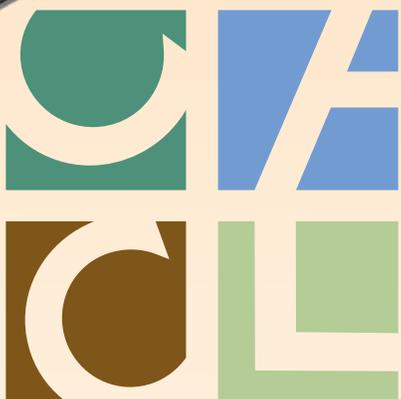


**COLLABORATING TO
CREATE ELDER
FRIENDLY
COMMUNITIES IN NEW
HAMPSHIRE**



**A SCAN OF
THE CURRENT
LANDSCAPE**



**CENTER ON AGING AND
COMMUNITY LIVING**

Collaborating to Create Elder Friendly Communities in New Hampshire: A Scan of the Current Landscape

Lead Authors:

Susan Fox, PhD

Laura Davie, MA

Alison Rataj, MSW

Research assistance provided by:

Leah Burke

Shikara Thody, MSW

Editorial assistance provided by:

Melissa Mandrell, MSW

Formatting provided by:

Stacey Gabriel, MPH

Marguerite Corvini, MSW

CACL thanks the Endowment for Health for their support in making this report possible. Endowment for Health staff who contributed to this report include:

Kelly Laflamme, MPA

Yvonne Goldsberry, PhD

Cheryl Dempsey

The Center on Aging and Community Living (CACL) is a collaboration between the Institute on Disability (IOD) and the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH). These two institutes have been actively engaged in projects related to aging and long term care for many years. Jointly, IOD and IHPP provide ongoing support in designing, implementing and evaluating systems change initiatives related to aging. CACL is a trusted university-based resource for applied research, evaluation and technical assistance, which will improve knowledge, policies and practices that guide New Hampshire citizens and policy makers in preparing for the aging of the population.

The Endowment for Health is a state-wide, private, nonprofit foundation dedicated to improving the health of New Hampshire's people, especially those who are vulnerable and underserved. The Endowment envisions a culture that supports the physical, mental, and social wellbeing of all people -- through every stage of life. The Endowment uses its voice and influence to lead others toward health-related policy change. The Endowment continues to shine the light on problems, bringing people together to plan and supporting their collective action to solve those problems. We are part of a community of organizations and individuals working together towards common goals, and using a set of common approaches to achieve those goals.

© 2015 UNH Center on Aging and Community Living and the Endowment for Health



Preface

September 2015

As we age, we all should have appropriate, affordable, accessible and equitable options for how, where and from whom we receive supports and services. These options should be person-centered and culturally effective. But the truth is that today's system of care for elders doesn't work this way for everyone.

The data is clear; New Hampshire is aging and aging quickly. The last U.S. Census revealed that New Hampshire was the fourth oldest state in the country. And by 2030, residents age 65 and over will be approximately one-third of the state's population.

The reality is that we are all aging and, assuming we live long lives, will all someday face challenges and choices about how and where we age. Most of us will need supports from health care professionals, supports for daily living, and the support of family and friends as we age.

Working together through a collective impact approach to address an aging New Hampshire, we can change that reality. Over the past year and a half, the Endowment for Health has had the pleasure and honor of working and learning alongside tireless advocates, service providers and elders themselves who care deeply about the health and well-being of our state's oldest residents. Together, we can realize our shared vision of communities where New Hampshire's culture, policies and services support our elders and their families and provide a wide range of choices that advance health, independence and dignity.

In a collective impact approach, the work begins with a shared understanding of the key challenges and opportunities before us and a commitment to solving it together through agreed upon actions and strategies. The process starts with mapping the landscape. This significant work by the Center on Aging and Community Living (CACL) at the University of New Hampshire is a knowledge base from which we will create shared goals, identify existing and emerging strategies and set a course for creating the elder-friendly communities we all want to live in as we age.

We at the Endowment for Health are incredibly grateful for the hard work of our partners at the University of New Hampshire Center on Aging and Community Living and the numerous stakeholders from across the state who contributed to this environmental scan.

Sincerely,



Kelly A. Laflamme, MPA
Program Director

Table of Contents

Introduction	1
Chapter 1: Fundamental Needs Are Met	10
Chapter 2: A Broad Range of Living Arrangements Are Available	25
Chapter 3: Support Provided to Caregivers and Families	39
Chapter 4: Social and Civic Engagement Options are Plentiful	49
Chapter 5: Quality Physical and Mental Well being Supports are in Place	57
Chapter 6: Advocates of Elder Issues Are Effective	87

INTRODUCTION

The fact that the population of the United States is aging is no surprise; the demographic projections are well documented. There have never been as many older adults living as there are today, and this number will only increase. Northern New England is aging more rapidly than the rest of the country, with Vermont, Maine, and New Hampshire having the oldest populations in term of median age (U.S. Census, 2014). New Hampshire is expected to be the fastest aging state in New England through 2030, with nearly one-third of its population being over the age of 65 (Norton, 2011). This phenomenon is anticipated to place substantial pressure on publicly-funded health programs and long-term services and supports in the Granite State.

But the story of the aging of the population is not only about increased numbers. As longevity increases, the average age of the older population will see a dramatic increase. The number of persons over the age of 85 in the United States is expected to increase five-fold by 2040. As the possibility for functional limitations and disability increases with age, the need for long-term, formal, and informal supports is expected to increase as the number of older adults, particularly those over the age of 85

increases. In addition, women continue to live longer than men; on average, life expectancy for women is three years longer than for men. These factors create a complex picture of aging, which includes a growing population of older adults, a majority of whom will be women; and a growing number of those over the age of 85, who are more likely to require some type of assistance as they age.

It is a mistake to look at our aging population in a singular way. Although we tend to make generalizations about older adults, as a group, they are more physiologically and socially diverse than any other age group (Brummel-Smith & Mosqueda, 2003). As we age, we become more and more diverse, as there are no two people who have had the same life experiences, shaping who we are over our lifetimes. The baby boomers (those born between 1946 and 1964) are likely to be the most diverse cohort of older adults we have seen to date, and it is likely that they will redefine our conception of age and aging. Older adults bring a diverse set of skills, talents, and knowledge that should be tapped as a significant natural resource to support a new and exciting vision of aging.

Redefining Aging

In order to redefine our concept of aging we need to create a shared vision of our future and build a collective will to work toward that vision. To this end, a broad spectrum of community stakeholders has been engaged in creating a vision of “elder friendly communities” for New Hampshire.

This body envisions a future where New Hampshire’s culture, policies and services support elders and their families, providing a wide range of choices that advance health, independence and dignity. The group’s work was influenced by the World Health Organization’s (WHO) definition of an “age-friendly world” which identifies eight interconnected domains related to creating



age-friendly communities. The WHO identifies community and health care, transportation, housing, social participation, outdoor spaces and buildings, respect and social inclusion, civic participation and employment, and communication and information as important domains in creating an “age-friendly world”(WHO, 2014). Building on this framework, the New Hampshire group identified six key domain areas as critical to the creation of elder friendly communities in New Hampshire. These domains are represented in the wheel.

The “collective impact” model is being utilized to build a movement to transform how New Hampshire thinks about aging. The collective impact model brings participants from different sectors together to cooperate on a common agenda for solving a specific social problem, using a structured form of collaboration (Hanleybrown, Kania, & Kramer, 2012). Collective impact hinges on the idea that in order for organizations to create lasting solutions to social problems on a large scale, they need to coordinate their efforts and work together around a clearly defined goal. There are five key conditions that distinguish collective impact from other types of collaboration: agreement on a common agenda, collecting shared data to measure

results consistently, participating in mutually reinforcing activities, maintaining consistent and open communication, and dedicated staff to serve as the backbone support for the entire initiative.

Vulnerability in Aging

Poverty is an important indicator to consider when assessing how well individuals are able to address their basic needs for food, shelter, health care, and transportation. Cubanski, Casillas, and Damico (2015) conducted research through the Kaiser Foundation and reported poverty rates for persons over the age of 65 at 10% of the U.S. population. This rate is lower than rates for children under the age of 18 (20%) and adults between 19 and 64 (13%), primarily due to the fact that older adults have income from social security.

Poverty levels vary based on household size and age. The 2015 U.S. Federal Poverty Guidelines, published by the U.S. Department of Health and Human Services in the Federal Register, are used by the Census Bureau to prepare estimates of the number of individuals and families in poverty. These guidelines are used as the eligibility criterion for many federal programs.

Annual Update of the HHS Poverty Guidelines, (2015)

Household Size	Poverty Guideline
One	\$11,770
Two	\$15,930
Three	\$ 20,090
Four	\$24,250
Five	\$ 28, 410
Six	\$ 32,570
Seven	\$36, 730
Eight	\$ 40,890

While poverty rates are lower among adults over the age of 65, this is often a misrepresentation of whether and how their basic needs are being met. A better measure of how well individuals are able to meet their basic needs may be economic security. Wider Opportunities for Women (WOW, 2013a) defines economic security as the income level at which older adults are able to cover their basic living expenses without the use of public or private assistance. WOW publishes a series of fact sheets assessing the economic security of U.S. elders. Their data indicate that economic insecurity varies by gender and race. Half of all women over the age of 65 are economically insecure, as compared to 40% of men over the age of 65. Race is also an important factor in economic insecurity, with 72%

of African-American women and 77% of Hispanic women experiencing an economic security gap. Based on their analysis, the economic security gap for New Hampshire seniors is \$7,842, placing New Hampshire eighth in the nation in terms of lack of economic security for elders (WOW, 2013b). For more information visit their website ⁽¹⁾.

Methods

This study was conducted by researchers at the University of New Hampshire, Center on Aging and Community Living. It is intended to inform the collective impact process by providing data to help inform stakeholders about current research, best practices in the field, and the current landscape in New Hampshire. The report is divided into sections according to the six key domain areas identified by the state’s emerging Elder Health Advisory Committee.

Research began in each key domain area by using terms pertinent to the domain name and aging, utilizing a variety of search engines through the UNH Library (including Social Science Citation Index, Social Work Abstracts, and PsycINFO). National best practices were identified as programs,

located anywhere in the country including New Hampshire, for which published research was available that indicated positive program outcomes.

Google searches were used frequently to find specific programs that are cited in the report. New Hampshire advocates, program directors, aging experts, and others were consulted to clarify information obtained on New Hampshire programs.

A draft of the report was presented to the Elder Health Advisory Committee on June 25, 2015, which yielded further suggestions for inclusion in the report. A number of Advisory Committee members provided additional information and data, which is included in the final version of the report. While we made every effort to identify New Hampshire programs within each domain, the report is not exhaustive. We know there are many other examples of important programs and initiatives. This report is intended to be a starting place for an action planning process that will result in specific goals and activities to achieve the vision of creating elder friendly communities throughout New Hampshire.

Highlighted Recommendations: “A Scan of the Current Landscape”

Based on the findings of this environmental scan and the input of advisory committee members, experts in the field, and personal communications, a number of recommendations emerged that are summarized here.

Support a Broad and Diverse Coalition to Guide This Work

The work outlined in this report will require the collective efforts of a broad and committed constituency. A coalition of interested advocates, organizations, policy makers, and community members will be needed to guide this work and to maintain the momentum that is being built through the planning process. The time is right to engage in this work if we are to realize the vision of elder friendly communities across New Hampshire.

Engage Local Communities to Address the Needs of Their Aging Population

Solutions to meeting the needs of New Hampshire residents as they age must be coordinated at the local level in a way that ensures

Introduction

that residents' needs, as well as the needs of their family and paid caregivers, are addressed. Easy access to clear and understandable information, education, and training is critical for older adults, their family caregivers, and others who endeavor to support them. Funding for basic community safety net services is continually at risk, and it will be important for local communities to advocate for the resources they need to meet this growing need.

Engage Minority Communities to Ensure Culturally Appropriate Services

Issues related to creating elder friendly communities span all ethnic groups and populations. It is important to understand the needs across all populations, including ethnic minorities; people of color; immigrants; refugees; and the lesbian, gay, bisexual, transgender (LGBT) community. Programs and services should be culturally appropriate to meet the needs of all New Hampshire families. Leaders within minority communities must be involved in discussions and decision making at all levels.

Establish a Northern New England Task Force on Technology and Aging

Technology holds much promise in increasing access to health care, needed services, and transportation; enhancing options for aging in community; increasing civic and social engagement; and improving health outcomes. It is recommended that a summit on technology and aging be convened, across the northern New England states, to address the broad range of issues related to technology, aging in place, and access to health care. The creation of a task force on technology and aging could help to identify and promote technological developments that have the potential to support older adults to live and thrive in their homes and communities.

Support the work of the State and Regional Coordinating Councils to Develop Transportation Solutions

Mobility and access to community services is a critical aspect of an elder friendly community, yet transportation continues to be one of the most intractable problems facing New Hampshire. The work of the State and Regional Coordinating Councils to coordinate transportation services throughout the

state must continue to be supported.

Educate Employers About the Benefits of an Older Workforce and Promote the Development of Family-Friendly Workplace Policies Across the Lifespan

Employers need to be engaged on many levels. Employers need information about the needs of their employees who are caregivers, as well as the value of hiring older adults. Employers should be provided with information and support to develop family-friendly workplace policies and benefits that provide flexibility for older workers, as well as support family caregivers across the lifespan.

Improve the Recruitment, Training, and Retention of a Broad Range of Health Care Workers

In the coming years, New Hampshire will need to recruit, train, and retain a broad range of health care workers, including physicians, nurses, home care workers, community health workers, and direct support professionals. Efforts to provide a livable wage for home care workers should be supported. This work needs to include employers, state policy makers, and legislators in order to improve the

recruitment, training, and retention of this critical workforce.

Develop a Comprehensive Communication and Public Engagement Campaign

In order to impact change around aging -related issues and promote elder friendly communities, society's view of aging needs to change, includes stereotypes, stigma, and our fear of aging and dying. Cultural views of older adults that are positive and realistic must be promoted. In order to frame a positive image of aging, a comprehensive communication and public engagement campaign is needed. A multipronged approach that reaches out to key players across different sectors is imperative if we are to find creative solutions to address the changing needs of an aging population. The general public, legislators, municipal officials, policymakers, housing developers, community service providers, and business leaders need to be engaged in a dialogue about the needs of older residents at the state, regional, and local levels.

Establish a Grassroots Advocacy Movement

An issue that cuts across all of the key domain areas is the need to establish a grassroots advocacy movement in order to work to make aging issues a community-wide priority. The movement should engage community members across generations; promote collaboration across organizations, businesses, and community leaders; educate the public about aging issues; and utilize technology to reach the largest possible constituency. Building on existing efforts in New Hampshire, a more strategic and effective approach is needed to build an effective, state-wide advocacy network.

The vision developed by the Elder Health Advisory Committee to promote elder friendly communities “where New Hampshire’s culture, policies and services support our elders and their families, providing a wide range of choices that advance health, independence and dignity” can be realized through the collective efforts of those who have come to the table to provide their voice, expertise, and resources. The information and recommendations contained in this report should serve as a resource and starting point for the planning effort that is being undertaken, not as the final word on any of the six domain areas being addressed.

References

- Annual Update of the HHS Poverty Guidelines; HHS Notice, 80 (14) Fed. Reg. 3236 (January 22, 2015).
- Brummel-Smith, K., & Mosqueda, L. (2003). Stages of human development. In R.B. Taylor (6th Eds.). *Family medicine principles and practice* (pp. 10 – 17). New York: Springer-Verlag Inc.
- Cubanski, J., Casillas, G., & Damico, A. (2015). Poverty among seniors: An updated analysis of national and state level poverty rates under the official and supplemental poverty measures. Retrieved from The Kaiser Foundation: <http://files.kff.org/attachment/issue-brief-poverty-among-seniors-an-updated-analysis-of-national-and-state-level-poverty-rates-under-the-official-and-supplemental-poverty-measures>
- Hanleybrown, F., Kania, J., & Kramer, M. (2012). Channeling change: Making collective impact work. Retrieved from Stanford Social Innovation Review: http://www.ssireview.org/blog/entry/channeling_change_making_collective_impact_work
- Norton, S. (2011). New Hampshire’s silver tsunami: Aging and the health care system. Concord: New Hampshire Center for Public Policy Studies.
- U.S. Census (2014). New Hampshire quick facts. Retrieved from: <http://quickfacts.census.gov/qfd/states/33000.html>
- Wider Opportunities for Women (WOW). (2013a). Living below the line: Economic insecurity and older Americans. (Issue Brief: No. 2). Retrieved from: <http://www.wowonline.org/wp-content/uploads/2013/09/Living-Below-the-Line-Economic-Insecurity-and-Older-Americans-Women-Sept-2013.pdf>

Wider Opportunities for Women (WOW) (2013b). The economic security scorecard: Policy and security in the states. Retrieved from: <http://www.wowonline.org/wp-content/uploads/2013/05/WOW-Economic-Security-Scorecard-2013.pdf>

World Health Organization (WHO) (2014). Age friendly world. Retrieved from <http://agefriendlyworld.org/en/>

Website Links

(1) Wider Opportunities for Women: <http://www.wowonline.org/>



FUNDAMENTAL NEEDS ARE MET

THE ELDER HEALTH ADVISORY COMMITTEE IDENTIFIED FUNDAMENTAL NEEDS AS: "FOOD, SAFETY, INFORMATION ABOUT SERVICES, SHELTER AND WARMTH, AND TRANSPORTATION."

