid as Primary Payer (%)</td>
<td>77.6</td>
<td>4</td>
<td>66.3</td>
</tr>
<tr>
<td>NF Occupancy Rate (%)</td>
<td>90.9</td>
<td>12</td>
<td>82.6</td>
</tr>
</tbody>
</table>

Source: Gibson, Gregory, Houser, & Fox-Grage, (2004). Across the States – Profiles of Long-Term Care. AARP Public Policy Institute

Medicaid Expenditures

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>GA</th>
<th>Rank</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicaid Spending (millions), 2003</td>
<td>$7,586</td>
<td>11</td>
<td>$259,565</td>
</tr>
<tr>
<td>Medicaid LTC Spending (% of Total Medicaid), 2003</td>
<td>16.8</td>
<td>50</td>
<td>32.3</td>
</tr>
<tr>
<td>LTC Spending per Capita</td>
<td>$147</td>
<td>48</td>
<td>$288</td>
</tr>
<tr>
<td>-- NF Spending per Capita</td>
<td>$103</td>
<td>39</td>
<td>$154</td>
</tr>
<tr>
<td>-- HCBS Spending per Capita</td>
<td>$31</td>
<td>49</td>
<td>$95</td>
</tr>
<tr>
<td>Medicaid Reimbursement per Day for NF Care, 2002</td>
<td>$91</td>
<td>45</td>
<td>$118</td>
</tr>
</tbody>
</table>

What Do We Know About Traditional LTC?

• Bias toward institutionalization
• Medical model
• Schedule rules!
• Highly regulated
• Quality assessment – primary focus on structure and safety
Innovations/Policy Choices
- Improving NH/home care balance
- Culture change
- Mutual Support
- PACE

HCBS Waivers
- Give states flexibility to offer services in home and community
- Can waive:
  - Statewideness
  - Comparability of services
  - Community income and resource rules for the medically needy
- Real Choice Systems Change
- Consumer directed care

Eden Alternative
- William Thomas (1991)
- Changes in today’s nursing homes
- Environment that promotes autonomy & dignity
- More home-like
  - Animals
  - Children
  - Plants
- Better for staff too!
Stages in Culture Change in NHs

• **Institutional**
  – medical model, hierarchical, no permanent staff assignments

• **Transformational**
  – “Symbolic” changes, permanent staff assigned to units

• **Neighborhood Model**
  – Traditional units —> smaller functional areas

• **Household Model**
  – Self-contained living areas ≤ 25 residents have own kitchen, LR, DR
  – Staff – cross-functional, self-led teams
  – Flattening of hierarchical organization

Green Houses

• Small LTC community of elders and staff
• Deinstitutionalize LTC
  – Warm
  – Smart
  – Green
• Private room/private bath
• Comfortable daily life
• First ones built in Tupelo, MS – 2004
  – 4 ten-person homes

Communities of Mutual Support

• New Movement
• “Aging in Community”
• First one opened: ElderSpirit Community 2006

What is PACE?

• Program for All-Inclusive Care for the Elderly
• Ideal for the dually eligible
• An integrated system of care for the frail elderly that is:
  – Community-based
  – Comprehensive
  – Capitated
  – Coordinated
• First center = 1973
• Permanent provider status = 1997

PACE

• Serves frail, NH eligible – average age: 80
• Key – ability to coordinate care
• Interdisciplinary team
• Capitated payment
• PACE centers – average 3 days/week
• Transportation
• 32 programs in 18 states as of 2004 (not GA!)
• Future – more payment sources, rural
How Well?
• Geriatric Education Centers funded by HRSA throughout the country beginning in 1984
• Training for health care professionals
• Georgia GEC funded for the first time in 2005
• What’s next?

