A Review of Aging Taskforces
Common Recommendations, Evidence-Based Programs, and Available Resources

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Table of Contents

Introduction

As the baby boomer generation starts retiring, many city, county, state, and federal governments; non-profit organizations; and international agencies have decided to address the issues of an aging population by assigning a task force to review the problems and report back recommendations. This memorandum has reviewed a handful of those task forces at different government levels and summarized their common issues and general recommendations. Many of the task forces looked at for this memorandum were focused on specific topics such as long-term care, elder abuse, employment, or housing while some were broad and overarching. In some cases, the task forces have specific action plans and concrete objectives, and a few have based their recommendations on evidence-based or best practice programs.

The major issue areas addressed by these task forces on aging included health and healthcare, lack of information and education about older adult services, elder abuse, lack of transportation, housing issues, caregiver stress, care management, lack of community engagement, older adult unemployment, and lack of continuing education opportunities.

Many common recommendations included disseminating information about services, increasing daily physical exercise, education about better nutrition and chronic diseases, protecting vulnerable seniors from all forms of abuse, increasing transportation services, allow for zoning changes and establish universal design features in homes to make it easier to age in place, increasing respite services for caregivers, promoting civic participation, and promoting re-training and lifelong education.

This memorandum will introduced common concerns and issues that were identified by the task forces, present a chart of common, generalized recommendations categorized by issue area, and then provide some specific examples and concrete action steps pulled from the task forces' reports. In addition, the memorandum will explain evidence-based programs versus best practices programs with nationally recognized examples. Lastly, included is an annotated bibliography of the task forces' reports and corresponding web links.

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Common Concerns and Issues Identified by the Task Forces

Listed below are the seven areas that were most commonly identified by the task forces as being the areas of greatest concern for an aging population. The bulleted lists include common issues for each topic area.

1. Information and Education about Services in all areas

    Almost every task force found a lack of easily accessible information about the types of services offered to older adults. This included general information and specific information for each topic area such as healthcare and housing. In general, public education about older adult services and programs was often identified as insufficient.
    - Information not easily accessible for older adults
    - General public unaware of older adult services

2. Health and Health Care

    Older adults often identify access to affordable health care as a concern because they are at greater risk of suffering from chronic and acute diseases. In addition, many task forces noted that too few older adults receive the daily exercise and nutrition they need which could prevent diseases, falls, and unnecessary health care costs.
    - Decreasing health and mobility
    - Chronic Illness/Disease
    - Cost of health care
    - Access to health care
    - Lack of physical exercise or activity
    - Poor nutrition
    - Lack of easily accessible healthy meals or foods

3. Elder Abuse (Physical, Emotional, and Financial)

    About half of the task forces' reports mentioned preventing elder abuse of all kinds: physical abuse, emotional abuse, neglect, and financial abuse and exploitation. The Michigan Task Force on Elder Abuse referred to it as "a mostly unrecognized and unreported social problem."
    - Vulnerable seniors
    - Underreporting of abuse
    - Decentralized and incomplete methods for reporting abuse
    - Inconsistencies in elder abuse definitions, reporting, and legal matters
    - Caregiver stress resulting in abuse
    - Lack of awareness about financial scams and exploits

4. Transportation

Transportation was cited as a problem because as people grow older, they often lose their ability to drive and with that their independence or capacity to age in place. Transportation was often mentioned in conjunction with community planning and housing issues.

- Service gaps
- Lack of affordable transportation and transportation choices
- Lack of transportation near housing and other needed services

5. Housing

Housing was the second most mentioned problem identified by the task forces. Many cities, counties, and states want to promote older adults to "age in place". The CDC defined "'aging in place' as the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level." However, the task forces recognized the problems with zoning and building codes, community layouts and livability, in home care, and rising home costs as barriers to older adults aging in place.

- Lack of affordable housing and rising costs
- Lack of community planning for an aging population
- Struggle for older adults to age in place
- Houses are not build or structured for elderly inhabitants
- Zoning ordinances create a barrier for shared housing, grannie flats, and livable communities

6. Care Management, Caregiving, and Long-term Care

As older adults age they need more living assistance and medical care, and many of the task forces identified the capacity strain the baby boomers would create as a problem. In addition, many of the task forces believed that informal caregivers often do not have the support they need, and as a result, have high levels of unhealthy stress.