The World Health Organization (WHO) identifies protecting those who are most vulnerable as a key component of age-friendly communities. At the most basic level, a community must be able to meet the fundamental needs of older adults for food, shelter, safety, and transportation. Meeting these basic fundamental needs is important for overall health in older adults. Lack of these supports is a significant predictor of mortality rates; Blazer, Sachs-Ericsson, and Hybels (2005) note that when older adults perceive their basic needs are unmet they are more susceptible to higher mortality rates. An assessment of the availability of supports to meet these fundamental needs is critical in evaluating the overall health and well-being of older adults in the New Hampshire.

There are a number of federal and state programs that address transportation, food security, shelter, and heating assistance for low-income older adults. However, most of these programs have stringent criteria including age variability between programs and income eligibility guidelines that restrict access to those with moderate to

low incomes who may not be able to meet their basic needs. Overall, only about half of American communities have thought about how to address the needs of an older population that will double over the next 25 years. A nationwide survey of 2,000 communities conducted by the National Association of Area Agencies on Aging, the International City/County Management Association, the National Association of Counties, and the National League of Cities and Partners for Livable Communities, found that many have basic health and nutrition programs for older adults, but few have done a comprehensive assessment of how they can help older residents remain independent and productive (Moos, 2006).

The Current Landscape in New Hampshire

While poverty rates for persons over the age of 65 nationally are lower than for either children or adults under the age of 65, poverty rates increase dramatically with age. Based on analysis of data derived from the 2012 U.S. Census

American Community Survey of people living in New Hampshire, Rollins (2015) found that 15.5% of adults over the age of 75 and 24.8% over the age of 85 are living in poverty. A greater percentage of older women in New Hampshire live in poverty than older men, with 18.2% percent of women over the age of 75 living in poverty compared to 11.4% of men.

There were variations in poverty levels by county. For those 75 and older, the poverty rate ranges from just under 13% in Strafford County to 19.5% in both Carroll and Belknap Counties. For those over the age of 85, Rockingham County has the lowest poverty rate at 19.9% , while Coos and Grafton top the list with poverty rates of 31.4% in both counties.

Household sizes across New Hampshire range between 1.8 and 2.2 members for those over the age of 75, dropping to 1.6 to 2.3 over the age of 85. Additionally, New Hampshire is considered a primarily rural state, with 40% of the population living in rural and small towns.

The harsh winter conditions and lack of reliable, state-wide public transportation impact how basic needs for safety, shelter, warmth, food, and transportation are met for this most vulnerable population.

While New Hampshire ranks above average on many national indicators related to the well-being of older adults, many older adults may be falling through the cracks. Seniors Count NH (2015) reports on their website that:

- 40% of Manchester’s frail seniors are seriously limited in the ability to move freely and care for themselves.
- 50% of Manchester residents age 65 and older live alone and are at high risk for accidents, depression, and isolation.
- Many seniors are living without proper nutrition or medication.
- 30% of Manchester’s inner city seniors have no vehicle, 12% have no phone, and 26% live below the poverty line.
- Many services are available to seniors, but they don’t know how to or cannot afford to access them for their basic needs.
- Basic services, such as assistance with bill paying, grocery shopping, and transportation are among the most serious service gaps in Manchester.

Chapter 1

Manchester is likely to have the largest urban area of New Hampshire, with greater access to health and human services, than rural areas of the state. It is expected that seniors living in more rural areas of New Hampshire would have similar, if not greater, challenges in accessing basic supports and services.

This section outlines the programs and services available to older adults in New Hampshire to meet their fundamental needs in the areas of nutrition, safety, access to information about services, shelter and warmth, and transportation.

Nutrition

The USDA defines food insecurity as “the state of being without reliable access to a sufficient quantity of affordable, nutritious food.” New Hampshire ranks highly on measures of food security when compared to other states. The 2014 report on food insecurity among older adults, published by AARP, ranks New Hampshire among the five top states, with 92.3% of persons over the age of 60 identified as meeting the criteria for high food security (Strickhouser, Wright, and Donley, 2014). New Hampshire has a number of food assistance programs, including Meals on Wheels, Supplemental Nutrition Assistance Program (SNAP), Commodity

The WHO defines elder abuse as “a violation of human rights and a significant cause of illness, injury, loss of productivity, isolation, and despair.”

New Hampshire state law (RSA 161-F:43) defines abuse as “emotional, physical, or sexual conduct that results in injury or mental anguish of an incapacitated adult.”

Neglect is defined as “an act of omission which results or could result in the deprivation of essential services necessary to maintain the minimum mental, emotional, or physical health and safety of an incapacitated adult.”

Exploitation is defined as the “illegal use of an incapacitated adult’s person or property for another person’s profit or advantage, or the breach of a fiduciary relationship.... through the use of undue influence, harassment, duress, deception, or fraud.”

Self-neglect is defined as “an act or omission by an incapacitated adult which results or could result in the deprivation of essential services or supports necessary to maintain his or her minimum mental, emotional or physical health and safety.”

Supplemental Food Program (CSFP), food pantries, and other church and community organized food programs. Many of these food programs are not income-based, including Meals on Wheels, food pantries, local churches, and senior centers that offer hot meals. According to New Hampshire 2-1-1, a state-wide hotline that provides information and referral to services, there are 67 locations across the state that provide food assistance to residents of all ages.

In 2012, Meals on Wheels delivered more than 1.2 million meals to 11,596 people in New Hampshire. Congregate meals are served at Senior Centers throughout the state, and approximately 380,000 meals are served each year. Eligibility for these meal programs are not income-based, and there is no waiting list at this time. There is no fee to participate, but many sites request a small donation for meals.

In addition, SNAP (Supplemental Nutrition Assistance Program), previously known as the Food Stamp Program, serves 3.4% of seniors over the age of 75 and 3.7% of those over the age of 85 in New Hampshire (Rollins, 2015). National data indicates that approximately 25% of eligible New Hampshire residents over the age of 60 were enrolled in SNAP benefits in 2009, ranking New Hampshire 44th in the country in terms of SNAP participation rates (Cunyngham, 2010).

The Commodity Supplemental Food Program (CSFP) is a nutrition program that provides free food and nutrition information to promote good health for persons aged 60 and over. The program is available to those over the age of 60 whose income falls below 130% of the poverty guidelines. The program distributes food commodities each month.

In addition, participants can access fresh, locally grown fruits and vegetables from New Hampshire farmers during July and August, distributed through CSFP clinic locations across the state.

Safety

The health and safety of New Hampshire residents is of utmost importance. Elder abuse is far too common and women are abused at a higher rate than men (NCEA, 2015). Recent studies indicate national incidence rates of 7.6% to 10% of study participants reporting abuse (Acierno et al., 2010). The National Center on Elder Abuse (2015) indicates that reports from state Adult Protective Services agencies show an increasing trend in the reporting of elder abuse, with financial exploitation being the most frequently reported type of abuse.

The New Hampshire Bureau of Elderly and Adult Services (BEAS) is charged with investigating reports of abuse, neglect, and exploitation of incapacitated adults. Reports of suspected abuse, neglect, and exploitation are made to BEAS and investigated by the Office of Adult Protective Services. BEAS, law enforcement, legal advocates, and community providers work in partnership through an Elder Abuse Advisory Council that

Chapter 1

provides public education and awareness, develops resources and supports services, works to improve community relations, and examines and recommends legislation related to abuse, neglect, and exploitation of incapacitated adults (DHHS, 2011a). In addition, the Office of Long Term Care Ombudsman (OLTCO) investigates and resolves complaints or problems of residents residing in long-term health care facilities. The OLTCO provides services in the areas of prevention, intervention, and advocacy.

New Hampshire Legal Assistance (NHLA) offers legal assistance to persons over the age of 60 through the Senior Law Project (SLP). The SLP assists New Hampshire's seniors with a variety of civil legal problems with a focus on illegal/abusive debt collection, financial exploitation, and long-term care residents' rights. These legal services are available to low income seniors and include legal advice, short term services, and extended representation by attorneys and trained paralegals. The SLP also engages in outreach and education efforts to increase awareness of the legal rights of seniors (New Hampshire Legal Assistance, n.d.).

Elders have consistently been the target of scams. With recent technological advances, a

new generation of scams has amplified the issue, particularly around online scams and identity theft. According to the Federal Trade Commission, the number of complaints about consumer fraud against seniors has more than doubled since 2009 (Gotbaum, 2012). The state consumer protection bureau at the New Hampshire Attorney General's office receives complaints of these types of scams monthly.

The Coalition Against Later Life Abuse (CALLA) grew out of work by the Merrimack County Coordinated Community Response Team to provide a model of coordinated response to elder abuse. CALLA includes representatives from law enforcement, prosecution, adult protective services, financial services, emergency medical services, elder services, legal services, home care services, health care, mental health, long-term care, and faith communities. CALLA focuses its activities on the education of its members, the general public, and service providers from all sectors. The group utilizes a multidisciplinary, collaborative approach to identifying and addressing the challenges and complexities of later life abuse. One of its subcommittees, Financial Abuse Specialty Team (FAST), further supports CALLA's work by focusing

specifically on elder financial exploitation and increasing the ability of professionals to recognize, investigate, and stop exploitation (C. Steinberg, personal communication, July 1, 2015).

Environmental safety is another crucial consideration for many community-dwelling older adults, as many seniors want to remain living in their family home but do not have the funds and/or capacity to keep up with home maintenance and repairs. This can create a serious safety issue as homes deteriorate. Local organizations, such as Seniors Count in Manchester, senior services organizations, Community Action Programs, and ServiceLink Aging and Disability Resource Centers (SLRC) provide outreach and assistance to frail seniors to help them remain safe in their homes. New Hampshire 2-1-1 lists 13 home maintenance and repair services that offer volunteer or low-cost handyman or fix-it services. Examples include Community House Calls in Chester; Cover Home Repair; in White River Junction, VT, and Community Toolbox in Portsmouth. An innovative volunteer approach is Those Guy's in Lyme, NH. Those Guy's is a men's service organization that will assist with minor household repairs, yard work, etc. to support residents to age in place.

Access to Information About Services

Many states, including New Hampshire, provide information regarding elder services through the local Aging and Disability Resource Center (ADRC) network. In New Hampshire, the ADRCs are also known as ServiceLink Aging and Disability Resource Centers (SLRC). The SLRC network is New Hampshire's single entry point for all New Hampshire residents, regardless of age, disability, or income levels, for information and assistance in navigating the spectrum of long-term services and supports. The SLRC website contains a resource directory, which enables older adults and their families to search for services in their area ⁽²⁾. According to a 2014 report compiled by AARP, The Commonwealth Fund and the SCAN Foundation (Reinhard, Kassner, Houser, Ujvari, Mollica, & Hendrickson, 2014), New Hampshire's SLRC network has been ranked #1 in the country in terms of offering a full range of information and referral services and serving as a single entry point for persons needing assistance in accessing services.

Similarly, New Hampshire 2-1-1 provides a toll free phone number and website that provides information regarding services throughout the state.

Chapter 1

2-1-1 is a collaboration with Granite United Way, Eversource Energy (formerly Public Service of New Hampshire), and the State of New Hampshire ⁽³⁾. In addition, some communities and agencies have developed resource guides specific to community services available in their area.

Shelter/Warmth

Winters in New Hampshire can pose a threat to many residents, especially older adults living independently in their homes, as heating homes during the colder months can be costly. Ensuring adequate shelter and warmth, is vital to assisting older adults to remain safely at home, and there are programs that can offer assistance. The Low Income Home Energy Assistance Program (LIHEAP) offers heating and weatherization assistance through local community action programs. The program is available to residents whose income falls below 200% of poverty. According to the New Hampshire Office of Energy and Planning (2014), 36,011 households received an average benefit of \$658 in the 2013 – 2014 heating season. Data is not available based on age of the households receiving benefits, but the benefit is available to all households regardless of age.

Generally, homelessness among adults over the age of 65 is relatively low. Corporation for Supportive Housing (CSH, 2011) reports a homelessness rate of about 4.2% nationally, but notes that this number is rising as the population of older adults increases. The low rate of homelessness is largely due to the variety of safety nets in place for older adults, including subsidized housing, Medicare, and Social Security as well as higher mortality rates among the older homeless population. New Hampshire provides funding to about 42 homeless shelters around the state. Granite United Way, in partnership with 2-1-1, provides information related to emergency housing and shelter (DHHS, 2011b). Finding more permanent and affordable housing can be a challenge, as the average wait for subsidized housing for older adults ranges from 1-2 years.

Transportation

Access to safe, reliable, accessible, and affordable transportation is a critical component of an age-friendly community. Transportation helps seniors to access needed medical care, groceries, community services, and social events. Lack of transportation leads to isolation, which has been found to be linked to greater health risks (Cornwell &

Waite, 2009). This is especially true for seniors living in rural communities, where access to transportation is limited.

Transport NH is a network of organizations throughout the state working to create an integrated transportation system that gives people options for getting around. According to their website, their vision is that “transportation in the Granite State drives a vibrant New Hampshire economy and supports healthy people, healthy communities and a healthy environment.” They promote safe, affordable, and accessible transportation that helps build a strong economy and healthy environment ⁽⁴⁾.

In 2007, the New Hampshire legislature established the State Coordinating Council (SCC) for Community Transportation, with representation from the state departments of Transportation, Health and Human Services, and Education; the Governor’s Commission on Disability; transit providers; the UNH Institute on Disability; NH AARP; Easter Seals; the community action agencies; regional planning commissions; the Coalition of Aging Services; and Granite State Independent Living. The SCC works with Regional Coordinating Councils (RCCs) in nine community transportation regions. The role of the RCCs is to develop

information that is helpful to transportation service users, identify opportunities for coordination between service providers, and advise the SCC regarding transportation coordination issues in their region (NHDOT, 2015).

A number of agencies provide transportation services in New Hampshire, but information on transportation options for seniors is not easily organized or accessible. Transport NH has created a resource that lists all transportation options in New Hampshire and is presented in a user friendly manner ⁽⁵⁾. For further assistance in finding transportation options, seniors can call their local ServiceLink Aging and Disability Resource Center.

Best Practices Nationally

Nutrition

Meals on Wheels is the largest and oldest community-based senior food nutrition program and is a proven best practice. The program provides more than just food to older adults living at home: it provides a sense of security and lessened feelings of isolation. Thomas and Mor (2013) found that states that spent more on home-delivered meals had fewer people with low care needs placed in nursing homes.

Chapter 1

They concluded that investments in community-based service networks result in lower utilization of nursing homes by persons with low care needs. A subsequent research study found that older adults on a waiting list for daily meal delivery reported poor self-rated health, screened positive for depression and anxiety, reported recent falls and fear of falling that limited their ability to stay active, were likely to require assistance with shopping or preparing food, and have hazards both inside and outside the home (Thomas & Dosa, 2015). In comparison, study participants who received daily home delivered meals showed greater improvements in anxiety, self-rated health, isolation, and loneliness, and had lower rates of hospitalizations and falls than those on the waiting list. These findings point to the benefits to both older adults and the long-term care system of a small investment in home delivered meals.

Safety

According to the National Center on Elder Abuse (NCEA, 2015), the exact number of people who experience elder abuse and neglect is unknown. National best practice guidelines recommend that the values, interests, and preferences of the vulnerable adult be the primary concern of any abuse and neglect investigation. While it is imperative to

ensure the health and safety of older adults, it is also important to maximize the vulnerable adult's independence and choice, to the greatest extent possible. Adult protective workers need to look for the least restrictive services first, pursue community-based services whenever possible, utilize family and informal support systems (as long as this is in the best interest of the individual), use substituted judgment in case planning when historical knowledge of the adult's values is available, and remember that inadequate or inappropriate intervention can be worse than no intervention.

The Elder Justice Roadmap is a resource for strategic planning to combat elder abuse. It was developed by the NCEA as the culmination of input solicited from 750 stakeholders and experts in the field. The roadmap identifies priorities and strategies for public and private engagement at the local, state, and federal levels. Strategies are categorized into four domains, including direct services, education, policy, and research. Priorities include increasing awareness of elder abuse, conducting research on brain health, better support and training for caregivers, quantifying the cost of elder abuse, and strategically investing more resources (Connolly, Brandl, & Breckman, 2015).