References


NOTE: For more information, see the additional references and links about the above topics in the “Compendium of Web Resources on Aging” that is on the CD-Rom in the conference folder.
Using Risk and Protective Factors and Geographic Information System (GIS) 
To Profile Older Adults

Douglas C. Bachtel, Ph.D.
The University of Georgia
Department of Family and Consumer Sciences

Abstract

This presentation uses a risk and protective factors paradigm developed by J. David Hawkins, Richard F. Catalano Jr., and Associates, first published in Communities That Care: Action For Drug Abuse Prevention, 1st Edition, San Francisco: Jossey-Bass Publishers, 1992. The Risk and Protective Factor paradigm was modified to better understand the challenges facing older adults. The paradigm uses U.S. Census data to identify variables that will shed light on the risk factors faced by older adults.

INTRODUCTION

The purpose this report is to profile the demographic factors shaping the delivery of services to older adults in Georgia. Special emphasis will be placed upon documenting the key demographic variables influencing the delivery of programs especially as it applies to older adults in the Atlanta Metropolitan Area. Analyzing contemporary issues facing older adults against the backdrop of the Atlanta Metropolitan Area’s changing demographic environment provides a starting point for understanding the key factors associated with delivering older adult promotion and prevention programs. Understanding the dynamics of these issues is fundamental to creating and maintaining a healthy and productive community.

RISK FACTORS

Previous research on substance abuse and problem behavior reveals that communities with a disproportionate share of certain types of behavioral characteristics tend to have a larger number of individuals having problems with the use of alcohol, tobacco, and other drugs (ATOD) than communities with low proportions of these activities.

Risk factors involve aspects of the community, the school, the family, the individual, and the individual’s peer group which contribute to problem behavior such as substance use. Information in Table 1 illustrates the major risk factors identified which contribute not only to alcohol, tobacco, and other drug use, but other adolescent behavioral problems as well.

Some of the risk factors can be easily measured from existing information collected by various state and federal agencies. These risk factors as well as other community characteristics can be graphed and mapped on a county-level and sub county-level basis, and compared with other geographic locations. By understanding the demographic forces which shape the development and continuation of risk factors, academic researchers and practitioners can educate citizens and decision makers about the severity of the current substance use problem in their communities. Informed decision makers and residents can also better understand the potential for prevention programs to have a broad, positive impact for community well-being.

PROTECTIVE FACTORS

The identification of the distribution and prevalence of risk factors has been shown to be an important element in prevention programming. Equally important is the identification of community protective factors. Protective factors include elements in the community, school, family, and individual which have been shown to increase resiliency in young people to help them protect themselves from the negative effect of risk factors.
Information in Table 1 (Rick and Protective Factors Table) shows the protective factors that have been identified which should be included as part of a comprehensive program to reduce the risk factors.

Research shows that support from the community, school, and family can reduce a youth’s likelihood of participating in problem behaviors. Providing structure for youths by challenging them or giving them a sense of purpose (such as increased responsibility) are ways in which communities, schools, and families can contribute to the positive development of their youth.

GEOGRAPHIC INFORMATION SYSTEM (GIS)

Detailed maps greatly assist with basic understanding of social, economic, and demographic phenomena. Mapping also plays an increasingly important role in consumer affairs, public safety, and health. The ability to apply computer mapping programs to business and governmental programs and initiatives represents a critical link in the age of information. Providing knowledge and training about these critical systems to researchers, practitioners, and decision makers will enable them to successfully navigate the emerging electronic community.

Geographic information systems (GIS) are computer programs designed for the input, storage, analysis, and presentation of spatial information, and spatially-related text information. The GIS system allows the user to analyze census data at the block, tract, municipal and county level. A census block is the smallest unit of geographical analysis. For example, the 28 county Atlanta Metropolitan Area has 1,923 census blocks and 688 tracts. Geographic features, roads, highways and political boundaries are all part of the GIS system. Numerous different combinations of features and data can be layered or incorporated into the analysis.

These GIS systems hold great promise for enhancing many public and private sector decision making activities including profiling the challenges facing older adults, housing demand forecasting, locating medical facilities, land suitability analysis, marketing, and health care analysis. Other related areas where GIS could provide support are economic development, infrastructure planning, transportation planning and human services planning. In addition, the private sector is developing GIS systems to assist with analysis, marketing, and feasibility strategies.