- Caregiver stress
- Need to increase resources and access to information about respite services
- Lack of education about the effects of caregiving
- Not enough employer flexibility for informal caregivers
- Shortage of long-term care workers and care managers
- Capacity shortages to handle the future demand for long-term care
- Lack of long-term care choices
- Need higher quality and more affordable long-term care

7. Employment, Community Engagement, and Education

Recognizing that older adults want to stay engaged in their communities and remain social after they retire, some of the task forces decided to address the lack of opportunities for older adults. This included a range of volunteer activities, lifelong learning opportunities, social and recreational activities, and employment opportunities. A few of the task forces decided to focus on the lack of re-training or job training for older adults who want to rejoin or remain in the workforce.

- Few employment opportunities for older adults

- Not utilizing older adults as resources
- Few continuing education opportunities
- Not enough community engagement opportunities

Chart of Common Recommendations

Recommendation	Washington	California	Michigan	Minnesota	Colorado	Hawaii	Oregon	Connecticut	Clark Co, WA	Snohomish Co, WA	Dane Co, WI	Orange Co, NC	Williamsburg, VA	Maturing of America	Center for Housing Policy	Aging of the American Workforce
Disseminating Information & Educating the Public About Services	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●
Single point of access for information			×				×			×				×		×
Make information more accessible	×		×	×			×	×						×		×
Marketing strategies			×	×	×		×	×	×	×	×	×				
Raise awareness about services	×	×	×	×	×		×	×	×	×		×				
Health and Healthcare	●	●			●	●	●	●	●	●	●	●		●		
Regular physical activity/exercise	×	×			×	×	×			×	×			×		
Utilize evidence-based programs		×			×	×	×					×				
Fall prevention programs	×	×			×	×	×				×					
Nutrition education								×	×		×	×		×		
Access to nutritious meals					×	×	×	×	×	×	×	×		×		
Chronic disease management	×					×	×					×				
Access to preventative healthcare					×		×			×		×		×		
Specialized training for first responders	×					×	×		×	×	×			×		
More recreational facilities							×		×			×		×		
Mental and behavioral services						×	×		×		×	×				
Elder Abuse (Physical, Emotional, and Financial)			●		●	●	●	●		●	●	●	●			
Train healthcare professionals to recognize signs of elder abuse			×				×									
Define/standardize "elder abuse"							×	×								
Increase elder abuse reporting			×				×			×						

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Standardize reporting mechanisms			×		×		×	×			×					
Enlist financial institutions to become frontline responders of financial abuse			×					×								
Transportation						●	●	●	●	●	●	●		●		
More transportation services and options							×	×	×	×	×	×		×		
Expand volunteer driver services						×	×	×	×		×	×				
Install larger, easier-to-read road signs									×							
Improve license renewal procedures and driver assessments							×		×		×			×		
Housing	●				●	●	●	●	●	●	●	●	●	●	●	
More affordable housing options							×		×	×	×	×		×	×	
Preserve affordable housing							×		×		×	×			×	
Establish zoning changes							×	×	×		×	×			×	
Create universal design features/home modifications						×	×	×	×		×	×		×	×	
Promote aging in place	×				×		×	×	×		×	×		×	×	
Community planning for an aging population	×						×		×	×	×	×	×	×		
Tax incentives and property tax relief	×					×	×	×	×		×	×		×	×	
Care Management, Caregiving, and Long-Term Care	●			●	●	●	●	●	●		●	●				
Promote stress management programs for caregivers									×							

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Increase caregiver respite services	×			×	×	×	×		×			×				
Disseminate information about services	×			×			×		×		×					
Support informal caregivers	×			×		×	×		×		×					
Increase training for caregivers/managers				×		×	×				×	×				×
Recruit a long-term care workforce	×			×	×	×	×	×	×		×	×				
Increase flexibility at the workplace for informal caregivers							×		×							
Employment, Community Engagement, and Education					●				●	●	●	●	●	●		●
Promote older adult civic participation									×	×	×	×		×		
Utilize older adult volunteers									×	×	×	×		×		
Promote job training and re-training					×		×		×		×	×		×		×
Entice boomers to remain in the workforce									×	×	×			×		×
Promote lifelong learning opportunities											×	×		×		
Encourage employers to utilize retirees who re-enter the job market											×	×		×		×
Promoting community engagement						×			×	×	×	×		×		

Examples of Specific Recommendations by Issue Area

Disseminating Information and Educating the Public about Services
- Determine which communication strategies are preferred by older adults and determine a marketing plan based on information gaps that are identified (Orange County).
- Encourage development of an annual Senior Resource Guide (Clark County).