Access to Information About Services

The Aging and Disability Resource Center Program (ADRC) is a collaborative effort of the U.S. Administration on Community Living and the Centers for Medicare & Medicaid Services (CMS). ADRCs serve as single points of entry into the long-term supports and services system for older adults and people with disabilities. ADRCs promote “a single entry point” in the hopes of addressing the frustrations consumers and their families experience when trying to find needed information, services, and supports. ADRC programs provide information and assistance, advice, and person-centered options counseling to help people to make decisions about their long term supports.

2-1-1 is a national hotline number providing information and referral to services. Many 2-1-1 programs throughout the country partner with independent nonprofits specializing in information and referral services; others may have 2-1-1 as a program within a United Way, a crisis center, area agency on aging, public library, or county government. More recently, there has been an emphasis on partnering with ADRCs for their streamlined process and person-centered approaches.

Shelter/Warmth

The Elders Living at Home Program, run by the Boston Medical Center, has been in existence for 25 years and is recognized as a best practice in homelessness prevention by the Massachusetts Interagency Council on Housing and Homelessness (ICHH). Participants must meet certain requirements including age, income, and being homeless or at risk of losing housing. The program provides emergency shelter and helps homeless elders find stable housing. They partner with three area housing authorities, to find stable housing for program participants (Boston Medical Center, 2014).

Transportation

The National Center on Senior Transportation provides a variety of resources on best practices around the provision of transportation services. There are a number of examples of best practices that we can learn from, even though the rural nature of New Hampshire calls for innovative approaches. One such example is a program, MyRide2, in Michigan, operated by the Area Agency on Aging, which uses a one-call/one-click mobility management service that assists seniors and adults with disabilities with locating transportation options. A mobility

specialist handles anything related to mobility and transportation needs, from older driver safety and finding transit options to scheduling rides for older adults and persons with disabilities ⁽⁶⁾. In Northern Virginia, service providers partner with local transportation providers, which has proven to be an efficient and effective method to expand senior transportation options ⁽⁷⁾. In Northern Virginia's rural areas, seniors rely heavily on volunteer-based programs, such as the Retired Senior Volunteer Program, which matches volunteer drivers with persons needing transportation services, although funding for this service has been reduced.

Programmatic, Policy, and Research Implications

While there are a number of programs and services that are designed to address the various needs of frail seniors, they are often at risk of funding cuts. There is also a lack of coordination across programs. It is often an overwhelming process for seniors to determine where and how to meet their needs for support. Rather than focus on individual program needs, which engenders fractured and discrete services, future research and program

development should focus on effective strategies to integrate services and supports to meet the needs of the whole person. It will also be important to look at differences across New Hampshire in how services are provided in order to meet the unique needs of both rural and urban residents.

There is a marked lack of awareness of available services, despite the best efforts of the SLRCs and 2-1-1 to educate the public about their services. Further efforts are needed to determine the most effective methods for reaching older adults and their caregivers across the state.

It is generally understood that New Hampshire is a largely rural state and much of the population has little access to transportation options, but there is currently little data to support this understanding. In 2005, a survey was conducted of 749 New Hampshire residents to document their perceptions of and access to transportation. The survey was a collaborative effort between the University of New Hampshire, the Merrimack-Belknap County Community Action Program, and the Endowment for Health. The survey found the majority of respondents felt that public transportation should be available in their area, especially for people with disabilities and older adults. The responses indicated people would

be willing to pay more in taxes and fees to access transportation (Antal, Dornblut, & McIver, 2005). These same transportation questions are being included in the current Granite State Poll in order to assess if, and how, public opinion has shifted over the last two years. Additionally, NH DOT Rail & Transit has commissioned the first-ever state-wide study of transit and community transportation. Among the outputs of the study will be an inventory of transportation services and identification of gaps. The study will start in early 2016, and will be published in 2017 (R. Harris, personal communication, July 2, 2015). These data will be very helpful as New Hampshire continues to struggle with quantifying and meeting the transportation needs of its most vulnerable residents.

Recommendations

Increased Care Coordination

In order to holistically address the fundamental needs of New Hampshire residents as they age, services must be coordinated at the local level in a way that ensures that each individual's needs for nutrition, safety, warmth/shelter, transportation, and information are met.

For example, Community Care Coordination models offer partnerships between health care professionals, clinics and hospitals, specialists, pharmacists, mental health professionals, and community services to provide patient-centered, coordinated care.

Increased Communications

It is important to continue to find creative and innovative ways to reach out to New Hampshire's most vulnerable seniors and their families in order to ensure they are aware of the resources available within their community. Listings of community resources need to be available in both print and electronic formats, as well as in a variety of languages.

Increased Funding

Funding for these basic community safety net services is continually at risk at both the federal and state budget level. Research has proven that a small investment in these community-based services can delay unnecessary nursing home placement (Thomas & Mor, 2013). It is critical that New Hampshire maintain adequate funding for this critical, community-based safety net infrastructure.

References

Use Elder Justice Roadmap

The incidence of elder abuse, exploitation, neglect, and fraud is growing across the country. New Hampshire should utilize the Elder Justice Roadmap, developed by the NCEA, as a framework for developing a comprehensive response to this growing concern.

Increased Transportation

Transportation continues to be one of the most intractable problems facing New Hampshire. Despite progress that has been made in coordinating transportation services across the state, the lack of affordable, accessible, and reliable transportation continues to be raised as a major barrier to community living for vulnerable populations. The advent of Medicaid Care Management has shifted the players and landscape of transportation coordination, and future solutions will need to go beyond the nonprofit agency model. It will be important to develop creative partnerships among NH DHHS, DOT, local communities, and transportation providers to find innovative and cost effective ways to address New Hampshire's transportation issues.

Acierno, R., Hernandez, M., Amstadter, A., Resnick, H., Steve, K., Muzzy, W., & Kilpatrick, D. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The national elder mistreatment study. *American Journal of Public Health, 100*(2), 292-297. doi:10.2105/AJPH.2009.163089

Antal, P., Dornblut, S., & McIver, M. (2005). New Hampshire resident views on the use, availability, and need for public transportation. Retrieved from the Institute on Disability/UCED at the University of New Hampshire, Community Action Program Belknap-Merrimack Counties, and Endowment for Health: <http://www.iod.unh.edu/pdf/New%20Hampshire%20Resident%20Views%20on%20the%20Use%20Availability%20and%20Need%20for%20Public%20Transportation%20Dec%202005.pdf>

Blazer, D. G., Sachs-Ericsson, N., & Hybels, C. F. (2005). Perception of unmet basic needs as a predictor of mortality among community-dwelling older adults. *American Journal of Public Health, 95*(2), 299-304. doi:10.2105/AJPH.2003.035576

Boston Medical Center. (2014). Elders living at home program. Retrieved from: <http://www.bmc.org/eldersathome.htm>

Connolly, Marie-Therese, Brandl, Bonnie, & Breckman, Risa (2015). The Elder Justice Roadmap: A Stakeholder Initiative to Respond to an Emerging Health, Justice, Financial and Social Crisis. National Center on Elder Abuse, Administration on Aging. Retrieved from: http://www.ncea.acl.gov/Library/Gov_Report/index.aspx

Cornwell, E. Y., & Waite, L. J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of Health and Social Behavior, 50*(1), 31-48.

Corporation for Supportive Housing (CSH). (2011). Ending homelessness among older adults and elders through permanent supportive housing. Retrieved from National Leadership Initiative to End Homelessness: <http://www.csh.org/>

Cunyngham, K. (2010). State trends in supplemental nutrition assistance program eligibility and participation among elderly individuals. Retrieved from Mathematica Policy Research Inc.: http://www.mathematica-mpr.com/~media/publications/PDFs/nutrition/SNAP_elderly.pdf

DHHS. (2011a). Elder abuse advisory council. Retrieved from: <http://www.dhhs.state.nh.us/dcbcs/beas/elderabusecouncil.htm>

DHHS. (2011b). Shelter services. Retrieved from: <http://www.dhhs.nh.gov/dcbcs/bhhs/shelter.htm>

Gotbaum, R. (2012) Seniors increasingly target of scams. New Hampshire Public Radio. Retrieved from: <http://nhpr.org/post/seniors-increasingly-target-scams>

Moos, B. (2006). Officials urge U.S. cities to become 'elder friendly': Experts call for plan to meet the needs of an aging population. *Dallas Morning News, Texas*.

National Center on Elder Abuse (NCEA). (2015). Statistics/Data. Retrieved from Administration on Aging: <http://www.ncea.aoa.gov/Library/Data/>

NH Department of Transportation (NHDOT). (2015). State coordinating council for community transportation. Retrieved from: <http://www.nh.gov/dot/programs/scc/>

NH Legal Assistance. (n.d.). Seniors. Retrieved from: <http://www.nhla.org/legal/seniors-17>

NH Office of Energy and Planning. (2014). Fuel assistance program. Retrieved from: <http://www.nh.gov/oep/energy/programs/fuel-assistance/highlights.htm>

Protective Services to Adults, N.H. Rev. Stat. Ann. § 161-F: 43 (2002).

Reinhard, S.C., Kassner, E., Houser, A., Ujvari, K., Mollica, R., & Hendrickson, L. (2014). Raising expectations, 2014: A state scorecard on long-term services and supports for older adults, people with physical disabilities, and family caregivers. Retrieved from AARP, The Commonwealth Fund, and The SCAN Foundation: <http://www.longtermscorecard.org/2014-scorecard#citation>

Rollins, N. (2015). Data compiled from the American Community Survey 2012 5-year sample of people living in New Hampshire, age 75+. Institute on Disability, Durham, NH.

Seniors Count NH. (2015). Our seniors are falling through the cracks. Retrieved from Easter Seals NH: <http://www.easterseals.com/nh/our-programs/senior-services/SeniorsCount.html>

Strickhouser, S., Wright, J., & Donley, A. (2014). Food insecurity among older adults. Retrieved from AARP Foundation: http://www.aarp.org/content/dam/aarp/aarp_foundation/2015-PDFs/AF-Food-Insecurity-2015Update-Final-Report.pdf

Thomas, K. S., & Dosa, D. (2015). More than a meal: Results from a pilot randomized control trial of home-delivered meal program. Retrieved from Meals on Wheels America: <http://www.coconino.az.gov/DocumentCenter/View/9272>

Thomas, K. S., & Mor, V. (2013). The relationship between older Americans act Title III state expenditures and prevalence of low-care nursing home residents. *Health Services Research*, 48(3), 1215-11226.

Website Links

(2) ServiceLink Aging and Disability Resource Centers: <http://www.servicelink.nh.gov/index.htm>

(3) NH 2-1-1: <http://www.211nh.org/>

(4) Transport NH: <http://transportnh.org>

(5) List of Transportation options in NH: <http://transportnh.org/2015/06/15/oh-the-places-youll-go/>.

(6) MyRide2: <http://www.seniortransportation.net/ResourcesPublications/MyRide2.aspx>

(7) Aging and Transit Partnership in Northern Virginia: <http://www.seniortransportation.net/ResourcesPublications/PrinceWilliam.aspx>



A BROAD RANGE OF LIVING ARRANGEMENTS ARE AVAILABLE

THE ELDER HEALTH ADVISORY COMMITTEE DEFINED THIS DOMAIN AS: “PLANNING AND ZONING, RESOURCES AVAILABLE TO SUPPORT LIVING AT HOME, AFFORDABILITY, AND HOME MODIFICATIONS OPTIONS.”

Safe and affordable housing is identified as an important social determinant of health and well-being. As people age, their ability to remain living safely in their homes diminishes, yet aging in place has been shown to be associated with physical and mental well-being (Vivieros & Brennan, 2014). For people to age safely at home, there must be both affordable and accessible housing, as

Adequate housing is “structurally and mechanically safe and sound; having features that meet the physical needs of the residents and their guests; costing no more than 30 percent of a person’s income; and being located in a safe community that provides adequate transportation options, access to employment opportunities, access to food options (preventing hunger), and opportunities for social engagement (preventing isolation) (AARP 2015a).”

well as access to supportive services to help them remain in their homes and communities. The aging of our population presents significant challenges for creating solutions for elder housing that are affordable, accessible, independent, and integrated

into our communities.

Current literature refers to both “aging in place” and “aging in community” when referencing housing arrangements for an aging population. It is important to understand the distinctions between these terms. Aging in place emphasizes aging in a familiar environment, preferably one’s own home, while aging in community refers to aging in one’s community while transitioning into settings that provide increased support and care. The goals of aging in place are to keep people in their homes for as long as possible and to reduce the high cost of living typically associated with institutionalized aging. Aging in the community means that as an individual’s conditions, needs, and desires change, they are able to move into a setting that accommodates them while remaining in a familiar community (Cowen & Donovan, 2014). Iecovich (2014) identifies a number of “best practices” for aging in place, including social inclusion, community

planning, integration of services, and technology. The goal of any housing efforts related to seniors must focus on supporting seniors to live and thrive in their homes and communities.

While the concept of aging in place is widely supported by many older adults and senior advocates, some argue that the notion has been oversold and could be a disservice to many who are not safe living in their own home. Dr. Stephen Golant (2015), in his book “Aging in the Right Place,” argues that older people may hold onto living in a home that is not physically accessible, is expensive to maintain, and not located in places that are convenient to stores or medical services. He promotes the design and development of long-term care alternatives that meet the diverse needs of seniors across all income brackets.

Affordability and Accessibility

The cost of aging in place in one’s home can be out of reach for many older adults, especially as their need for care and support increases. Housing is the largest expense for older adults, with 59% of older renters and 33% of homeowners with mortgages spending more than 30% of their income

on housing costs (Harrell, 2011). As we age, our need for support to live independently increases, and the cost of services to support older adults with activities such as cooking, shopping, housekeeping, personal hygiene, and medication management can be out of reach for many.

While affordability is important, accessibility is equally critical to many older adults who may need physical modifications in order to remain living in their homes and communities. Home modifications have been found to be important accommodations in order to increase accessibility and quality of life for an individual, as well as to allow them to remain comfortable in their own home for as long as possible (McCunn & Gifford, 2014). The majority of older adults own homes and will be faced with the choice of aging in place by adapting their home or relocating to an environment that can accommodate their changing needs and wishes (Alley, Liebig, Pynoos, Banerjee, & Choi, 2007).

A number of features are important to consider in designing housing for older adults. It is important that developers use Universal Design standards when building new homes. Universal Design means designing products, buildings, public spaces, etc. so that they can be used by everyone

across the full range of human diversity. For example, curb cuts are design features that help all people navigate city streets more easily, not just people who use wheelchairs. In order to age at home, most of us will need to adapt our homes to accommodate our changing needs. Principles of Universal Design are important considerations when designing, building, and adapting homes for older adults.

Range of Living Arrangements

A number of common themes can be drawn from the literature on elder housing, including the importance of maintaining a sense of community and relative independence, the critical issue of affordability, and the need for comprehensive care regardless of housing or financial situation. While safe and affordable housing is critical to one's ability to remain living in the community, access to adequate supportive services is equally important.

Retiring baby boomers exploring their options for housing and care have different housing priorities than previous generations. A number of new and innovative housing models are being developed and are as varied and individualistic

as the boomer generation. Key aspects of all of these models are providing affordable, safe, and accessible housing with the availability of supportive services as needed. These options include accessory apartments, shared housing arrangements, cohousing arrangements, multi-family apartments, village models, assisted living, continuing care retirement communities, and naturally occurring retirement communities (NORCs) (Ragsdale & McDougall, 2008).

Accessory Apartments

An accessory apartment is a separate dwelling unit on a single family property, either attached or unattached to the main dwelling. It has also been called an in-law apartment in the past. The advantage of an accessory apartment for aging in place can be either to generate additional income for older adults to allow them to remain living in their home or as a smaller, more accessible unit that accommodates their changing needs.

Shared Housing

Shared housing is an option for older adults who either want to share their home with someone in order to generate additional income or get help

with household chores, or who want to live with someone else who owns a home and is interested in home sharing. This is an option that is becoming more popular throughout the country as more states feature home sharing organizations, which facilitate housemate matching.

Cohousing

Cohousing is a type of collaborative housing where residents live an environmentally-sound lifestyle and enjoy a cooperative, inter-generational neighborhood. Residents live in private homes and share common facilities and outdoor areas. Residents actively participate in the design and operation of their neighborhoods with a common goal of sustainable living and developing good connections with neighbors. This type of housing began in Denmark in the late 1960s and spread to North America in the late 1980s. There are now more than a hundred cohousing communities completed or in development across the United States and Canada ⁽⁸⁾.