At the state level, the Georgia Departments of Transportation, Natural Resources, and Community Affairs are involved in GIS activities, as well as well as the University System. Federal agencies using GIS technology include the U.S. Geological Survey, the Environmental Protection Agency, Centers for Disease Control and Prevention, U.S. Department of Agriculture, U.S. Forest Service, the military, and the Bureau of the Census.

Numerous local planning boards currently use GIS technology including the numerous Atlanta Metro County Planning Departments and the Atlanta Regional Center. In addition, Nations Bank, Georgia Power, Oglethorpe Power, and numerous other major corporations have implemented GIS technologies.

APPLICATION OF RISK AND PROTECTIVE PARADIGM TO OLDER ADULTS

Five variables were selected for analysis. They include: Percent of population 65 years and older living alone, living in poverty, who are household renters, who use 35% or more of their income on rent, and those 65 years or older who do not have a car. The information in the map clearly shows areas where older adults are at risk. This information can form the basis of developing and improving services that can better assist older adults in need of a host of different services as well as the location of facilities for older adults.

A potential problem, however, exists with regard to the use of this paradigm. The problem involves the availability of protective factor data for mapping purposes. A comprehensive effort will be required to assemble the necessary information in an appropriate data base format for GIS researchers to develop suitable maps. This problem, however, can be overcome with coordinated out research activities that involve researchers and practitioners.
<table>
<thead>
<tr>
<th>RISK FACTORS</th>
<th>PROTECTIVE FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community</strong></td>
<td></td>
</tr>
<tr>
<td>Availability of ATOD</td>
<td>Family and school support</td>
</tr>
<tr>
<td>Community norms and attitudes</td>
<td>Youth centers and recreation activities</td>
</tr>
<tr>
<td>No sense of community</td>
<td>Involvement of religious organizations</td>
</tr>
<tr>
<td>Economic and Social Deprivation</td>
<td>Service organization involvement</td>
</tr>
<tr>
<td>Transitions and Mobility</td>
<td>Health education</td>
</tr>
<tr>
<td><strong>School</strong></td>
<td></td>
</tr>
<tr>
<td>Academic failure</td>
<td>Nurturing Staff</td>
</tr>
<tr>
<td>Lack of commitment to school</td>
<td>Success is expected of all students</td>
</tr>
<tr>
<td>Judgmental attitudes of staff</td>
<td>Students challenged academically</td>
</tr>
<tr>
<td>Delinquency</td>
<td>Fostering autonomy</td>
</tr>
<tr>
<td>Drop out</td>
<td>Positive school climate</td>
</tr>
<tr>
<td>Truancy</td>
<td>Students are given responsibility</td>
</tr>
<tr>
<td></td>
<td>Cooperative learning experiences</td>
</tr>
<tr>
<td></td>
<td>Opportunities in extra-curricular activities</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
</tr>
<tr>
<td>History of high risk behavior</td>
<td>Close bonds established in infancy</td>
</tr>
<tr>
<td>Family management problems</td>
<td>High warmth, low criticism parenting</td>
</tr>
<tr>
<td>Parental attitudes and apathy</td>
<td>Sense of trust and open communication</td>
</tr>
<tr>
<td>Dysfunctional family</td>
<td>Supportive and affectionate</td>
</tr>
<tr>
<td>Lack of support for school programs</td>
<td>Set standards, foster and expect success</td>
</tr>
<tr>
<td></td>
<td>Structure, discipline, clear and fair rules</td>
</tr>
<tr>
<td></td>
<td>Children have meaningful responsibilities</td>
</tr>
<tr>
<td><strong>Individual/Peer</strong></td>
<td></td>
</tr>
<tr>
<td>Alienation</td>
<td>Achievement motivation</td>
</tr>
<tr>
<td>Rebelliousness</td>
<td>Problem solving skills</td>
</tr>
<tr>
<td>Lack of bonding to society</td>
<td>Autonomy</td>
</tr>
<tr>
<td>Anti-social behavior</td>
<td>Sense of purpose, future and self esteem</td>
</tr>
<tr>
<td>Early initiation of problem behavior</td>
<td>Assertiveness and refusal skills</td>
</tr>
<tr>
<td>Friends who engage in problem behavior</td>
<td>Decision-making and planning skills</td>
</tr>
<tr>
<td>Negative peer pressure</td>
<td>Friendship-making skills</td>
</tr>
<tr>
<td></td>
<td>Positive peer influence</td>
</tr>
<tr>
<td></td>
<td>Social compliance</td>
</tr>
</tbody>
</table>
Variables Used:
- 65+ as a % Total Pop.
- 65+ Living Alone as a % Total 65+
- 65+ in Poverty as a % Total 65+
- 65+ Renters as a % Households 65+
- 65+ Paying 35% of Income in Rent as a % Renters 65+
- 65+ No Car as a % of Households 65+