Health and Health Care
- Develop a healthful food store incentives program (Clark County).
- Make oral health services available to low-income and rural older adults and those who participate in nutrition programs (Colorado).

Elder Abuse
- Create limits on liquid assets that a guardian may control (Michigan).
- Promote a centralized toll-free number to report abuse (Michigan).
- Communities should offer education and training for older adults about how to protect themselves against financial fraud and predatory lending (Maturing of America).

Transportation
- Expand existing public transit schedules to improve weekend transportation options, especially at midday (Orange County).
- Continue to add shelters, benches and seat, landing pads, and other amenities to transit stops as funds are available (Clark County).
- Communities should offer driving assessment and training to help older adults remain on the road as safely as possible for as long as possible. Communities should also consider improvements to roadway design such as large print road signs, grooved lane dividers, dedicated left turn lanes, and extended walk times at pedestrian crosswalks to accommodate older drivers and pedestrians (Maturing of America).

Housing
- Property tax relief programs for low-income and age eligible households (Housing an Aging Population).
- Define "family" broadly when establishing zoning regulations for "single-family" homes to allow for accessory housing units, in-law apartments, and stand-alone units on a family member's property (Connecticut).
- Require government-subsidized housing to incorporate universal design principles (Housing an Aging Population).
- Concentrate new housing near employment, shopping, healthcare, transportation, and other services (Clark County).
- Naperville, IL removes snow from driveways of older residents and Laredo, TX provides smaller garbage receptacles for elderly upon request (Maturing of America).

Care Management, Caregiving, and Long-term Care
- Expand tuition credits and loan forgiveness options, and develop a program similar to the GI Bill for health and long-term care workers (Minnesota).

- Encourage community organizations and faith-based organizations to offer more respite services (Orange County).
- Encourage middle and high school students to work and volunteer in health and long-term care settings (Minnesota).
- Greater workplace flexibility for informal caregivers including:
    - Relocation of an employee may include moving an older family member too and resources need to be available to do this (Dane County).
    - Encourage employers to provide onsite adult day care facilities for employee's family members (Clark County).

Employment, Community Engagement, and Education
- Advertise lectures, continuing education classes, and resources offered at the Senior Centers, libraries, and other community locations (Clark County).
- Facilitate self-employment for older workers such as replicating Project GATE (Aging of the American Workforce).
- Communities should promote employment options-such as part-and flex-time work options-and to attract and retain an aging workforce (Maturing of America).

Evidence-Based and Best Practice Programs

Many task forces supported their recommendations with evidence-based programs. These are programs that recommend ways for older adults to maintain their health, stay active, and help prevent chronic diseases. The programs focus on physical activity, nutrition, and falls prevention. To be considered evidence-based, the program has to have undergone extensive research and randomized controlled studies in which evidence demonstrates the program is effective in improving the health of older adults and preventing chronic diseases. The following examples were taken from the *Evidence-Based & Best Practice Programs for Healthy Aging, Caregiving, and Care Transitions* by the Aging and Disability Resource Connection (ADRC) of Oregon.[1]

Examples of evidence-based programs:

Chronic Disease Self-Management

- **Living Well** is Stanford University's Chronic Disease Self-Management Program. It is a six week workshop that provides tools for living a healthy life with chronic conditions such as diabetes, arthritis, asthma, and heart disease. The workshop provides support for normal daily activities and dealing with the emotions chronic conditions can cause. The program also includes:
    - Positive Self-Management Program for people with HIV
    - Diabetes Self-Management Program specifically for people with diabetes
    - Chronic Pain Self-Management Program
    - Better Choice, Better Health, and an on-line version of the workshop.
    http://patienteducation.stanford.edu/.

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[1] http://www.oregon.gov/DHS/spwpd/sua/docs/evd-bsd-pract.pdf.

- **National Diabetes Prevention Program** is a lifestyle change program that significantly reduces the risk of developing type II diabetes among people at high risk. Participants work with a lifestyle coach in a group setting to make modest and attainable behavior choices. The intervention lasts one year, including 16 weekly sessions and six monthly post-core sessions.
- www.cdc.gov/diabetes/prevention/about.htm.

Physical Activity and Falls Prevention

- **Active Living Every Day** is a program developed by the Cooper Institute and Human Kinetics. It is 12 weeks, and self-paced to help people with sedentary lifestyles become and stay physically active. The course can be offered in a group or one-on-one format.
www.humankinetics.com/ppALP

- **Arthritis Foundation Exercise and Aquatics Programs** offer low-impact exercises that can be done either sitting or standing to help relieve stiffness and pain and to build strength and stamina. Classes meet 2-3 times per week for at least eight weeks. The programs were developed specifically for people with arthritis or related conditions, but are also appropriate for other frail or deconditioned older adults.
www.arthritis.org/exercise.php.