Age-Restricted Communities

Age-restricted communities typically require that at least one of the home owners is fifty five or older, and most do not allow anyone under the age of eighteen to reside in the community. These communities are also known as 55+ communities, lifestyle communities, retirement communities, or active adult communities. They offer various amenities depending on the types of homeowners they are trying to attract, such as club houses, golf, community activity centers, pools, educational programs, etc.

Village to Village Models

Village to Village models are membership-driven, grassroots organizations serving residents in a defined geographic region. Villages coordinate access to affordable services and supports in order to support members to remain living and thriving in their homes. Services can include transportation, social and educational events, home repairs, access to medical services, health and wellness programs, and access to vendor discounts. Currently there are more than 150 villages both in the United States and internationally, with over 120 in development ⁽⁹⁾.

Assisted Living

The U.S. Department of Health and Human Services (2015) defines an assisted living facility as a residential living arrangement that provides individualized personal care, assistance with Activities of Daily Living, help with medications, and services such as laundry and housekeeping. Some assisted living facilities provide health and medical care, but not at a nursing home level of care. Facilities range from small homes to large apartment-style complexes. Levels of care and services vary.

Continuing Care Retirement Communities

Out of all the options for elder housing, Continuing Care Retirement Communities (CCRCs) are the most expensive. They are a hybrid of independent living, assisted living, and nursing home care. These living facilities offer a tiered approach of different living situations based on the individual's level of health and independence, which allows residents to remain living in the same community as their needs for care increase (AARP, 2015b).

Naturally Occurring Retirement

Communities

The definition of a Naturally Occurring Retirement Communities (NORC) varies greatly. According to the U.S. DHHS, "a NORC is a geographic area that has a significant proportion of older people residing in a specific area or in housing that was not designed or planned with seniors in mind" (Ormond, Black, Tilly, & Thomas, 2004). However, there is disagreement as to what a significant proportion or age cutoff is to be included in that population. New Hampshire has many communities that could likely be considered NORCs, as they are neighborhoods, communities, or housing complexes that are not specifically designed for older adults but with a high percentage of older residents. There is an opportunity to coordinate service delivery around these naturally occurring retirement communities.

Green House Model

While most older adults state a strong preference for living at home as they age, nursing facility care remains an important resource for those who need this level of care. A promising practice in nursing home care is the Green House model that provides a home-like atmosphere. The

model emphasizes meals and social gatherings, and features outdoor components of the home that allow residents to leave the building. The goal of the Green House is to provide residents with the support that they need while allowing them to maintain a sense of control over their day-to-day routines in a home-like setting (Ragsdale & McDougall, 2008).

The Current Landscape in New Hampshire

In their 2014 randomized phone survey of 1000 New Hampshire residents over the age of 50, AARP found that the majority of respondents want to stay in their own homes as they age, but many do not feel they have what they need to do so (Bridges, 2015). As noted in this section, older adults need both affordable and accessible housing and access to supportive services and care in order to remain living at home. An important consideration for New Hampshire as our population ages will be how to support residents' desire to remain living safely at home while receiving needed services and supports.

Community Planning and Zoning

New Hampshire's housing landscape is undergoing changes as the demand for smaller housing units and rental properties increases. This trend is different than the housing landscape of previous decades, when young families were moving into the state and the demand for single-family, multi-bedroom homeowner properties was high.

The UNH Cooperative Extension published an Information Brief on Planning for an Aging Population (Cowen & Donovan, 2014). In this brief they identify the need to create community planning practices and policies that address the multi-generational needs of New Hampshire communities. They identify zoning and land use regulations that hinder the creation of elder friendly communities and housing options that are increasingly popular with older adults such as restrictions on multi-family homes, homes within commercial areas, or accessory apartments. Housing costs, affordability, and accessibility further restrict the options available to older adults. Additionally, public transport is extremely limited in New Hampshire, especially in rural areas, and is a critical issue for those older adults who are no longer able to drive.

In a report prepared for the New Hampshire

A Broad Range of Living Arrangements Are Available

Housing Finance Authority (NHHFA), Delay and Thibeault (2014) raise a number of concerns related to housing for older adults (65 years or older) in New Hampshire. They note that many older adults are looking for smaller housing units appropriate for one or two individuals. Since the housing stock in New Hampshire is primarily larger homes, there is growing competition for smaller housing units between younger people and retiring individuals looking to “downsize”. In addition, rental properties are increasingly expensive and vacancy rates have decreased to a low of 2.2% state-wide (NHHFA, 2015), making it even more challenging for older adults to find affordable housing.

Housing Options in New Hampshire

Private and public organizations support a variety of housing options for seniors within New Hampshire. For example, Southern New Hampshire Services (SNHS) provides supportive housing for older adults. They manage 28 affordable housing projects comprised of 795 affordable apartments across the state for low income seniors. Low income residents of these subsidized apartments pay a maximum of 30% of their income to housing and heat/utilities are included (SNHS, n.d.).

The New Hampshire Community Loan Fund is a national leader in helping residents who live in manufactured housing to convert mobile home parks into consumer cooperatives owned and governed by their residents. These mobile home cooperatives create affordable and secure living options for all of the residents, many of whom are older adults ⁽¹⁰⁾.

The Moore Options for Seniors program, based in Manchester, facilitates a home share model that connects seniors and individuals with extra space in their homes in a mutually beneficial, long-term arrangement. Individuals who may have difficulty living alone or maintaining a home can share a home to reduce housing costs, share housework and have the security of a “roommate” (Moore Center, n.d.).

New Hampshire has two cohousing developments; Nubanusit Neighborhood and Farm in Peterborough and Pinnacle in Lyme. Nubanusit Neighborhood and Farm is a multi-generation, family-friendly cohousing community. It is the first eco-friendly cohousing community in New Hampshire and is regionally recognized for its vision ⁽¹¹⁾.

Pinnacle cohousing is being developed in

Lyme and will have a total of 36 member-owned homes on 120 acres with waterfront on Post Pond. Their vision is to create an attractive, comfortable, environmentally intelligent neighborhood in which one can live, raise a family, and live long into retirement; aging in one's own home within an inter-generational community ⁽¹²⁾.

There are age restricted communities in every county in New Hampshire (it was not possible to get a total count of them). An internet search reveals the availability of age restricted communities in almost every large town and major city. Prices for homes in these communities vary based on the type of housing, location, and amenities provided.

There are two types of assisted living residences in New Hampshire – Residential Care Homes and Supported Residential Care Homes. Residential Care Homes are designed to support adults who do not meet nursing home level of care but cannot or do not wish to live on their own. Residential Care Homes provide 24-hour support and provide assistance with activities of daily living, such as personal hygiene, special diets, and supervision in taking medications. Supported Residential Care Homes provide comprehensive care for individuals who are unable to live independently and have needs

for medical care. They offer the same services as a Residential Care Home, and also provide medical supports including nursing interventions. Both types of assisted living residences can be publicly or privately owned homes and can provide assistance on a long-term basis to support older adults to remain living in the community. There are 33 assisted living facilities in New Hampshire, but few are Medicaid licensed (About Assisted Living, 2015).

New Hampshire offers both private and state-run nursing facilities located throughout the state. There are 76 nursing homes in New Hampshire. Four are part of a Continuing Care Retirement Community: Havenwood-Heritage Heights in Concord, Kendal at Hanover, Riverwoods at Exeter, and Langdon Place of Keene. Only Havenwood-Heritage Heights in Concord and Langdon Place of Keene accept Medicaid.

The costs of different housing types vary greatly according to the Genworth (2015) Financial Cost of Care Survey; the median cost of assisted living in New Hampshire is \$61,230; a semi-private room in a nursing facility is \$115,340; and 44 hours of in-home care costs \$54,912.

There are three formal Village to Village Network locations in New Hampshire that are in operation (Monadnock, New London, and Nashua)

and one that is in development (Lyme). All of these organizations are member organizations that help to coordinate access to affordable and reliable services to help older adults to remain living at home and active in their communities (VtVN, 2015).

Individuals who age in place are often able to do so with the help of home modifications and adaptations as their level of ability and mobility changes. However, these modifications can be expensive, especially for an individual on a fixed income. New Hampshire Medicaid covers some home modifications and adaptive technology, but not all, and only for individuals who qualify for Medicaid coverage. There are a number of programs throughout New Hampshire that provide low-cost or volunteer assistance with home modifications. These are referenced previously in the Fundamental Needs: Safety section.

Best Practices Nationally

Homesharing organizations are being developed throughout the United States and are proving to be a promising practice in supporting older adults to remain in their homes and communities. HomeShareVT is a nonprofit, volunteer-based

organization that is well established and facilitates matching older adults who wish to add income from a renter or need help with homeowner chores with potential housemates. The HomeShare VT process is initiated with an application from an individual who is either a homeowner looking for a housemate or an individual seeking a room within someone's home. There is no age or income requirement and, if a match is successful, a contract is developed and monitored carefully by HomeShareVT⁽¹³⁾.

Support and Services at Home (SASH) is a program established in Vermont that provides coordinated care and a range of services to support residents in supported housing. It is funded under a Medicare demonstration program as well as a variety of grants and foundations. SASH focuses on preventive health care and services coordination, self-management education and coaching, and support during transitions from facilities to home. The SASH program reported a number of promising outcomes during the initial pilot year⁽¹⁴⁾.

The Housing Assistance Council (HAC) is a national nonprofit organization that helps build homes and communities across rural America. It oversees the Rural Senior Housing Initiative, which supports the development of housing for rurally-

based low-income seniors. According to their website⁽¹⁵⁾, they provide small grants to local nonprofits that are developing, preserving or repairing homes for low-income seniors; training and technical assistance to help such groups; loans to rural senior housing projects for both rental and homeownership; advocacy on issues affecting the housing of low-income rural seniors; and research and information on such issues (HAC, 2014).

A number of national programs are developing to support older adults to live safely and thrive in their homes. One example is Community Aging in Place, Advancing Better Living for Elders (CAPABLE) in Baltimore, MD. The program utilizes a team that includes occupational therapists, nurses, and handymen to meet the identified needs of program participants. The program received funding from the Centers for Medicare and Medicaid Services' Innovation Program and has shown promising initial results (Szanton et al., 2015).

Programmatic, Policy, and Research Implications

The housing stock in New Hampshire is not matched with the changing needs of aging baby

boomers and younger families. The stock of large, older homes does not match the needs of many older adults and younger families who desire smaller, more affordable and accessible homes. Further assessment is needed to determine the housing needs of a changing population and how to best meet those needs.

Information on the availability of elder housing in New Hampshire is difficult to access. The creation of an online resource for researchers, older adults, caregivers, and family members would be a useful tool to serve both as a repository of data around housing and as a resource for those looking for housing.

Home modifications and technology advancements are an important consideration in supporting people to remain at home as they age. Limited funding for home modifications is available through certain Medicaid programs. For those who are not on Medicaid and who do not have adequate income to cover these expenses, funding is very limited. Flexible funding for these types of supports has been found to be very beneficial in programs such as Seniors Count in Manchester. Further research into creative ways to fund home modifications, technology to support people to age in place, and other adaptive

equipment would be very beneficial.

Local zoning ordinances in many communities restrict the range of housing options that can be pursued, such as home sharing, accessory apartments, multi-unit homes, etc. Further research into the housing preferences of a changing population, zoning restrictions, and recommendations for zoning changes would be of benefit.

There has been little research in New Hampshire that looks at the housing challenges for immigrant and refugee populations as they age. Anecdotally, it appears that they face some of the same challenges as other older adults in finding affordable, accessible, and safe housing; yet encounter numerous additional barriers in finding appropriate housing and supportive services. In addition to language and cultural barriers, older immigrants and refugees often have little or no retirement savings and are not eligible for social security benefits. Many immigrant and refugee families are multi-generational and the elders depend on receiving care and support from their children. As Geraldine Kirega of SPARK the Dream notes, “In Africa you are rich when you have kids because kids will take care of you in your old age.” But this is changing as younger family members are beginning to reject this

notion as they adapt to the United States’ culture. It will be important to examine poverty levels as well as cultural barriers to accessing housing, health care, and other fundamental needs in these populations.

Recommendations

Multipronged Approach to Address Needs

A multipronged approach to address the housing needs of an aging population is recommended. Collaboration needs to occur with key players across different disciplines to find solutions to address the housing needs of a changing population. Professionals, including housing developers, home builders, and realtors need to come together with health and human service providers to strategize how technology and housing design features can support older adults to live and thrive in their homes and communities.

Large Stakeholder Involvement

Policy solutions should be addressed by engaging the general public, legislators, municipal officials, and other policymakers in a dialogue about the housing needs of older residents at the state, regional, and local levels. A special emphasis needs

to be placed on working with local planning officials to address needed changes in zoning laws to allow for development of multi-unit housing, accessory apartments, and other housing models that support an aging population.

Diversify Housing Options

Housing preferences are as diverse as the population of older adults, and the possibilities for living arrangements are vast. In particular, immigrant and refugee community leaders must be included in the evaluation, planning, and decision making around their community's needs. We need to embrace multiple strategies for addressing the diverse housing needs of an aging population. We also must work to educate the general public on how to make thoughtful and sustainable housing.

References

- AARP. (2015a). Housing. Retrieved from: <https://secure.aarp.org/aarp-foundation/our-work/housing/>
- AARP. (2015b). About continuing care retirement communities. Retrieved from Housing Options: http://www.aarp.org/relationships/caregiving-resource-center/info-09-2010/ho_continuing_care_retirement_communities.html
- About Assisted Living. (2015). About assisted living in New Hampshire. Retrieved from: <http://www.aboutassistedliving.org/assisted-living-new-hampshire>
- Alley, D., Liebig, P., Pynoos, J., Banerjee, T., & Choi, I. H. (2007). Creating elder-friendly communities: Preparations for an aging society. *Journal of Gerontological Social Work*, 49(1-2), 1-18.
- Bridges, K. (2015). Voices of 50-plus in New Hampshire: Opinions and perspectives. Retrieved from AARP Research: <http://www.aarp.org/research/topics/politics/info-2015/voices-50-plus-new-hampshire.html>
- Cowen, S. & Donovan, M. (2014). Planning for an aging population. (Issue Brief: No. 3) Retrieved from University of New Hampshire Cooperative Extension: http://extension.unh.edu/resources/files/Resource004767_Rep6786.pdf
- Delay, D., & Thibeault, R. (2014). Senior housing perspectives: Housing needs in New Hampshire, part II. New Hampshire Center for Public Policy Studies, 2.
- Genworth. (2015). New Hampshire state median: Annual care costs in 2015. Retrieved from Long Term Care Costs Across the U.S: <https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html>

A Broad Range of Living Arrangements Are Available

Golant, Stephen M. 2015. *Aging in the right place*. Baltimore, MD: Health Profession Press.

Harrell, R. (2011). *Housing for older adults: The impacts of the recession*. (Issue Brief 53) Retrieved from AARP Public Policy Institute: <http://assets.aarp.org/rgcenter/ppi/liv-com/insight53.pdf>

Housing Assistance Council (HAC). (2014). *Rural Senior Housing Initiative*. Retrieved from: <http://www.ruralhome.org/sct-initiatives/rshi>

Iecovich, E. (2014). *Aging in place: From theory to practice*. *Anthropological Notebooks*, 20(1), 21-33.

McCunn, L., & Gifford, R. (2014). *Accessibility and aging in place in subsidized housing*. *Seniors Housing & Care Journal*, 22(1), 18-29.