Source: US Census Bureau, 2000
Abstract

Numeric data relevant to the development of service programs for older adults at the state and local level are available from the U.S. Census Bureau, other government agencies, independent organizations, and research archives. This presentation focuses on useful sources of data available to practitioners serving older adults. The presentation also provides information on obtaining further assistance.

Presentation

Sources of Data
• Census Bureau
• government agencies
• independent organizations
• research archives

Census Bureau
• small areas
e.g., counties, census tracts, block groups
• demographics
• socio-economic
e.g., grandparents as caregivers
• housing

Pre-determined tables (Census)
American Factfinder (http://factfinder.census.gov)
• Census of Population and Housing
  — “100 percent” and sample data
  — 2000 & 1990
  — smallest areas
• American Community Survey (ACS)
  — sample data (different methodology)
  — 2004 data available
  — geography more limited

Custom cross-tabulations (Census)
• Advanced Query (2000 Census)
  — restricted access
    • State Data Centers
  — some small area coverage
  — full sample
  — limited choices for cross-tabulation
  — disclosure filters

Custom cross-tabulations (Census)
• PUMS Files (2000 & ACS)
  — more cross-tabulation choices
  — limited sub-state coverage
— sub-sample
— Requires data expertise

Government agencies
• Administration on Aging
• National Center for Health Statistics
• other state and federal

Independent organizations
• Policy and Research for professionals in aging (AARP)
  http://www.aarp.org/research/
• iPUMS – Integrated Public Use Microdata Series (MPC)
  http://www.ipums.umn.edu/usa/index.html
  research archives
• National Archive of Computerized Data on Aging (NACDA)
  http://www.icpsr.umich.edu/NACDA/
  — Not all data available to non-members

Sources of help

State Data Centers
 http://www.census.gov/sdc/www/
  – Census and some other government data
  – reference / consultation
  – data retrieval assistance
  – Some SDCs charge a fee.

Sources of help
Libraries
http://www.usg.edu/galileo/about/inst/
  – reference / referral
  – government document
Abstract

This presentation provided background on the White House Conferences on Aging of 1961, 1971, 1981, and 1995, which resulted in important legislation such as Medicare, the Older Americans Act, and the Family Caregiver Act. The format, development, and reports of the December, 2005, Conference were outlined, and participants were charged with continuing the momentum through state and local actions to implement the priority resolutions adopted by the 1200 delegates. They were asked to serve on workgroups to address liveable communities, health and wellness, long term care, transportation, and professional and nonprofessional caregivers, answering the questions: what is our status today in Georgia, what are the gaps, and what are the priorities to approach or resolve the gaps.

White House Conference Remarks

Bob Blancato
President
Martz, Blancato and Associates, INC.

Thank you Maria as well as SE4A and Georgia 4 A for their support.