- **Fit and Strong** was developed by the University of Chicago as a physical activity program for older adults with arthritis designed to be offered three times per week for eight weeks. Each session includes a 60-minute exercise program and a 30-minute education and group problem-solving session to help participants develop ways of incorporating exercise into their daily lives.
www.fitandstrong.org.

- **Healthy Moves for Aging Well** was developed by the Partners in Care Foundation in collaboration with other Southern California organizations. This physical activity program is offered one-on-one to home-bound frail, high-risk sedentary older adults. The program was designed to be supported by case managers as an additional service of their community-based case management program.
www.picf.org/landing_pages/22,3.html

- **Matter of Balance (MOB)** was adapted from Boston University Roybal Center by Maine's Partnership for Healthy Aging. This community workshop teaches practical coping strategies to reduce the fear of falling. The group-based course is led by trained lay leaders over eight weekly two-hour sessions.
www.mainehealth.org/mob

- **Otago Exercise Program** is an individually tailored falls prevention exercise program that is delivered in participants' homes. A trained physical therapist provides four home visits followed by phone support and a booster session. Exercise includes a series of leg-strengthening, balance-retraining exercises, and a walking plan that get progressively more difficult.
www.acc.co.nz/preventing-injuries/at-home/older-people/information-for-programme-providers/index.htm#P42_2959.

- **SAIL (Stay Active & Independent for Life)** is a strength and balance fitness class developed in Washington for older adults that includes education on preventing falls. The classes meet three times per week for an hour. Exercises can be done seated or standing and include moderate aerobic, strength, and stretching exercises. Instructor training is available in-person or online through Pierce College.
  www.synapticseminars.com.

- **Strong For Life** was developed by Boston University. This six-week home-based exercise program increases strength, balance, and overall health. Volunteer coaches instruct frail homebound participants on how to exercise using an exercise video and monitor their performance.
  www.ncoa.org/improve-health/center-for-healthy-aging/strong-for-life.html

- **Tai Chi Moving for Better Balance** was developed by the Oregon Research Institute in Eugene. This simplified, eight-form version of Tai Chi, offered in community settings, has been proven to decrease the number of falls and risk of falling in older adults. Classes meet two to three times per week for at least three months. Program outcomes include decreased falls, and a decrease in fear of falling. A two-day instructor training is offered in the Eugene area, and occasionally in other areas of the state with support from the DHS Public Health Division.
   www.ori.org

- **The Arthritis Foundation Walk With Ease Program** is a community-based physical activity and self-management education program. It is conducted in groups of 12-15 people led by trained leaders in a structured six-week program. One-hour sessions are held three times a week over the six-week period for a total of 18 sessions. While walking is the central activity, Walk with Ease also includes health education, stretching and strengthening exercises, and motivational strategies. Group sessions include socialization time, a brief scripted pre-walk informational lecture, warm up and cool down, and a 10-35 minute walking period. Walk with Ease was specifically developed for adults with arthritis who want to be more physically active, but is also appropriate for people without arthritis, particularly those with diabetes, heart disease and other chronic conditions, who want to get more active. Instructor training is offered on-line.
  www.arthritis.org/walk-with-ease.php,

Medication Management

- **HomeMeds program** (formerly called the Medication Management Improvement System or MMIS) was adapted from the Vanderbilt University Medication Management Model by the Partners in Care Foundation in California. This intervention is designed to enable case managers, social workers and nurse case managers to enter a participant's medication into a computer-based alert system, and to resolve identified medication problems with involvement of a consulting geriatric pharmacist.
  www.homemeds.org

Depression and Mental Health

- **Brief Intervention and Treatment for Elders (BRITE)** was developed in Florida with support from SAMHSA, this program modifies the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model specifically for use with older adults with substance misuse or abuse. The program helps people age 55+ to identify nondependent substance use or prescription medication issues, and to provide effective service strategies that can prevent substance abuse. http://brite.fmhi.usf.edu

- **Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)** is designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. This case manager-led program typically lasts for 3-6 months. It was developed by the Huffington Center on Aging at Baylor College of Medicine, Sheltering Arms and the Care for Elders Partnership in Houston. http://careforelders.org/default.aspx/MenuItemID/290/MenuGroup/Initiatives+%26+Tools.htm