Moore Center. (n.d.). *HomeShare*. Retrieved from: <http://mooreoptionsforseniors.org/homeshare/>

New Hampshire Housing (2015). *Rents Continue to Climb in New Hampshire*. Press release: June 23, 2015. Retrieved from: <http://www.nhhfa.org/news/releases/2015/release150623.html>

Ormond, B. A., Black, K. J., Tilly, J., & Thomas, S. (2004). *Supportive services programs in Naturally Occurring Retirement Communities*. Retrieved from U.S. Department of Health and Human Services, Urban Institute: <http://aspe.hhs.gov/daltcp/reports/norcssp.htm>

Ragsdale, V., & McDougall, G. J. (2008). *The changing face of long-term care: Looking at the past decade*. *Issues in Mental Health Nursing*, 29(9), 992-1001. doi:10.1080/01612840802274818

Southern New Hampshire Services (SNHS). (n.d.). *Supportive housing for elderly*. Retrieved from: <http://www.snhs.org/programs/housing-homeless/support-elder/>

Szanton, S., Wolff, J., Leff, B., Roberts, L., Thorpe, R., Tanner, E., Boyd, C., Xue, Q. L., Guralnik, J., Bishai, D., & Gitlin, L. (2015). *Preliminary data from community aging in place, advancing better living for elders, a patient-directed, team-based intervention to improve physical function and decrease nursing home utilization: The first 100 individuals to complete a Centers for Medicare and Medicaid Services innovation project*. *Journal of the American Geriatrics Society*, 63(2), 371-374. doi: 10.1111/jgs.13245

U.S. Department of Health and Human Services. (2015). *Assisted living*. Retrieved from: <http://longtermcare.gov/where-you-live-matters/living-in-a-facility/assisted-living/>

Village to Village Network (VtVN). (2015). *About VtV Network*. Retrieved from: http://www.vtvnetwork.org/content.aspx?page_id=22&club_id=691012&module_id=65139

Vivieros, J., & Brennan, M. (2014). *Aging in every place: Supportive service programs for high and low density communities*. Retrieved from Center for Housing Policy: National Housing Conference: <http://www.nhc.org/media/AgingInEveryPlace.pdf>

Website Links

- (8) Cohousing Association of the U.S.: <http://www.cohousing.org/>
- (9) Village to Village Models: <http://www.vtvnetwork.org/>
- (10) Community Loan Fund: <https://www.communityloanfund.org/how-we-help/roc-nh>
- (11) Nubanusit Neighborhood and Farm, Co-Housing Development in Peterborough: <http://www.peterboroughcohousing.org/>
- (12) Pinnacle Co-Housing in Lyme: <http://www.cohousing.org/Pinnacle%20Cohousing>
- (13) HomeShareVT: <http://www.homesharevermont.org/about-us/>
- (14) SASH: www.sashvt.org
- (15) Rural Senior Housing Initiative: <http://www.ruralhome.org/sct-initiatives/rshi>



SUPPORT IS PROVIDED TO CAREGIVERS AND FAMILIES

THE ELDER HEALTH ADVISORY COMMITTEE DEFINED THIS DOMAIN AS: “ACCESS TO INFORMATION ON SERVICES AND SUPPORTS; CAREGIVER EDUCATION AND TRAINING PROGRAMS; FLEXIBLE FUNDING TO MEET THE UNIQUE NEEDS OF CAREGIVERS; MORE CONSISTENT PAY FOR FORMAL PAID CAREGIVERS AND RESPITE CARE.”

For purposes of this section, caregivers are defined as unpaid relatives or friends who are caring for an aging family member who experiences a chronic illness or disability and requires assistance with everyday activities such as personal care, household chores, or other daily supports. Paid caregivers are also a critical support to both those who require care and to their family caregivers. The importance of their role and the issues related to workforce development will be addressed in the health and well-being section of this report.

Caregiving is a role that most of us experience at various points across the lifespan. Parents are caregivers for their children. This role is extended well beyond the typical years for some parents with children with disabilities or mental illness who need care into adulthood. Many of us move in and out of the role of caregiver as we take on support for aging parents or other relatives.

Issues related to family caregiving are particularly salient today due to a convergence of factors, including longer life expectancy; the aging of the baby boomers, the largest population cohort in history; and medical advancements that help people live longer but often with chronic, disabling conditions. Additionally, many baby boomers are finding themselves at the nexus of caring for aging parents while preparing for their own aging and still caring for children at home or caring for an adult child with disabilities (Fox, 2015).

Who Are Caregivers

The Family Caregiver Alliance (FCA) (2012) estimates that more than 65 million Americans provide informal care to family and friends who, due to a disability or chronic illness, are unable to carry out basic daily activities such as personal hygiene,

meal preparation, medication management, and basic household tasks. They estimate that 36% of family caregivers care for a parent, and seven out of 10 caregivers are caring for loved ones over 50 years old. The most current data on caregiving can be found in the Caregiving in the U.S. 2015 research report issued by the National Alliance on Caregiving and AARP (Weber-Raley and Smith 2015). This report notes that the majority of caregivers are women (60%), are caring for one person (82%) and are caring for a relative (85%). The average caregiver is 49 years old. Sixty percent of caregivers are white, and 20% are Hispanic.

Studies beginning in the early 1980's have consistently found that older adults who need assistance generally have at least one family member who provides them with some level of support (Johnson & Catalano, 1983). Current studies indicate that anywhere from 78 - 80% (Thompson, 2004) to 90% (IOM, 2008) of all long-term care is provided by unpaid caregivers, and 86% of these caregivers are family members (FCA, 2012). Despite this fact, the publicly funded long-term care system continues to reflect an institutional bias, in both policy and financing structures. The current long-term care system is focused on rebalancing toward

a greater reliance on home and community based services. This shift, combined with changes in health care delivery such as shorter hospital stays, places families at the center of this system change as they are expected to provide greater levels of in-home care to their aging family members (Fox, 2015).

According to a 2010 study by AARP, the number of grandparents caring for their grandchildren has increased significantly over the past decade. The study reports that 4.9 million US children under the age of 18 live in a household headed by a grandparent, and approximately 20% of these children have neither parent present in the household. While many grandparents express that they enjoy caring for their grandchildren, it presents a number of financial, health, housing, education, and work challenges (Goyer, 2010).

The Costs of Caregiving

Caregiving exacts physical, emotional, and financial tolls on caregivers. Caregivers are the backbone of the long-term care system, and the economic contribution of this care to the system is significant. There is a very real financial cost to caregivers who leave the workforce, or cut back

on hours at work, in order to care for ailing family members. The economic cost to individual female caregivers is estimated at \$324,044 over a lifetime, which includes \$131,351 in lost Social Security benefits, \$50,000 in lost pension benefits, and \$142,693 in lost wages (MetLife Mature Market Institute, 2011).

The FCA estimates that approximately 37.1 billion hours of care are provided by informal caregivers of older adults each year in the United States. The value of these family caregiver services is estimated to be \$450 billion a year, almost twice as much as is actually spent on homecare and nursing home services combined (\$158 billion) (Evercare, 2009; Feinberg, Reinhard, Houser, & Choula, 2011). Family caregivers are the foundation of long-term care nationwide, exceeding Medicaid long-term care spending in all states (Evercare, 2009).

The Current Landscape in New Hampshire

In 2010, the New Hampshire Behavioral Risk Factor Surveillance System (NH BRFSS) included questions about caregiving. The NH BRFSS is conducted annually in collaboration with the Centers

for Disease Control as part of a national system of health surveys. The purpose of BRFSS is to identify the prevalence of major health risk behaviors among adults at the state-level. BRFSS defines “Caregiver” as a person who provides “regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability” (CDC, 2015).

A Snapshot of NH Family Caregivers

Based on the 2010 NH BRFSS results;

- *Caregivers represent 19.8% of the adult population in New Hampshire.*
- *New Hampshire caregivers are primarily women (64.3%), married (69%), and between the ages of 40-64 years (56.7%).*
- *Over 40% of New Hampshire caregivers are estimated to have graduated from a college or technical school, more than half are employed for wages, 16% are retired, and 54.9% report incomes of \$50,000 or more.*

This data is consistent with other national studies of caregivers and provides a good snapshot of caregivers in New Hampshire (Partch-Davies, Fox, Davie, & Patenaude, 2014).

AARP, in their 2009 policy brief on Long-Term Care in New Hampshire, estimates that 147,000 New Hampshire residents provide family caregiving to a loved one at home (AARP, 2009). According to the

Chapter 3

US Census Bureau (2012), over 20,000 grandparents in New Hampshire are living with their grandchildren and 34.4% are responsible for them, which equates to almost 7,000 New Hampshire grandparents caring for their grandchildren.

The National Family Caregiver Support Program (NFCSP) was established in 2000 under the Older Americans Act, Title III E. It provides grants to every state and territory to fund a range of supports that assist family and informal caregivers to divert older adults from spend down to Medicaid and nursing home placement. In New Hampshire, these funds have been used to establish the New Hampshire Family Caregiver Support Program (NHFCSP), administered by the New Hampshire Bureau of Elderly and Adult Services (BEAS). The NHFCSP is a nationally recognized family caregiver support program that aims to improve, or at minimum maintain, the family caregiver's ability to continue to provide care without sacrificing their personal health and well-being. New Hampshire's program was informed by the work of Dr. Mary Mittelman and colleagues who developed an evidence-based caregiver support program at New York University (NYU). Their work provided evidence that a combination of individual counseling and

additional support interventions improved overall caregiver well-being, delaying the necessity for nursing home placement. Effective interventions developed at NYU were instrumental in informing the design of the NHFCSP (Mittelman, Haley, Clay, & Roth, 2006).

The NHFCSP is managed at the local level through the ServiceLink Aging and Disability Resource Center (SLRC) network. The NHFCSP incorporates a number of components and is available to anyone caring for a person over the age of 60. Program components include information and referral; a comprehensive caregiver assessment; one-on-one counseling and support; ad-hoc telephone assistance; funding for respite care; flexible funding for caregiving related goods and services; caregiver support programs and training; and an evidence-based caregiver education program, Powerful Tools for Caregivers. Participants in the program may choose to receive any or all of the above services and supports, although financial support for respite care and caregiver supports are limited to those who meet program eligibility criteria. Upon entry into the program, a caregiver specialist meets with the caregiver and conducts an assessment of both caregiver and care recipient

needs. From this assessment, a plan of support is developed with the family caregiver, utilizing a person-centered approach.

There are many local family support groups throughout New Hampshire, mostly focused on a specific disease, disability, or chronic condition. Recently, a number of Alzheimer's Cafés have been established across the state, including in Atkinson, Concord, Dover, Exeter, Lebanon, Manchester, Nashua, Peterborough, and Portsmouth. An Alzheimer's, Dementia, or Memory Café is a gathering of individuals with memory loss along with their caregivers. The gathering provides an opportunity for socialization, support, and a welcome break from the challenges experienced by both the individual and their caregiver ⁽¹⁶⁾.

The Coalition of Caring Caregivers Conference was created in October of 2006 to promote and strengthen the well-being of caregivers who provide care for a family, friend or relative who is aging, chronically ill, or disabled. They hold an annual conference for caregivers that provides information and education as well as a break from caregiving responsibilities⁽¹⁷⁾.

The New Hampshire Lifespan Respite Coalition was established to recruit and train a

pool of qualified respite care providers that New Hampshire caregivers can easily access to meet the needs of those they care for, thereby enhancing the quality of life for caregivers across the lifespan ⁽¹⁸⁾.

NAMI NH (2015) provides a variety of supports to family members who have a loved one with mental illness. They offer family support groups around the state, individual support from a family support specialist, and resource guides specific to caregivers of older adults with mental illness.

Adult Day programs not only provide services to the older adult, but a needed break for the family caregiver, often allowing the caregiver to remain working. There are both medical and social adult day services throughout New Hampshire. However, according to the New Hampshire Adult Day Association, seven Adult Day Centers have closed in the past two years, primarily due to limited reimbursement rates from Medicaid (P. Faist, personal communication, July 6, 2015).

To meet the specific language and cultural needs of new immigrant and refugee populations, new adult day programs are being developed in New Hampshire. Maintaining Independence is an organization that runs an adult day program for Bhutanese and Nepali community members who

are elderly and/or developmentally disabled. These programs hire nurses and other staff who speak the participants' native language and provide culturally appropriate meals and activities, as well as classes in English as a Second Language and Citizenship Test Preparation. Additional programs are planned to begin in 2016 that will serve the state's Latino populations (K. Worth, personal communication, August 17, 2015).

Best Practices Nationally

A number of caregiver support programs have been implemented and tested across the country. Interventions that provide a combination of caregiver education, skill training, and individual therapy have been shown to be the most effective in supporting caregivers, resulting in more positive caregiver outcomes. There are numerous caregiver support programs across the country and best practice has shown that successful programs should include a set of core services including assessment, individual counseling, caregiver education, caregiver support programs, and respite care.

An example of an evidence based caregiver support program is the Resources for Enhancing

Alzheimer's Caregiver Health (REACH) program, which has been replicated in many sites across the country. REACH is a structured multi-component caregiver intervention that is based on an individualized assessment of caregiver needs. Interventions are tailored to the unique needs of each caregiver and include a variety of strategies including the provision of information, skills training, problem solving, role playing, stress management, and telephone support (Burgio, Collins, Schmid, Wharton, McCallum, & Decoster, 2009).

Another renowned best practice is the support that L.L. Bean offers to working caregivers. These benefits include flexible hours, leave of absence policy allowing up to six months off, Employee Assistance Programs, elder care seminars, and educational programs about retirement options. Additionally, L.L. Bean is working to provide benefits and supports that attract older workers (Covert, Davie, & Fox, 2014).

There is a plethora of informational resources for family caregivers on the internet. The Eldercare Locator is a public service of the U.S. Administration on Aging and provides links to state and local area agencies on aging and community-based organizations that serve older adults and their

caregivers ⁽¹⁹⁾. This website provides information and resources to help older adults and their families begin their search for resources.

Programmatic, Policy, and Research Implications

Informal, unpaid, family caregivers are the under-recognized cornerstone of the long-term care system in the United States. A coherent set of policies and programs that strengthen this critical foundation of the long term care system is important. Schuster (2014, p. 4) calls for “public policies that support family caregivers with meaningful financial, social and physical help for the challenges we all face as our society ages.”

Studies have shown that investments in supports for family caregivers will reap large payoffs for state and federal budgets by delaying unnecessary and costly institutionalization (Feinberg et al., 2011). Funding for these critical supports in both state and federal budgets are needed to maintain these family caregivers as an integral part of the long term care system. The Older Americans Act is an important source of funds for caregiver

support programs, because it funds services that support both the older adult and their family caregiver.

Caregiving has been shown to impact caregivers’ earnings. Social Security credit for workers who must leave the workforce to care for an aging parent or spouse is also an important consideration for supporting family caregivers. The proposed Social Security Caregiver Credit Act of 2014 allows for individuals who serve as caregivers of dependent relatives to be deemed wages for up to five years of caregiving service. If passed, this bill would provide increased retirement security for millions of Americans, mostly women, who must leave the workforce to care for a dependent relative. In addition, income tax credits for dependent care of an aging parent or spouse, similar to the child and dependent care tax credit, would help caregivers manage the added financial burdens of caregiving. Further study is needed to assess ways to protect the earnings of caregivers across the lifespan.

Recommendations

Access to Information

Caregivers need access to information about the care needs of their loved one and the availability of services. Most have to navigate a confusing and fractured long-term care system on their own. Easy access to clear and understandable information, education, and training is critical for family caregivers who are often responsible for providing complex levels of medical and personal care. This information needs to be accessible to older caregivers who may not be as technologically savvy as their younger counterparts, as well as to the new generation of caregivers who are adept at using the internet to find resources. The Aging and Disability Resource Center (ADRC) Network is an important resource for caregivers. It is important to educate the general public as well as state and federal policy makers about the importance of this vital network.

Stronger Network of Caregiver

Support Programs

Caregivers must be strong advocates for their loved one; they know the needs of their loved one best. Caregiver support programs should include

coaching for caregivers on how to reach out for help, advocate for the individual needs of their loved one as well as their own needs, and advocate for the collective needs of older adults and caregivers. Parents of children with developmental disabilities have a number of programs and resources that teach them about their rights and how to advocate for their child's needs. There is little available for caregivers and families of older adults to teach them how to advocate for their needs. This is not only a disservice to individual caregivers, but has resulted in a weak advocacy network for aging services in general. Programs need to consider how to transfer the knowledge and skills developed in the developmental disability field to the field of aging.

Educate Employers about

Caregiver Employees

It is important to educate employers about the needs of their employees who are caregivers. In addition, we need to assist employers with information to help them develop family friendly policies that support caregivers across the lifespan. Workplace benefits that have been found to benefit working caregivers include flexible work hours, paid sick days, paid family leave time, caregiver support

and education programs, and telecommuting (NAC & AARP, 2015).

Diversity of Needs

Issues related to caregiving for aging family members span all ethnic groups and populations. It is important to understand the needs across all populations, including people of color; immigrants; refugees; and the lesbian, gay, bisexual and transgender (LGBT) communities and assure that programs are culturally appropriate to meet the needs of all New Hampshire families.

Educate Stakeholders About Caregiver's Needs

The needs of family caregivers of older adults are often overlooked or poorly understood by the public and policy makers. We need to continue to educate the general public, legislators, policy makers, employers, and others about the critical role that caregivers fulfill. Caregivers need education, support, and evidence-based services that provide essential relief from their caregiving; flexibility and support from employers in order to continue working; and tax relief to help offset the economic hardship often resulting from caregiving.