- I join with Mike McClendon in expressing appreciation for having this event which offers validation of a key part of the White House Conference commitment to implementation.
- And to Kathryn’s question—yes, the implementation strategies will be in the final report.
- This conference succeeded in largest measure due to work of delegates before during and now after including and especially Georgia.
- This WHCoA had a different mandate—to address issues of boomers and seniors—since boomers began to turn 60 this year.
- We also had a mandate to produce solutions to key issues now and into the future.
- Review of the top ten showed concern about the present and the future.
- Immediate advocacy called for in top resolution on the Older Americans Act. Reauthorize in six months. Things were on track toward that. House has bill already passed out of Subcommittee—going for vote in full Committee this Wednesday and possibly on House floor before Memorial Day.
- Senate also moving but as of Friday night they are stalled.
- They too were going to move a bill out of Committee this week but we, as of yet, have no bill and the Committee action was postponed. That could be a devastating development because time is so tight. If you want to see reauthorization done, be in touch with your Senators today. There will be discussions and even some disagreements about specifics in a reauthorization bill, but the process must move forward. Not the environment to leave things to chance.
- Another benefit to reauthorizing is the prospect of getting enhanced elder abuse prevention or elder justice language into such a bill.
- The bi-partisan Elder Justice Act is intended to increase our federal commitment to fighting elder abuse, neglect and exploitation. Some of it can be adopted in the Older Americans Act—but not unless there is a reauthorization bill.
- Also, immediate advocacy is needed from WHCoA to restore money for the Geriatric Education Centers mentioned earlier.
• Later advocacy issues are plenty as well. I guess the signature issue of this Conference is long term care. It weaves its way throughout the Conference resolutions and to accomplish what delegates asked for will take a multi year commitment.
• Also implementation will involve the states—just a sample of the following resolutions—and you can see the state role...
  o Transportation
  o Older Americans Act
  o Consumer direction in health care
  o Medicaid reform
  o And the top 10 resolutions, especially to improve state and local based integrated delivery systems.
• Also implementation will involve the states—just a sample of the following resolutions—and you can see the state role...
• Advocates have used this conference for what it is - an advocacy opportunity to raise issues higher—whether it be mental health or caregiver issues.
• All 50 resolutions have relevance but as we move forward it is more than change we seek—it is a transformation of thinking and action on our whole way of doing business.
• We must do more than tweak laws—it is more about breaking down individual silos and build coordinated systems—the fiscal realities of today do not allow us the luxury of living in a non coordinated world—must stress coordination and integration.
• We have to also demand more of our elected officials and have them practice foresight in their work on our behalf. It is atrocious how we live in this policy world of immediacy and never look ahead—this white house conference can provide direction.
• Our formal White House Conference process ends in about one month but the ideas and energy need to continue for the good of what was produced by these delegates.

Let us work together.
Introduction

The roundtable discussions allowed conference participants to organize into small groups and discuss the four central themes presented at the conference; they were: Life Long Planning, Health and Wellness, Professional and Nonprofessional Caregivers, and Livable Communities. The purpose of the session was to communicate and share innovative ideas, provide workable recommendations, to improve these areas of concern, and address the opportunities and challenges presented by the ever increasing older population.

A major goal of this conference was to foster closer ties between those who are in the forefront of gerontology and geriatric research and those who are on the front-line practitioners serving older adults in Georgia. In this manner, the conference was building win-win opportunities for both groups. Through the roundtable discussions, both academicians and practitioners were able to collaborate and brainstorm workable strategies for Georgia’s older population.

Conference participants included a variety of professionals in the fields of healthcare, academics, public policy, housing, finance, and senior services. In each group, participants were asked to identify strategies to benefit older Georgians.

The discussions yielded the following:

**Life Long Planning**

- Public and private financing of services and benefits for current and future older Americans.
- Increased personal savings and investments for retirement.
- Incentives are needed in the health insurance industry to include Long Term Care (LTC).
- Standardize criteria for evaluating financial planners and educate consumers through mandatory life skills seminars in high schools, technical colleges, and universities.
- Creative ways need to be found to identify older American’s “hidden assets” such as antiques, dolls, etc.
- Incentives for retirees to return to work. Eliminate penalties for state retirees who return to work.