- **PEARLS** is a time-limited and participant-driven program that teaches depression management techniques to older adults with minor depression or dysthymia. It is offered to people who are receiving home-based services from community services agencies. The program consists of in-home counseling sessions followed by a series of maintenance session contacts conducted over the telephone. Community-based depression care managers use problem-solving treatment, social and physical activity planning, and pleasant events in a series of eight 50-minute sessions over a 19-week period with 3-6 subsequent telephone contacts. www.pearlsprogram.org

Alzheimer's and Caregiving

- **Community Stress-Busting Program for Family** Caregivers is a nine-week community workshop to improve the quality of life of family caregivers providing care for people with Alzheimer's disease or other dementias. Developed at the University of Texas, the program uses two trained facilitators to conduct the weekly 90-minute sessions. www.caregiverstressbusters.org

- **New York University Caregiver Initiative** is a six month counseling and support intervention for spouse caregivers that is intended to improve the well-being of caregivers and delay the nursing home placement of patients with Alzheimer's disease. The program uses social workers or mental health providers to provide individual and family counseling sessions, support groups, and follow-up counseling and phone support. http://nrepp.samhsa.gov/ViewIntervention.aspx?id=74

- **Powerful Tools for Caregivers** is a six-week education program developed by Legacy Caregiver Services, focuses on the needs of the caregiver, and is for family and friends who are caring for older adults suffering from stroke, Alzheimer's, Parkinson's disease or similar long-term conditions. The class provides participants with the skills and confidence you need to better care for yourself while caring for others. www.powerfultoolsforcaregivers.org/

- **REACH II (Resources for Enhancing Alzheimer's Caregiver Health)** is a six-month multi-component home and phone-based intervention provided by case managers for Alzheimer's family caregivers. The intervention is designed to reduce caregiver burden and depression, improve caregivers' ability to provide self-care, provide caregivers with social support, and help caregivers learn how to manage difficult behaviors in care recipients.
  http://nrepp.samhsa.gov/ViewIntervention.aspx?id=129

- **RDAD (Reducing Disability in Alzheimer's Disease**) was developed at the University of Washington; this program encourages exercise and problem-solving to help reduce depression among adults with dementia and their family caregivers. The program uses trained consultants to provide approximately 12 one-hour home visits over a 12-week period.
  www.aoa.gov/AoA_Programs/HPW/Alz_Grants/reducing.aspx

- **Savvy Caregiver** is a 12-hour training program usually delivered in two-hour sessions over a six-week period. Developed at the University of Minnesota, the program focuses on helping caregivers think about their situation objectively and providing them with the knowledge, skills, and attitudes they need to manage stress and carry out the caregiving role effectively. Research has demonstrated significant positive outcomes regarding caregivers' beliefs about caregiving, their reactions to the behavioral symptoms of their care recipient, and their feelings of stress and burden.
  www.rosalynncarter.org/caregiver_intervention_database/dimentia/savvy_caregiver/

- **STAR-C** was developed by the University of Washington's School of Nursing Northwest Research Group on Aging. The STAR-Caregivers (STAR-C) program is a home-based behavioral intervention to decrease depression and anxiety in individuals with Alzheimer's disease and their family caregivers. It consists of eight weekly hour-long in-home sessions followed by four monthly telephone calls.
  www.aoa.gov/AoA_Programs/HPW/Alz_Grants/star-c.aspx

- **Tailored Caregiver Assessment and Referral (TCARE) Model** is an evidence-based caregiver assessment and referral tool used to tailor support and services unpaid caregivers receive to their unique needs. The screening and assessment process helps caregivers identify if they are at high risk for stress and depression, provides support and guidance, and helps caregivers create an individualized plan to meet their goals and needs while identifying available resources that best meet the caregiver's needs.
  http://www.aasa.dshs.wa.gov/Professional/TCARE/documents/TCARE%20Fact%20Sheet.pdf.