References

- AARP. (2009). Long-term care in New Hampshire. Retrieved from: http://assets.aarp.org/rgcenter/health/state_ltc_b_09_nh.pdf
- Burgio, L. D., Collins, I. B., Schmid, B., Wharton, T., McCallum, D., & Decoster, J. (2009). Translating the REACH caregiver intervention for use by area agency on aging personnel: The REACH OUT program. *The Gerontologist*, 49, 103–116.
- CDC. (2015). Behavioral Risk Factor Surveillance System. Retrieved from: <http://www.cdc.gov/brfss/index.html>
- Covert, S., Davie, L., & Fox, S. (2014). Tri-state roundtable on aging conference report. Maine Council on Aging; Endowment for Health.
- Evercare. (2009). Evercare survey of the economic downturn and its impact on family caregiving. Retrieved from National Alliance for Caregiving: http://www.caregiving.org/data/EVC_Caregivers_Economy_Report%20FINAL_4-28-09.pdf
- Family Caregiver Alliance (FCA). (2012). Selected caregiver statistics. Retrieved from National Center on Caregiving: <https://caregiver.org/selected-caregiver-statistics>
- Feinberg, L., Reinhard, S. C., Houser, A. & Choula, R. (2011). Valuing the invaluable: 2011 update. The growing contributions and costs of family caregiving. Retrieved from AARP Public Policy Institute: <http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf>
- Fox, S. W. (2015). Life interrupted: The experience of informal caregivers of aging family members (Doctoral dissertation). University of New Hampshire, Durham, NH.

Chapter 3

Goyer, A. (2010) More grandparents raising grandkids. Retrieved from AARP Public Policy Institute: http://www.aarp.org/relationships/grandparenting/info-12-2010/more_grandparents_raising_grandchildren.html

Institute of Medicine (IOM). (2008). Retooling for an aging America: Building the health care workforce. Retrieved from The National Academy of Sciences: www.nap.edu/catalog/12089.html

Johnson, C. L., & Catalano. D. J. (1983) A longitudinal study of family supports to impaired elderly. *The Gerontologist*, 23(6), 612-618.

MetLife Mature Market Institute. (2011). Study of caregiving costs to working caregivers: Double jeopardy for baby boomers caring for their parents. Retrieved from National Alliance for Caregiving, Center for Long-Term Care Research and Policy: <https://www.metlife.com/assets/cao/mmi/publications/studies/2011/Caregiving-Costs-to-Working-Caregivers.pdf>

Mittelman, M. S., Haley, W. E., Clay, O. J., & Roth, D. L. (2006). Improving caregiver well-being delays nursing home placement of patients with Alzheimer Disease. *Neurology*, 67(9), 1592-1599.

National Alliance Mental Illness New Hampshire (NAMI NH). (2015). Side by side. Retrieved from: <http://www.naminh.org/we-educate/training-opportunities/side-side>

National Alliance for Caregiving (NAC), &AARP. (2015). Caregiving in the U.S., a 2015 report. Retrieved from the AARP Public Policy Institute: http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Final-Report-June-4_WEB.pdf

Partch-Davies, T., Fox, S., Davie, L., & Patenaude, C. (2014) *Understanding caregiving in New Hampshire utilizing the Behavioral Risk Factor Surveillance Survey (Unpublished report)*. University of New Hampshire, Durham, NH.

Schuster, J. L. (2014). Fierce urgency of now: White House focus on working families must include help for caregivers. *Aging Today*, 5, 4-6.

Thompson, L. (2004). Long-term care: Support for family caregivers. Issue brief published by the Long-Term Care Financing Project, Georgetown University.

U.S. Census. (2012). American Community Survey. For more information see: www.census.gov/acs

Weber-Raley, Lisa & Smith, Erin. (2015). Caregiving in the U.S. NAC and AARP Public Policy Institute. Retrieved from: <http://www.caregiving.org/caregiving2015/>

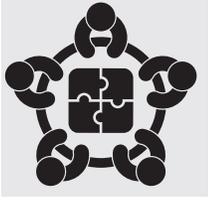
Website Links

(16) Alzheimer's Cafés: <http://www.alzheimerscafe.com/public.html.alzheimersatoz.com/Welcome.html>

(17) Coalition of Caring Caregivers Conference: <http://www.coalitionofcaring.org/>

(18) NH Lifespan Respite Coalition: <https://nhlifespanrespite.wordpress.com/about/our-mission/>

(19) Eldercare Locator: <http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx>



SOCIAL AND CIVIC ENGAGEMENT OPTIONS ARE PLENTIFUL

THE ELDER HEALTH ADVISORY COMMITTEE DEFINED THIS DOMAIN AS: “MEANINGFUL CONNECTIONS WITH FAMILY, FRIENDS AND NEIGHBORS; PAID AND VOLUNTEER WORK OPPORTUNITIES; ACTIVE ENGAGEMENT IN SOCIAL LIFE; AND CULTURAL AND RELIGIOUS ACTIVITIES ARE PLENTIFUL.”

Research has shown that social engagement is an important component of successful aging (Adams, Leibbrandt, & Moon, 2011) and can have a positive effect on mental and physical health (Glass, Mendes de Leon, Bassuk, & Berkman, 2006; Everard, Lach, Fisher, & Baum, 2000) as well as mortality (Agahi & Parker, 2008). The multiple health risks associated with the lack of social connectedness and perceived loneliness in older adults has been well-documented (Cornwell & Waite, 2009), including higher rates of morbidity and mortality, depression, and cognitive decline. It is clear that any strategy to maintain the health and well-being of older adults must include opportunities for social and civic engagement.

Social and civic engagement activities can be identified as informal, formal, or solitary. Informal activities include interactions with family, friends, and neighbors. Formal activities include more

organized involvement in groups or organizations. Solitary activities include such actions as reading or watching TV, typically performed alone. Research suggests that the informal social connections to family and friends have a stronger influence on well-being than either formal or solitary activities (Longino & Kart, 1982; Adams et al., 2011). This is an important concept when considering how to develop elder friendly communities. How do we create opportunities for older adults to remain engaged in the social fabric of their communities?

There are a number of definitions of civic engagement. Common threads in these definitions are that civic engagement can be either individual or collective actions with a goal of identifying and tackling issues that affect the general public. Civic engagement can take the form of volunteerism, as well as organizational or political activities. Activities are typically focused on creating change to improve

Chapter 4

the quality of life of a community. Civic engagement includes a wide range of activities, from volunteering for a community organization, writing a letter to the editor, serving on a community board, running for elected office, or voting.

Batista and Cruz-Ledon (2008) note the importance of civic engagement as an aspect of productive aging. They note that older adults have skills, experience, and leadership potential that can benefit the community, as well as increase the quality of life for the older adult. Links have been found between volunteering and improved health (Morrow-Howell, Hinterlong, Rozario, & Tang, 2003), happiness and life satisfaction (Kochera, Straight, & Guterbock, 2005), and decreased mortality and disability rates (Lum & Lightfoot, 2005).

In order to prioritize aging issues, it is imperative to change older adults' status in the community and to develop communities that are elder friendly. Viewing elders as significant contributors to society and providing opportunities for meaningful engagement are core characteristics of aging friendly communities (Austin, McClelland, Perrault, & Sieppert, 2009). Research indicates that to build strong, supportive environments for all people, cities should move toward

intergenerational communities that stress the importance of each individual, regardless of age, as an integral and valued part of society (Generations United, 2012). An intergenerational community constructs partnerships between local groups and organizations, builds on the positive resources each generation has to offer, and advances policies and practices that acknowledge and promote intergenerational interdependence (Generations United, 2012).

A recent report by Oxford Economics (2013), funded by AARP, describes "The Longevity Economy" as the sum of all economic activity supported by the consumer spending of households headed by someone age 50 or older. They conclude that the longevity economy is transforming the larger US economy as older adults fuel economic growth. They recommend that businesses must recognize new spending habits of an older market, understand how technology is used by older adults, manage health care costs, and adjust to longer working lives as well as a multi-generational workforce. This report highlights an important shift in thinking about older adults as significant contributors to society rather than a drain on public spending.

The Current Landscape in New Hampshire

In 2014, Oxford Economics released state level data as part of their report to AARP on “The Longevity Economy” described above. They report that while 39% of New Hampshire’s population in 2013 was over the age of 50, they accounted for 50% of New Hampshire’s GDP and represented 38% of New Hampshire’s workforce. Overall, New Hampshire residents over the age of 50 contribute to the state’s economy in a greater proportion than their share of the population.

According to data retrieved from the Corporation for National and Community Service website (NCOC) (2014), 28.9 % of New Hampshire residents age 65 – 74 volunteer, as compared to 27.1% nationally; 23.2% of those over the age of 75 volunteer as compared to 20.4% nationally. Those between the ages of 65 – 74 year old report that they volunteer 64 hours per year, the highest of all age groups. Nationally this same age group reports volunteering 92 hours per year. So, while more older adults in New Hampshire volunteer than the national sample, they volunteer for fewer hours on average.

There are many opportunities for older

adults in New Hampshire to remain engaged in both paid and volunteer work, religious activities, civic activities, and educational opportunities. The challenge is to figure out how to keep people engaged as they age and become more frail. A number of examples of social and civic engagement opportunities are outlined below.

An example of how retired community members are giving back to support their community is Those Guy’s in Lyme. Those Guy’s is a men’s service organization, established by a group of local retired men, that provides assistance to local residents who need a hand with things like transportation to medical appointments, minor household repairs, yard work, etc.

New Hampshire has the third largest legislative body in the English speaking world and the largest state legislature in the U.S., with many of its 424 members over the age 60 (State of New Hampshire, 2012). A 2007 survey found that nearly half of the members of the House were retired, with an average age of 60 (Fraser, 2007). This presents a great opportunity for New Hampshire seniors to remain engaged in state government and give back to the community.

The United Valley Interfaith Project (UVIP)

Chapter 4

is a community organizing group that emerged from several congregations in the Upper Valley of New Hampshire. UVIP promotes several initiatives including an “Aging in Community Campaign.” This campaign aims to improve the quality of life for seniors across the Upper Valley region by supporting seniors’ needs to support them to remain safely in their homes and active in their communities. UVIP has achieved success by partnering with Alice Peck Day Memorial Hospital and other local groups interested in the needs of aging residents (UVIP, 2014).

Senior Centers are designated community focal points through the Older Americans Act. There are 54 Senior Centers in New Hampshire, reaching most every part of the state. Programing varies from one center to the next, but most offer a range of services and activities that reflect the interests and skills of the local members. A key goal of senior centers is to empower the people they serve, link them with paid and volunteer work opportunities, and connect them with needed services ⁽²⁰⁾. In addition to Senior Centers, programs for older adults are organized through local libraries, Recreation Centers, Meals on Wheels program sites, and other community based organizations.

New Hampshire has a number of educational programs that help seniors stay active, engaged, and continually learning. Elderhostel was founded in 1975 by two friends working at the University of New Hampshire. In 2010 the name was changed to Road Scholar in order to appeal to the next wave of older travelers, the baby boomers. Road Scholar organizes educational travel tours throughout the world targeted to older adults.

The Osher Lifelong Learning Institute (OLLI) is a member-led organization that provides lifelong learning opportunities for individuals over the age of 50. OLLI at Granite State College is one of over 119 OLLI programs at colleges and universities nationwide. The program has four learning sites (greater Concord, Conway, Manchester and the Seacoast area) and over 1,000 members ⁽²¹⁾.

The New Hampshire Masters Games (NHMG), formerly called the Granite State Senior Games, is an opportunity for athletes over the age of 50 to remain active and fit by participating in a variety of competitive sports. They offer competitive opportunities to engage in eighteen different sports, including archery, badminton, basketball, track and field, shuffleboard, race walking, and tennis.. They promote health and well-being and maintaining

an active and healthy lifestyle among the 50+ population⁽²²⁾.

Best Practices Nationally

Senior Corps is a national organization that connects seniors (55 years and older) to volunteer opportunities in community organizations in every state. The program helps seniors to contribute their skills, knowledge, and experience to make a difference in their communities. Programs funded through the Senior Corps include Foster Grandparents, Retired Senior Volunteer Program (RSVP), and Senior Companions. Foster Grandparents connects seniors with children to serve as a role model, mentor, and friend. RSVP connects seniors to a range of volunteer opportunities in their communities. Senior Companions are volunteers who provide assistance to adults who need support to remain living at home. This support also allows family caregivers a break from their caregiving responsibilities or time to run errands. All of these programs help seniors to remain active and involved in their communities⁽²³⁾.

SCORE is a nonprofit association, supported by the US Small Business Administration, which

utilizes volunteers to help small businesses get established and grow. There are over 320 SCORE chapters nationally, six of which are in New Hampshire. SCORE mobilizes a network of over 11,000 volunteers, who are current and former business professionals, to help small businesses at no charge or at a very low cost. SCORE is a great way for retired business people to stay engaged, give back to their community and help build the local economy⁽²⁴⁾.

Programmatic, Policy, and Research Implications

Isolation and loneliness are significant issues for frail seniors, as well as their caregivers. Isolation and loneliness can occur in all living arrangements, whether at home, assisted living, or nursing homes. Isolation occurs as a result of a complex set of circumstances and cannot be easily defined, identified, or addressed. The AARP Foundation recently completed a study to provide a framework for isolation in adults over 50. Further research in this area is warranted.

Today's older adults have varying degrees of comfort and mastery with the use of technology.

However, technology use among older adults is increasing. Technology offers great promise in helping older adults stay connected to family and friends, obtain medical services, and be supported to live and thrive in their homes and communities. The possibilities for the use of technology are endless and should be further explored.

Isolation among people of color, immigrants, refugees, and other minority groups needs to be further studied. While there is a need for activities to engage older adults from these populations, it is unlikely that current programs are adequate to meet the diverse interests and needs of these populations. Further research is needed to understand the extent of the need, how to engage older members of minority groups, and appropriate service delivery methods.

Recommendations

Offer a Range of Social Activities

It is important to provide a range of social activities tailored to appeal to the diverse interests and talents of older adults. We need to ensure that these activities are culturally appropriate and provide options for seniors from diverse

backgrounds and interests. These activities must be accessible, including providing transportation, handicapped accessible locations, and other accommodations to meet the needs of participants. These opportunities should include multi-generational activities as well.

Educate Employers

It is critical to provide opportunities for older adults to be engaged in paid and volunteer employment. Additionally, we should support employers with tools and technical assistance to encourage them to hire older adults. Employers should be provided with information and technical assistance to help them develop workplace policies and benefits that provide flexibility for older workers, as well as caregivers, to allow them to continue working.

Offer Opportunities for Engagement

We need to support opportunities for older adults to become and/or remain engaged in the political process, including local, state, and national politics. The opportunities to serve in the legislature or on non-profit boards in New Hampshire are vast and the skills, experience, and talents that

older adults bring to the table are immense. It is important to provide opportunities for older adults to learn the skills necessary to become engaged in the political process and to serve on non-profit boards. Additionally, New Hampshire offers a unique opportunity to engage older adults in national politics through our first in the nation primary status.

Meaningful Social Connections

As informal family and social connections are most important to well-being, communities need to provide opportunities for meaningful connections with family, friends and neighbors. It is important to have access to a range of cultural, social, and religious activities in addition to the more formal and organized civic engagement activities. Regardless of living arrangement, opportunities for social and civic engagement are critical to enhance the well-being of all community members.

References

- Adams, K. B., Leibbrandt, S., & Moon, H. (2011). A critical review of the literature on social and leisure activity and wellbeing in later life. *Ageing and Society*, 31, 683-712. doi: 10.1017/S0144686X10001091
- Agahi, N. & Parker, G. (2008). Leisure activities and mortality: Does gender matter? *Journal of Aging and Health*, 20(7), 855-871.
- Austin, C., McClelland, R., Perrault, E., & Sieppert, J. (2009). The Elder-Friendly Communities program. *Generations*, 33(2), 87-90.
- Batista, L.C., & Cruz-Ledon, A. M. (2008). The relationship between civic engagement and health among older adults. In M.S. Plakhotnick and S.M. Nielsen (Eds.), *Proceedings of the Seventh Annual College of Education Research Conference: Urban and International Education Sections* (pp. 8 – 12). Miami, Florida: International University.
- Cornwell, E. Y., & Waite, L. J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of Health and Social Behavior*, 50(1), 31-48.
- Everard, K. M., Lach, H. W., Fisher, E. B., & Baum, M. C. (2000). Relationship of activity and social support to the functional health of older adults. *Journal of Gerontology Social Sciences*, 55B(4), S208-S212. doi:10.1093/geronb/55.4.S208
- Fraser, G. (2007). N.H. Legislature doesn't mirror population. *The Eagle Tribune*.

Chapter 4

Generations United. (2012). America's best intergenerational communities: Building livable communities for children, youth, families, and older adults. Retrieved from Generations United, and the MetLife Foundation: <http://www.aarp.org/content/dam/aarp/livable-communities/learn/civic/americas-best-intergenerational-communities-aarp.pdf>

Glass, T. A., Mendes de Leon, C. F., Bassuk, S. S., & Berkman, L. F. (2006). Social engagement and depressive symptoms in late life: Longitudinal findings. *Journal of Aging and Health*, 18(4), 604-628.