**Livable Communities**

- Change building and zoning requirements to allow for good senior housing options including single family housing, shared housing, and public housing.
- More leverage and government funding, tax credits, incentives for affordable housing.
- Make builders and developers more socially responsible for creating social and livable communities by encouraging universal design.
- Coordinate social and health services that give the elderly the maximum opportunity to age in place.

**Health and Wellness**

- Establish collaborations between private and public sectors to support a social marketing campaign for disease prevention and healthy lifestyles for seniors.
- Work with senior centers to improve their current programs and identify best practices for older adults of various races, ethnicities, and cultures.
- Implement K-12 gerontology health and wellness education and nutrition education for the general public.
Professional and Nonprofessional Caregivers

- Support older adult caregivers raising their relative's children.
- Support informal caregivers of seniors to enable adequate quality and supply of services.
- Attain adequate geriatric education and training for all healthcare professionals, paraprofessionals, health profession students, and direct care workers.
- Improve education and geriatric care giving services in rural areas throughout Georgia.

Summary

The results of the discussion groups will be shared with the all of the conference participants. The next step is to develop practical strategies for implementing the ideas proposed and uncovered at the roundtable discussions. Basically, the main points stressed the importance of using information to make decisions influencing older adults, increasing the services, and finding ways to increase funding to this growing population.

CONFERENCE EVALUATIONS

An evaluation form was developed and put into each conference participant’s registration packet. Only a small number of the respondents were dissatisfied with the program or the speakers. In addition, an overwhelming majority of the respondents indicated that they enjoyed the conference and believed that another conference should be developed for next year. The respondents were satisfied with the facilities as well as the food. However, the respondents indicated the amount and type of breaks could have been designed differently. Overall, the participants were satisfied with the conference and the facilities. Below is a copy of the evaluation form and count of responses.
### The Program

<table>
<thead>
<tr>
<th>The Program</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was a match between what I learned and what I expected to learn.</td>
<td>16</td>
<td>36</td>
<td>4</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>The Speakers were prepared and organized.</td>
<td>39</td>
<td>25</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The topics were relevant to the challenges facing Georgia's older adult population.</td>
<td>34</td>
<td>27</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The total length of the program was appropriate.</td>
<td>22</td>
<td>32</td>
<td>3</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>A one day conference was sufficient for the material covered.</td>
<td>25</td>
<td>27</td>
<td>5</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>I enjoyed the conference and feel that another should be developed and held next year.</td>
<td>32</td>
<td>23</td>
<td>7</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

### The Facilities

<table>
<thead>
<tr>
<th>The Facilities</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>The pre-event registration was</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>22</td>
<td>24</td>
<td>5</td>
</tr>
<tr>
<td>The on-site event registration process was</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>22</td>
<td>32</td>
<td>7</td>
</tr>
<tr>
<td>The Cobb Galleria meeting room environment was</td>
<td>-</td>
<td>1</td>
<td>5</td>
<td>19</td>
<td>34</td>
<td>-</td>
</tr>
<tr>
<td>The layout of the meeting room and roundtable discussions were</td>
<td>2</td>
<td>1</td>
<td>8</td>
<td>22</td>
<td>21</td>
<td>2</td>
</tr>
<tr>
<td>The amount and type of breaks was</td>
<td>-</td>
<td>4</td>
<td>21</td>
<td>22</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>The advertising (how you heard about the conference) was</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>33</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>The location of the conference was</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>30</td>
<td>23</td>
<td>-</td>
</tr>
<tr>
<td>The quality of the food was</td>
<td>1</td>
<td>4</td>
<td>8</td>
<td>34</td>
<td>14</td>
<td>-</td>
</tr>
</tbody>
</table>

**What additions or improvements would you like to see for future programs?**

_________________________________________________________________________
_________________________________________________________________________

**Any additional comments about issues or areas of concern.**

_________________________________________________________________________
_________________________________________________________________________