Care Transitions

- **Bridge Program** is a hospital-based 30-day intervention that uses a trained social workers to provide a hospital visit and follow-up phone visit and phone support linked to aging services in the hospital and community.
  www.transitionalcare.org/the-bridge-model/

- **Care Transitions Intervention** was developed by Eric Coleman. This four-week community or hospital-based intervention uses trained "transition coaches" to do a hospital visit, home visit,

and three follow-up phone calls addressing four pillars: use of a patient medical record, medication reconciliation, knowledge of red flags or warning signs, and follow-up with a primary care provider.
www.caretransitions.org

- **Guided Care** was developed by Chad Boult. This primary care based program uses a nurse to provide in-home assessment, care planning, self-management support, and support for care transitions for older adults with complex health conditions.
www.guidedcare.org

- **GRACE (Geriatric Resources for Assessment and Care of Elders)** is an ongoing primary care-based intervention that that uses a social worker, nurse practitioner, interdisciplinary team, and clinical protocols addressing common geriatric conditions to improve quality of care and effective care transitions. The program is designed to improve the quality of geriatric care so as to optimize health and functional status, decrease excess healthcare use, and prevent long-term nursing home placement.
http://medicine.iupui.edu/IUCAR/research/grace.aspx

- **Project BOOST (Better Outcomes for Older Adults through Safe Transitions)** is a hospital-based intervention that is designed to identify high-risk patients on admission, and reduce 30 day readmission rates. The intervention uses risk assessment tool, patient records, a teach-back process, and risk-specific interventions and discharge processes.
www.hospitalmedicine.org/BOOST/

- **Transitional Care Model** was developed by Mary Naylor. This one to three month intervention uses a transitional care nurse to provide hospital and home visits, participation in a follow-up physician visit, and telephone support.
www.transitionalcare.info/

Best practice programs are different from evidence-based because they have not undergone rigorous evaluation, but they are based on existing research that demonstrates effective methods. Below are some examples of best practice programs:

Examples of Best Practice Recommendations

Chronic Disease Self-Management

- **Healthy Changes for Living With Diabetes** was developed by Providence Center on Aging in Portland. This ongoing program uses trained volunteer group leaders and a defined curriculum assist older adults in the day-to-day self-management of Type II diabetes by focusing on diet and physical activity during weekly group meetings.
 www.ncbi.nlm.nih.gov/pubmed/19075087

Physical Activity and Falls Prevention

- **Arthritis Foundation Tai Chi Program** was designed for people with arthritis, this 12-movement Sun-style Tai Chi program was developed by Paul Lam and is supported by the Arthritis Foundation.
  www.arthritis.org/tai-chi.php

- **Better Bones & Balance** is based on research at Oregon State University's Bone Research Laboratory. This strength and stepping exercise class is designed to reduce the risk of osteoporosis-related fractures. Outcomes include improved strength, balance and mobility, and reduced bone loss.
  http://extension.oregonstate.edu/physicalactivity/bbb

- **Healthy Lifestyles** is a three-day health promotion intervention for people with disabilities developed by the Oregon Office on Disability and Health (OODH) at Oregon Health & Science University. The workshop is offered in English and Spanish by OODH through Oregon's Independent Living Centers. Healthy Lifestyles uses an integrated wellness and empowerment approach and provides participants with knowledge and skills to adopt healthy behaviors.
  www.ohsu.edu/oidd/oodh/HL/index.cfm

- **Strong Women** is a group strength-training exercise program developed at Tufts University and designed for midlife and older women. Outcomes include increased strength, improved bone density, improved health and self-confidence.
  www.strongwomen.com/

Healthy Eating

- **Eat Better Move More** is a 12-week program developed for congregate meal program participants, and usually led by individuals with a nutrition background. Weekly 30 minute sessions provide basic activity and nutrition education and encourage participants to be physically active and eat a more healthy diet. A second 12-week series is available for sites that have completed the first series.
  http://nutritionandaging.fiu.edu/You_Can/index.asp

- **Healthy Eating for Successful Living in Older Adults** was developed by the Lahey Clinic in collaboration with other Boston-area organizations. This is both an education and support program to assist older adults in self-management of their nutritional health. The workshop is conducted over six weekly two-and-a-half hour sessions with a peer leader and a RD/nutritionist resource person.
  www.ncoa.org/improve-health/center-for-healthy-aging/healthy-eating-for-successful.html

- **Eat Smart, Live Strong** is a program designed to improve fruit and vegetable consumption and physical activity among low-income able-bodied 60-74 year olds who are eligible for SNAP or other publically-funded nutrition programs.
  http://snap.nal.usda.gov/resource-library/nutrition-education-materials-fns/eat-smart-live-strong

Care Transitions

- **Project RED** is also known as the Re-Engineered Discharge. This hospital-based program works with patients to organize post-discharge plans, follow-up visits, and patient understanding of their condition, medications, and warning signs.
www.bu.edu/fammed/projectred

Annotated List of Resources

Below is a list of the task forces that had more comprehensive policy recommendations and specific action steps. These task forces covered a wide range of topics versus one topic area. The boxed in task forces are recommended as being the most informative and helpful.