Kochera, A., Straight, A., & Guterbock, T. (2005). Beyond 50.05: A report to the nation on livable communities. Washington, DC: AARP.

Longino, C. F., & Kart, C. S. (1982). Explicating activity theory: A formal replication. *Journal of Gerontology*, 37(6), 713-722.

Lum, T.Y. & Lightfoot, E. (2005). The effects of volunteering on the physical and mental health of older people. *Research on Aging*, 27(1): 31-55.

Morrow-Howell, N., Hinterlong, J., Rozario, P. A., & Tang, F. (2003). Effects of volunteering on the well-being of older adults. *The Journals Of Gerontology: Series B: Psychological Sciences And Social Sciences*, 58B(3), S137-S145. doi:10.1093/geronb/58.3.S137

National and Community Service (NCOC). (2014). Retrieved from: <http://www.volunteeringinamerica.gov/>

Oxford Economics. (2013). The Longevity Economy: Generating economic growth and new opportunities for business. Retrieved from: <http://www.aarp.org/livable-communities/livable-in-action/info-2014/the-longevity-economy.html>

Oxford Economics. (2014). Info-graphic of New Hampshire's Longevity Economy. Retrieved from: <http://www.aarp.org/livable-communities/livable-in-action/info-2014/the-longevity-economy.html>

State of New Hampshire. (2012). Retrieved from: <https://www.nh.gov/nhinfo/stgovt.html>

United Valley Interfaith Project (UVIP). (2014). Our issues campaign. Retrieved from: <http://www.unitedvalleyinterfaith.com/campaigns/#new-page-1>

Website Links

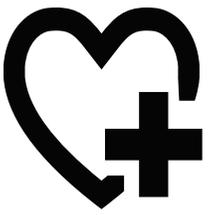
(20) Senior Centers: <http://www.seniorcenterdirectory.com/new-hampshire/>

(21) Osher Lifelong Learning Institute (OLLI): <http://olli.granite.edu/>

(22) New Hampshire Masters Games: <http://nhmastersgames.org/>

(23) National Service (Senior Corps): <http://www.nationalservice.gov/programs/senior-corps>

(24) SCORE: <https://www.score.org/>



QUALITY PHYSICAL AND MENTAL WELL-BEING SUPPORTS ARE IN PLACE

THE ELDER HEALTH ADVISORY COMMITTEE DEFINED THIS DOMAIN AS “ACCESS TO PREVENTIVE CARE; ACCESS TO MEDICAL, MENTAL HEALTH AND PALLIATIVE CARE; PLANNING FOR END OF LIFE CARE.”

The World Health Organization (WHO) defines health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or injury (WHO, n.d.)” Good health and wellness is critical for older adults to remain independent, remain in the community, and continue to participate in activities that give meaning and pleasure to life (Felderman & Oberlink, 2003). The current approach to health care is carried out in siloes, including payment, regulatory, provider, and service delivery systems. The lack of integration across the health system is compounded by the dearth of knowledge and attention to the social determinants of health. As New Hampshire moves forward in addressing elder health, an integrated approach to assuring physical and mental well-being is essential to success.

The WHO has identified access to affordable community and health services as a critical component in creating age-friendly communities. They note that a range of preventive acute and long term care services need to be readily accessible in locations convenient for older adults in order to meet their diverse health care needs. The NH Elder Health Advisory Committee also identified access to preventive, medical, mental health, and palliative care; and planning for end of life care as important components of an elder friendly community. As physical access to necessary health care services is not always practical, such as in rural parts of the state, other mechanisms to facilitate access to care are important. These mechanisms can include the utilization of Community Health Workers (CHWs), physician home visits and the use of technology to bring clinical services into the home. Additionally,

the availability of an adequate and well-trained health care workforce is critical to assuring access to care.

Access to Preventive Services

Clinical preventive services, which include immunizations, screening tests, and counseling to prevent the onset or progression of disease and disability, are important tools to maintain the health of older adults. These services can help prevent chronic disease, reduce associated complications, and decrease the impact of functional limitations. Despite the effectiveness of preventive services in promoting better health and increasing cost-effectiveness, along with recent mandates for insurance plans to cover preventive services, only 25% of adults age 50 to 64 years and less than half of adults age 65 years and older are up-to-date on receiving core preventive services (CDC, 2012).

Fall prevention programs are critically important in order to reduce the risk of falling and the concomitant problems associated with falls in older adults. Falls are the leading cause of fatal and nonfatal injuries for older adults, which impact the older adult's ability to live independently, and

increase the risk of nursing facility placement or early death. Fall prevention programs include three main strategies: balance training and physical activity, medical management, and environmental/home modifications; and have been shown to significantly reduce the risk of falling in older adults (Tinetti et al., 1994).

National Falls Data from 2013

- *2.5 million nonfatal falls among older adults were treated in emergency departments, and more than 734,000 of these patients were hospitalized.*
- *Falls are leading cause of fatal and nonfatal injuries for older adults, with 20-30% of people who fall suffering moderate to severe injuries such as lacerations, hip fractures, and head traumas.*
- *25,500 older adults died from unintentional fall injuries.*

(Derived from: CDC, 2015)

Access to Medical Care

The medical care needs of older adults are often considerable with approximately 80% of older adults requiring ongoing care for at least one chronic condition, 50% having multiple chronic conditions,

and 60% managing three or more prescription medications. As disability increases with age, access to a range of medical and supportive care is critically important for preventing new illnesses, adapting therapies to changing needs, potentially reducing acute care costs, and ultimately for maintaining the health and well-being of an aging population (Thorpe, Thorpe, Kennelty, & Pandhi, 2011).

Community Health Workers (CHWs) are widely used in global health, and the vast majority of reports on the use of CHWs come from developing countries. In the U.S., CHWs are being used to expand access to care, particularly for hard to reach populations, such as ethnic minorities and people living in rural regions (Kash, May, & Tai-Seale, 2007; Viswanathan et al., 2010). Viswanathan et al. (2010) report that CHWs serve as a bridge between the health care system and the community and typically offer education, counseling and, in some models, treatment to hard-to-reach populations. They note that there is some evidence to suggest that CHWs can increase appropriate health care utilization, such as improved rates of screening and engaging in follow up appointments within a general population. Verhagen, Steunenberg, De Wit, and Wynand (2014) conducted a systematic review of the impact of

CHWs on health outcomes for ethnic minority older adults. Their review of seven studies suggests that CHWs can be used to improve health care utilization, health behavior, and health outcomes among ethnic minority older adults.

Dr. Dennis McCullough (2008), a New Hampshire family physician, geriatrician, and author, advocates for geriatric medicine to take a more measured, reflective, and thoughtful approach in working with older patients, which he calls “slow medicine.” He argues that the current practice of medicine, which is disease-focused, technology-driven, and time-constrained, does not meet the needs of aging patients whose needs are complex and changing. Slow medicine requires families and health professionals to work together to better understand the complex needs of the older adult and make more appropriate decisions about their health care needs.

Oral Health Care

The U.S. health care system continues to keep oral health care outside what is traditionally considered the health care system. However, oral health is essential to physical wellbeing. Chronic disease and health conditions, including diabetes,

heart disease, stroke, and respiratory disease are linked with severe gum disease (Administration on Aging, 2014). Poor oral health also contributes to difficulty eating and chronic pain. The major barrier to oral health is lack of insurance for dental care. Dental coverage for older adults is not provided under Medicare or Medicaid and supplemental private insurance policies are expensive. As the baby boomer generation retires, they will lose dental insurance associated with employment, and rates of poor dental health in the U.S. are likely to increase (Ragovin, 2014).

Health Care Workforce

Access to health care is dependent on the availability of an adequate and well-trained health care workforce. Yet, as the U.S. population is aging, the healthcare workforce is also aging; average hours worked are falling; and many nurses, physicians, and other health care professionals are nearing retirement. Within the next decade there will be a shortage of 45,000 primary care physicians and 46,000 surgeons and medical specialists. By 2030, the Bureau of Labor Statistics predicts that the United States will need an additional 3.5 million formal health care providers, a 35% increase from

current levels, just to maintain the current ratio of providers to the total population (Spitzer, Davidson, & Allen, 2013). Anticipated shortages of health care professionals are projected to be particularly acute in mental health services as the demand for services grows with the aging population, the number of veterans with mental health issues increases, and individuals gain access to coverage for mental health treatment through the Affordable Care Act (SAMSHA, 2013). Further, more than half of all U.S. counties have no practicing psychiatrists, psychologists, or social workers, meaning that nearly 80 million Americans currently live in a mental health professional shortage area. The need to recruit and retain healthcare professionals will be a primary challenge as the population ages and more people require care.

Studies have consistently indicated that most older adults prefer home and community-based care services (HCBS), as opposed to nursing facilities. Additionally, HCBS is more cost effective than nursing facility care in most situations (New Hampshire Coalition for Direct Care Workforce, 2009). It is not surprising that personal care aides and home health aides top the list of the projected fastest-growing occupations in the country between 2010 and 2020,

with these positions expected to increase by 71% and 69%, respectively (PHI National, 2013). Home health aides and personal care aides rank third and fourth on the list of occupations projected to add the most new jobs to the economy over the coming decade (PHI National, 2013). Low wages, lack of benefits, difficult working conditions, and heavy workloads make recruitment and retention of workers difficult, even when unemployment rates are high. Issues related to the recruitment and retention of this vital workforce will become paramount as the direct-care workforce is projected to become the nation's largest occupational group with over 5 million workers by 2020 (PHI National, 2013).

Technology in Health Care

Technology holds much promise in improving access to health care, especially in more rural areas. Telehealth offers the technology to provide medical services, specialty consultations, and diagnostic capabilities in individual homes, as well as health care sites in more remote areas where these services are not readily available. Heightened computer literacy and the popularity of mobile telephones and electronic applications across all

age groups are transforming the dissemination and use of health information. Aging baby boomers are more electronically savvy than previous generations and have heightened expectations for easy access to health services. The evolution of these communication modalities is moving consumer trends toward greater involvement in self-care; focusing on improved health and physical fitness. For example, wireless health portals allow consumers to use personalized bio-data templates to obtain real-time feedback and self-evaluation of select health status variables. Additionally, the wide adoption of Electronic Medical Records, smart phones, miniaturized lab tests, and mobile imaging mean that tests normally provided through primary care offices can be available for use in the home with the potential to greatly increase access to a broad range of medical services (Spitzer, Davidson, & Allen, 2013).

Health care delivery is being positively influenced by technological innovations in the areas of preventive care, wellness, and interventions to address chronic conditions among older adults. Genetic engineering and bioinformatics are two areas where exciting developments are occurring that may help shape the future of health care.

Genetic engineering and nanotechnology are advancing the practice of personalized medicine, in which particular therapies are developed for people with specific gene sequences, and medicines and interventions are incorporated that best meet the individual genetic, lifestyle, and environmental differences. Bioinformatics allow patient health conditions (i.e. blood pressure, blood glucose, etc.) to be monitored through the use of a mobile device application. These devices not only collect the information but transmit it to physicians' smartphones or tablets (Spitzer, Davidson, & Allen, 2013).

Access to Mental Health Care

Attention is beginning to be paid to the high prevalence of psychiatric disorders in the nation's older adult population, which is especially of concern given their low utilization of mental health services. Persky (2015) notes that although adults 60 years of age and older constitute a large part of the U.S. population, their use of inpatient and outpatient mental health services falls far below expectations. It is estimated that 18 - 25% of older adults are in need of mental health care for conditions such

as depression, anxiety, psychosomatic disorders, adjustment to aging, and schizophrenia. In addition, older adults have the highest suicide rates (21%) of all age groups in the U.S. Yet, Persky notes, older adults account for only 7% of all inpatient psychiatric services, 6% of community mental health services, and 9% of private psychiatric care. Additionally, less than 3% of all Medicare reimbursements are for the psychiatric treatment of older patients.

Access to Palliative and End of Life Care

The overwhelming majority of U.S. health care costs are incurred in the final years of life; further, the current system has been slow to adapt to the challenges of an older population struggling with chronic illness (Lynn & Adamson, 2003). Older adults and their caregivers are faced with navigating a fragmented system offering a patchwork of uncoordinated services that do not meet their needs. Fragmented health care delivery to older adults is both inefficient and potentially harmful; older patients often receive services from multiple physicians without coordination, may receive duplicated care while not receiving needed services,

and may be exposed to increased risk of medical errors (Spitzer, Davidson, & Allen, 2013).

Palliative Care

Palliative care, hospice care, and end of life care are poorly understood and often confused by the general public. Palliative care, in particular, is largely unknown to the public, as well as being poorly understood by many health care providers. A 2011 report from Public Opinion Strategies indicates that 70% of the respondents had no knowledge of palliative care (Center to Advance Palliative Care, 2011). Yet, palliative care for older adults can greatly improve the lives of older adults in long-term care (Home Care Assistance, 2012), as well as for older adults living in the community, by allowing them to stay at home and in a familiar environment for as long as possible.

Palliative care focuses on the prevention and relief of suffering through early identification, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems (WHO, 2015). Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with serious illness. Personalized management of pain and a professional

who offers understanding and education are two hallmarks of palliative care. Palliative care helps decrease depression, reduces hospitalizations and high-risk interventions, and provides expert treatment of multiple, complex symptoms (Home Care Assistance, 2012). Palliative care can also be a helpful resource for family caregivers, allowing them to care for their loved one safely at home or in a setting of their choice.

Planning for End of Life

An important challenge to successful aging is the ability to maintain control over life events, especially as people experience loss of functions as a result of aging. To the extent that older people can plan ahead and make decisions regarding end of life issues, they are able to experience some sense of control when life circumstances change. In 1991, the U.S. Congress passed the Patient Self-Determination Act to encourage people to document their end of life wishes through advance directives (ADs) in order to ensure that their values and preferences are respected (Kahana, Dan, Kahana, & Kercher, 2004). However, the acceptance and adoption of ADs is mixed. One study of long-term care recipients utilizing data from the National Nursing Home

Survey and the National Home and Hospice Care Survey found that 88% of hospice care patients, 65% of nursing home residents, and only 28% of home health care recipients completed ADs (Jones, Moss, & Harris-Kojetin, 2011).

Older adults typically make healthcare decisions with their physicians, caregivers, or other individuals who help support them. Kahana et al. (2004) report that older adults tend to discuss end of life preferences with family but many have not discussed their wishes with their physicians. They note that some physicians are uncomfortable discussing end of life issues or do not value ADs, whereas others may not initiate such discussions because of time constraints, fear of upsetting patients, or having limited knowledge about ADs. Many patients wait for their physicians to initiate the conversation about advance care planning or wait until they receive a terminal diagnosis to consider the need for an AD.

While cultural considerations span all parts of this domain area, they can have a profound impact on the choice to participate in advance care planning, how we approach a serious illness, and how we view death and dying. Good communication and trust among health care providers, the older adult, and

their family is imperative at this stage, and cultural differences must be carefully considered. A cultural assessment provides a systematic way of gathering and documenting information about a patient's cultural beliefs, meanings, values, patterns, and expressions as they relate to a patient's perception and response to an illness (Leininger & McFarland, 2002). Cultural factors that should be considered include: views about death and dying, including cultural taboos, collective decision making as opposed to U.S. values of autonomy and personal rights; perceptions of physician status as the expert and decision maker; perception of pain and comfort level in requesting pain medication; role of religion and faith; and use of traditional healing (Coolen, 2012).

The Current Landscape in New Hampshire

New Hampshire has several cross-cutting initiatives that exemplify how the coordination of care across health and social service providers can improve the well-being of older adults. One programmatic example is the Seniors Count Frail Elder Community Liaison program in Manchester, which links frail elders who have been hospitalized with a community

liaison. The liaison follows the frail elder back to the community and provides ongoing care coordination across the three traditional silos of care: medical services, social and community based services, and informal family caregivers. The assessment tool utilized during a hospitalization includes financial resources, housing and home safety, food and nutrition, utilities, health care, legal, mental health/ psycho-social, substance abuse, mobility, family relations and other social supports, and life skills. The Community Liaison Program was piloted from Fall 2010 through Summer 2012. Initial findings were positive in improving coordination across the silos and reducing high levels of complex needs (Phillips, Fox, & Davie, 2012). This model program continues in Manchester through a partnership between several hospitals and Easter Seals (Phillips, Fox, & Davie, 2012; Seniors Count, 2015).