Clark County, WA
Growing Older in Clark County: Making Clark County a Better Place to Grow Up and Grow Old, Aging Readiness Task Force, February 2012.
http://www.clark.wa.gov/planning/aging/documents/12-0207_ARTF_Plan_Final_Maps_Complete_Print.pdf.

The task force, which consisted of members of the public at large and experts in a variety of fields, concentrated on healthy communities, housing, transportation and mobility, supportive services, and community engagement. The task force focused on creating a livable community defined by AARP as "one that has affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life."

Colorado
Colorado's State Plan on Aging, Governor John Hickenlooper, Department of Human Services, and Division of Aging and Adult Services, October 2011-September 2015
http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22SUA-StatePlanOnAging-2012-2015.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251774324162&ssbinary=true.

Colorado's State Plan's purpose is to provide a blueprint to increase organizational capacity in accordance with the Older Americans Act. The State Plan was created to fulfill Colorado's responsibilities to the Administration on Aging and to indicate future state activities, outcomes, and strategies.

Dane County, WI
Task Force on the Aging of Dane County, Area Agency on Aging of Dane County, March 2003
http://pdf.countyofdane.com/humanservices/aging/aging_task_force.pdf.

The task force was appointed by County Executive Kathleen Falk with the purpose of analyzing the implications and impact of increased longevity and a growing senior population. The task force was

charged with making recommendations to guide the County's response to the challenge of serving an aging population.

Hawaii
Hawaii State Plan on Aging, Executive Office on Aging, October 2011-September 2015.
http://www.hawaiiadrc.org/Portals/_AgencySite/State%20Plan_Final_AOAapproved_9_27_11.pdf.

The State Plan describes Hawaii's goals and strategies to ensure that long-term supports and strategies of older adults and individuals with disabilities, and their caregivers, are met. The State Plan was created for the U.S. Administration on Aging in accordance with the Older Americans Act.

Maturing of America
Maturing of America: Getting Communities on Track for an Aging Population, National Association of Area Agencies on Aging in partnership with the International City/County Management Association, National Association of Counties, National League of Cities and Partners for Livable Communities and funded by the MetLife Foundation.
http://www.n4a.org/pdf/MOAFinalReport.pdf.

The project surveyed 10,000 local governments to determine their aging readiness to provide programs and services to older adults and their caregivers, to ensure their communities are livable for all persons, and to harness the talents, wisdom, and experience of older adults to contribute to the community at large. The report then made recommendations based on those survey findings for the following areas: health, nutrition, exercise, transportation, public safety/emergency services, housing, taxation and finance, workforce development, civic engagement/volunteer opportunities, aging/human services, and policies/guidelines.

Orange County, NC
Orange County Master Aging Plan: Goals, Objectives and Strategies, Orange County Department on Aging, 2012-2017
http://www.co.orange.nc.us/aging/documents/FinalMAP4.20.12.pdf.

The Master Aging Plan is meant to comprehensively address the quality of life and health issues faced by the county's aging citizens, cover a wide range of topics from transportation to housing, and promote equity and diversity throughout the county.

Oregon
Governor's Task Force on the Future of Services to Seniors and People with Disabilities, Department of Human Services: Seniors and People with Disabilities, September 2002,
http://www.oregon.gov/dhs/spd/pubs/gtf/gtf_final.pdf.

Oregon is ranked tenth in the country for number of people over the age of 65, and they are projected to rank fourth in 10 years. The task force focused on the overarching issue of unprecedented demand for long-term care services. The task force recommended a cultural shift which included promoting personal responsibility for healthy behavior choices and preparing for future retirement; planning and sustainable growth in the housing, care, and services sectors; and financing achieved through a public-private partnership.

Below are the task forces that were devoted to a specific topic area. Those which are recommended as being informative and most helpful are boxed in for reference.

Aging of the American Workforce
Report of the Taskforce on the Aging of the American Workforce, Interagency Taskforce headed by the Department of Labor, February 2008
http://www.aging.senate.gov/letters/agingworkforcetaskforcereport.pdf.

The task force was created to address the challenges that an aging and retiring population has on the U.S. labor market including possible labor and skill shortages. The interagency task force's purpose was to identify these challenges and present workforce opportunities for the aging population. The task force focused on three main areas: (1) Employer response to the aging workforce, (2) Individual opportunities for employment, and (3) Legal and regulatory issues regarding work and retirement.

California
California Active Aging Network based on Marin County Task Force Model on Strength Training for Seniors, Established September 1996.
http://www.caactivecommunities.org/our-projects/california-active-aging-network/.

There are 31 California Active Aging Network task forces throughout California. They work to increase the number of Californians over the age of 50 that engage in daily physical exercise. These task forces use the California Active Communities' program model to implement community-based physical activity programs to improve strength, balance, mobility, functional fitness, and to reduce the risk of chronic disease and falls among older adults.

Center for Housing Policy
Housing an Aging Population: Are We Prepared? Center for Housing Policy, 2012
http://www.nhc.org/media/files/AgingReport2012.pdf.

The report examines the housing situation of older adults and the future implications of an aging population on housing. The report provides a detailed analysis of data from the American Housing Survey from the age group 65 and up and provides some final recommendations for handling housing issues for older adults.

Community Action Plan
The Williamsburg Community Action Plan on Aging: 2010-2020, A Report to the Senior Services Coalition of Williamsburg, Virginia, The Center for Excellence in Aging and Geriatric Health.
http://www.seniorservicescoalition.com/docs/CAPOA_Report.pdf.

The Community Action Plan establishes goals, strategies, and action steps to be implemented to ensure a more livable community for seniors. The plan included a needs assessment, demographic data, compilation of current community services and resources, and gathering input from the community via forums. Four priority areas were focused on as a result of the forums: (1) Awareness of and access to resources, (2) vulnerable seniors, (3) housing and neighborhood support, and (4) seniors as a resource.

Connecticut

Report of the Task Force to Study Aging in Place, Connecticut General Assembly, January 2013
http://www.cga.ct.gov/coa/pdfs/AginginPlaceTF/Aging%20In%20Place%20Task%20Force%20FINAL%20report.pdf.

The Aging in Place Task Force was established to address issues associated with infrastructure and transportation improvements, zoning changes, enhanced nutrition programs, improve fraud and abuse protection, expand home medical care options, tax incentives, and incentives for private insurance to help meet the needs to residents who wish to age in place.

Michigan

The Governor's Task Force on Elder Abuse, Michigan Office of Services to the Aging, August 2006.
http://www.michigan.gov/documents/miseniors/GovTaskForce_186155_7.pdf.

Governor Jennifer Granholm appointed the task force to meet between 2005 and 2006 to examine elder abuse issues and "identify new resources, best practices, and necessary changes in law and policies to assist in the prevention of elder abuse."

Minnesota

Reshaping Long-Term Care in Minnesota, State of Minnesota: Long-Term Care Task Force, January 2001
http://www.leg.state.mn.us/docs/pre2003/other/010126.pdf.

The long-term care task force was comprised of Minnesota legislators and state agency commissioners that met to address the states long-term care issues and develop strategies for handling those issues. Minnesota saw their increasing need for long-term care because the state had the second longest life expectancy and one of the highest proportions of persons age 85 and over in the country.

Snohomish County

Creating an Aging-Friendly Snohomish County, A five part series, Snohomish Health District
Series I. Voices from the Community: Focus Groups, July 2011
http://www.snohd.org/Shd_HS/Reports/FocusGrpSummary_Final.pdf.
Series II. Voices from the Community: Key Informants, November 2011,
http://www.snohd.org/Shd_HS/Reports/FinalKIReport.pdf.
Series III. Demographics of the Aging Population, April 2012
http://www.snohd.org/shd_hs/reports/finalelderlydemoreport.pdf.

This is a five part series conducted by the Health Statistics and Assessment Program at the Snohomish Health District in collaboration with the Senior Consortium of Snohomish County. The purpose of the series is to identify and understand the aging population within Snohomish County to define local priorities and identify gaps in social services. The series was completed with focus groups, health surveys, key informant interviews, and population-based data bases. Part four will include health care access data and part five will be population-based health data which have not yet been released.

Washington

Task Force on Long-Term Care Financing & Chronic Care Management, January 2008

Not available in electronic format. Please see the Office of Program Research for the hard copy.

Concerned that the number of Washingtonians aged 65 and older is set to double in the next twenty years, and a younger disabled population accounting for 37 percent of the population, the Washington State Legislature directed the task force to improve the state's ability to support the delivery of long-term care services that meet the current and future needs of Washington's citizens. The task force looked at advance planning and access to long-term care information, aging in place, support for informal caregivers, long-term care financing, chronic care, falls prevention, and health information technology.

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