As an example of policy-level work that is addressing the need to integrate care across sectors, the New Hampshire Citizens Health Initiative convenes a multi-sector set of partners to identify and consider solutions to major issues facing New Hampshire citizens. Launched in 2005 by then Governor John Lynch, the Initiative brings together stakeholders and leaders to improve the health and

health care system (New Hampshire Citizens Health Initiative, n.d.). Two projects that stemmed from the Initiative's work that can inform the conversation about issues in Elder Health are MapNH Health and the Accountable Care Project (ACP). MapNH Health is an interactive website for stakeholders to project possible outcomes over the next twenty years, given current trends in demographics, health behaviors, and socioeconomic factors ⁽²⁵⁾. The ACP includes data reporting for cost and utilization of health care for all age groups, including the population insured by Medicare. A working sub-group within the ACP is focusing on developing models for the integration of behavioral health and primary care for people with chronic disease and depression ⁽²⁶⁾.

In recent years, an expanded number of Accountable Care Organization (ACO) pilots have been initiated in the state. Many of these were initiated with CMS funding through the Affordable Care Act. The goal of these efforts is to incentivize the delivery of high-quality, coordinated care for Medicare patients. Success in meeting quality and cost goals results in financial benefit to the health system. Medicare offers several ACO programs: Medicare Shared Savings Program, Advance Payment ACO Model, and the Pioneer ACO model. These models

are active across New Hampshire with Dartmouth-Hitchcock and others, serving as an early adopters of the ACO model.

Access to Preventive Services

Access to preventive care occurs in two arenas, both within and outside of the traditional medical system. Within the medical system, primary care practices provide preventive services, including influenza vaccinations and cancer screening. Outside the medical system, community-based organizations, senior centers, faith-based organizations, and for-profit businesses, provide screenings for falls and blood pressure and offer flu clinics and other screening and vaccination services. The Affordable Care Act provides free preventive services for all 204,000 Medicare enrollees in New Hampshire. These individuals now receive preventive services, such as colorectal cancer screenings, mammograms, and an annual wellness visit without copayments, coinsurance, or deductibles.

The New Hampshire Falls Reduction Task Force was established in 1999 to reduce the risk of death and disability due to falls and to train professionals working with older adults ⁽²⁷⁾. According to data from the NH Falls Reduction Task Force, there were 11,604

hospital discharges and 44,963 emergency room discharges related to falls from 2005 – 2009, and costs for fall related hospitalizations and emergency department visits for older adults were approximately \$105.6 million in 2009. The Task Force is collecting data from two evidence-based community programs to determine their impact on reducing falls (Covert, Fox, & Davie, 2014). These programs include A Matter of Balance and Tai Ji Quan. A Matter of Balance is a program designed to reduce fear of falling and increase activity levels for older adults. The program includes eight, two-hour sessions led by a trained facilitator. Participants learn to view falls as controllable, set goals for increasing activity, make changes to reduce fall risks at home, and engage in exercise to increase strength and balance. Tai Ji Quan – Moving for Better Balance classes are held regularly throughout New Hampshire. Studies found that older adults practicing Tai Ji Quan reduced their risk of falls by 55% (Li et al., 2005), and adults with Parkinson’s disease improved functional capacity and reduced their risk of falling (Li et al., 2012).

Access to Medical Care

The US Census American Community Survey measures disability rates through six questions that assess whether a person exhibits difficulty with specific functions related to hearing, vision, cognition, self-care, or independent living and may, in the absence of accommodation, have a disability. Based on the 2013 American Community Survey data, 51% of New Hampshire residents over the age of 75 and 72% over the age of 85 are living with a disability (Rollins, 2015). As the number of older adults living with multiple chronic conditions increases, New Hampshire will be faced with a number of challenges to providing access to necessary medical care, especially in the more rural parts of the state. A number of interesting developments are being piloted to increase access to healthcare throughout the state. These include the utilization of community health workers (CHWs), providing physician house calls, using technology to bring clinical services into the home, as well as a number of disease management programs.

The utilization of community health workers is growing throughout the state. The Manchester Community Health Center and the Concord Visiting Nurse Association both utilize community health workers to work with older adults, including working

with older adults in the Latino community in Manchester. Training for community health workers is being provided by the New Hampshire Area Health Education Centers (AHEC), which has trained 4 cohorts of community health workers to date. In addition, a Community Health Worker Coalition has formed. In the fall of 2015, the Coalition will be developing a policy strategy, which will include how New Hampshire can utilize the ACA's expansion of payment models for CHW services.

Medicare provides payment for primary medical care delivered through house calls to frail elders who are unable to access office-based care. There are several physicians in New Hampshire who provide house calls to frail elders in the Concord and Manchester areas. The American Academy of Home Care Medicine is an association serving home care physicians and organizations that make house calls. Their website contains a listing of home care physicians throughout the US ⁽²⁸⁾.

Another innovative idea to bring care to older adults living in rural areas of the state is the Upper Valley Community Nursing Project (UVCNP). Community nursing dates back to the mid-19th century when nurses were focused on the health of individuals, families, and groups within a specific

Chapter 5

community. The primary goal of the UVCNP is to assist and advise communities in their efforts to hire a community or parish nurse in order to add a health professional with a particular skill set to the informal network of volunteers already providing care for older adults in many rural New Hampshire towns (L. Harding, personal communication July 7, 2015).

The New Hampshire Department of Health and Human Services oversees a Chronic Disease Self-Management Advisory Committee, which collaborates with the Northern and Southern Area Health Education Centers (AHECs). The AHECs have been facilitating trainer workshops and program evaluation, utilizing the Stanford Chronic Disease Self-Management Program's "Better Choices, Better Health" workshops. This is an evidence-based program designed to educate and coach individuals with chronic health issues. Sessions, which are offered in both English and Spanish, are held in community settings, senior centers, and physician offices (personal communication, K. St. Amand, August 18, 2015). The majority of participants in these programs (69%) are over the age of 60 ⁽²⁹⁾.

Addressing the needs of aging veterans in New Hampshire requires consideration of their unique needs. Approximately 48% of all veterans in New

Hampshire are over the age of 65. The Bureau of Community Based Military Programs was established in by the NH Department of Health and Human Services in 2008 to help facilitate military and civilian partnerships to better serve the state's veteran population. The Health Promotion Disease Prevention Program (HPDP) at the Manchester Veterans Administration Medical Center provides veterans with comprehensive health education, clinical services, and support for health-related behaviors. The HPDP Program works closely with the Patient Aligned Care Team (PACT) in Primary Care and provides resources to support clinical staff and veterans to address health promotion and disease prevention needs and interests ⁽³⁰⁾.

Oral Health Care

The NH DHHS Oral Health Program contracts with agencies across the state to provide preventive and restorative dental services for NH's children and adults who do not have access to dental care. In 2014, the Oral Health Program released findings from a survey of older adults who utilize New Hampshire's senior centers. The report reveals that there are significant geographic and socioeconomic disparities in the state. Older residents living in rural areas and

those with lower incomes have a significantly greater unmet need for dental care (DHHS, 2014). In addition to collecting survey information, the process identifies

Oral Health Survey of New Hampshire Older Adults, (2014)

- *18.4% of older adults have some type of dental insurance to help pay for routine dental care*
- *28.0% of older adults have no functional top to bottom tooth contact, which affects proper chewing*
- *15.9% of older adults have lost all of their natural teeth*
- *5.2% of individuals with no teeth have no dentures*
- *25.4% of older adults have untreated decay or root fragments*
- *6.8% are in need of periodontal care*

older adults with the greatest need for immediate dental care. Those individuals are referred to dental facilities with which the NH Bureau of Elderly and Adult Services has contracted for dental services using Title III funds (N. Martin, personal communication, September 9, 2015).

Lack of reimbursement for dental care by Medicare leaves older adults paying out of pocket for most of their oral health care needs. Older adults who

qualify for Medicaid do not fare much better.

New Hampshire is one of 16 states with no adult dental Medicaid benefit beyond emergency tooth extraction (McGinn-Shapiro, 2008). Federal Qualified Health Centers (FQHCs) are obligated to have a dental program, and many FQHC's fulfill this requirement through the use of vouchers to dental partners within their community. Four of New Hampshire's FQHC's provide on-site dental services: Families First Health and Support Center, Avis Goodwin, Mid-State Health Center, and Ammonoosuc Community Health Services. In addition, the Tamworth Dental Center, part of Tri-County Community Action Program, and EasterSeals in Manchester have limited funding to address oral health (N. Martin, personal communication, September 9, 2015).

Three programs of note bring oral health care to older adults in the community. The North Country Health Consortium coordinates the Molar Express, which visits local nursing homes and senior centers in the North Country. On the Seacoast, Families First Mobile Health Services team provides dental care screenings in addition to health care, counseling, and social work services at Margeson Apartments (Portsmouth Public Housing). In Exeter, St. Vincent dePaul Community Assistance Center

has a van outfitted with dental equipment, which provides limited extractions and restorative work for people experiencing dental pain or infection who meet income eligibility guidelines (G. Brown, personal communication, September 9, 2015; N. Martin, personal communication, September 9, 2015).

The NH Oral Health Coalition is a diverse group of organizations, agencies, and individuals concerned about the impact of oral health issues facing New Hampshire. A major goal of the coalition is to address the strategic areas of the New Hampshire Oral Health Plan. This plan is currently being updated with an expected release date of Fall 2015 (G. Brown, personal communication, September 9, 2015).

Health Care Workforce

The demand for health care services in New Hampshire is growing, while the supply of care providers across all health care sectors is declining. Primary care providers (including physicians, physician assistants, licensed nurse practitioners, dentists, and behavioral health providers) play a crucial role in providing front line care to meet patient needs for acute and preventive health services, managing chronic disease, providing long-term comprehensive care services, and navigating specialty care services.

The New Hampshire Citizens Health Initiative released a report in March 2008 entitled “Strategies to Address the Issues of Access to New Hampshire’s Primary Care Workforce.” The report noted that 42% of the state’s physicians were registered as primary care doctors and 58% as specialists. There was an increasing number of primary care vacancies throughout the state in private primary care practices, hospitals, dental offices, community mental health centers, and community health centers. The report warned that these vacancies collectively equate to a potential lack of a regular source of primary care for over 112,000 New Hampshire residents based on an average family practice panel size of 2,500 patients.

One initiative to address the need for recruitment and training of primary care providers is the New Hampshire Area Health Education Centers (AHECs). AHECs are academic and community partnerships that provide educational support to current and future members of the health care workforce. The NH AHEC is part of a national network of programs and is a partnership between the Dartmouth Medical School and two regional centers located in Littleton and Raymond. The AHECs mission is “to improve care and access to care, especially in rural and underserved areas by enhancing the health

Quality Physical And Mental Well-Being Supports Are In Place

and public health workforce in the state.” The AHECs provide a number of programs for K-12 students to explore careers in health care, learn about the health care field, and engage in community health initiatives. They also provide continuing education opportunities for health care professionals throughout the state ⁽³¹⁾.

Another initiative that is helpful in the recruitment and retention of physicians in areas that have difficulty recruiting medical professionals is the J-1 Visa Program. The J-1 Waiver Program in New Hampshire offers a visa waiver to foreign physicians who commit to serving for three years in an underserved area of the state, allowing them to remain in the United States for up to seven years. The program is managed through the NH Department of Health and Human Services and recruits primary care physicians, psychiatrists, and sub-specialty trained physicians to serve throughout New Hampshire⁽³²⁾.

New Hampshire is also facing a crisis in attracting adequate numbers of direct care workers to support our aging population. Occupational growth projections for 2006-2016 from the New Hampshire Employment Security Department show that direct care occupations -- Personal Care Aides, Home Health Aides, Nursing Aides/ LNAs, and Orderlies and Attendants -- are expected to add over 6,000 jobs by

2016, a 50% growth rate over the decade beginning in 2006 (PHI National, 2013). Further, Personal Care Aides and Home Health Aides are among the fastest-growing occupations in New Hampshire. Among occupations expected to generate over 1,000 jobs by 2016, Personal Care Aides rank third, growing by 75%, and Home Health Aides rank fifth, growing by 68% (PHI National, 2013). However, the demand for direct care workers is expected to outpace the growth in the supply of traditional workers, (i.e., women aged 25-54) who form the core labor pool of this workforce (NH Coalition for Direct Care Workforce, 2009). Specifically, New Hampshire data projects a 48% increase in the need for home health aides and a 43% increase for personal care aides (NH Employment Security, 2014).

Technology in Health Care

New Hampshire has begun to implement several technological advancements for older adults. A promising example is the work of the Dartmouth Institute, in collaboration with the Concord Visiting Nurse Association and Riverbend Community Mental Health, to study the benefits of using a device called “Health Buddy” with adults with serious mental illness. Health Buddy is an easy-to-use patient

Chapter 5

interface that can be used in the home and allows individuals to measure basic health indicators, including blood pressure, blood sugar level, and weight that transmits this information to their health care provider. This allows the health care provider to monitor the individual on a daily basis without an office or home visit, and assess their status and need for intervention. Early study results have been very promising. The Dartmouth Institute also offers a program called Tech Coaching for the public, which involves high school volunteers helping older adults troubleshoot problems they encounter with technology. The goal of these programs is to increase general technology skills and confidence as a precursor for utilizing technology to manage health (R. Pepin, personal communication, August 18, 2015).

Access to Mental Health Care

Access to mental health care is provided through ten Community Mental Health Centers (CMHCs), located regionally throughout the state. A program of interest is the Referral Education Assistance & Prevention (REAP) program. Founded in 1992 through the NH Finance Housing Authority and managed by Seacoast Community Mental Health Center, REAP provides preventive home

and community-based counseling and education services for individuals over the age of 60 suffering from alcohol or drug abuse, mental health issues, or difficult life changes. In 2007, the program expanded to include caregivers of “at risk” elders ⁽³³⁾.

NAMI NH is a grassroots non-profit organization dedicated to improving the lives of individuals affected by mental illness and their families. They offer support groups and educational programs and advocate for improved access to mental health services and supports. They offer a number of resources and guides for supporting older adults with mental illness ⁽³⁴⁾.

Access to Palliative End of Life Care

Approximately 20 acute care hospitals in the state indicate that they have palliative care programs, including the Manchester Veterans Administration Medical Center (MVAMC). In particular, the Dartmouth-Hitchcock Medical Center (DHMC) has long been a leader in New Hampshire and across the country in palliative care, especially its intersection with end of life care. Dr. Ira Byock, formerly with DHMC, is a leading authority on palliative medicine and was a significant influence in establishing DHMC’s Palliative Care Program. The program includes “A New

Quality Physical And Mental Well-Being Supports Are In Place

Perspective on Living”, which includes a care team that coordinates the medical, social, and spiritual needs of the individual and family. They also run the “No One Alone”, Palliative Care Volunteer Program which utilizes volunteers to visit, write notes, read, or simply sit bedside to support the individual and family

⁽³⁵⁾.

New Hampshire, as a result of the work of advocates, has a very good state-wide policy for advanced care planning. However, New Hampshire law identified that only the official state document, as outlined in state statute, is a valid advance directive (Malley, 2012). This state statute could be a limiting factor in widespread adoption of AD’s. In January, 2015, the surrogate decision maker law (RSA 137-J) was enacted expanding the utility of AD’s. This law amends the state’s advance directive statute and establishes a hierarchy of family members/friends who may make health care decisions for patients in certain situations in the absence of guardianship or ADs.

In 2013, a survey of acute care hospitals in New Hampshire found that 51% of patients had an AD; however, in 2015, that number decreased to 49%. Survey data also showed that, in 2013, 35% of patients had an AD in their medical chart while, in

2015, only 37% had an AD. This data is significant in that the majority of older adults die in a health care setting, and one-third of older adults lack health care decision making capacity before they die. These factors highlight the importance of the use of ADs (S. LaFrance, personal communication, July 6, 2015).

Project ENABLE (Educate, Nurture, Advise Before Life Ends) is located in three New Hampshire communities (Lebanon, Manchester, and Berlin) and is a collaborative project with Norris Cotton Cancer Center at the DHMC to improve end of life care for cancer patients. ENABLE coordinates care between the cancer center and local health care providers and hospice programs. ENABLE hosts palliative care teams that include a pain management specialist, psychologist, hospice liaison, case manager, pastoral caregiver, and palliative care coordinator. They also offer educational seminars for families and patients to help in navigating end of life issues ⁽³⁶⁾.

Provider Orders for Life Sustaining Treatment (POLST) is a system for portable medical orders for patients whose doctor or nurse practitioner think might die within the next twelve months. It is a voluntary program for patients and providers. A key objective is to improve the understanding and communication of a patient’s medical care choices

when patients move among different care settings (e.g., nursing home to hospital, hospital to hospice, etc.). The Foundation for Healthy Communities is a resource for education on POLST and offers a POLST Facilitator Education Program throughout New Hampshire to train health providers as certified POLST facilitators in their organization and community ⁽³⁷⁾.

The New Hampshire Hospice and Palliative Care Organization is a state-wide organization educating healthcare professionals and other caregivers, increasing public awareness, and advocating for legislative and regulatory changes ⁽³⁸⁾. They sponsor an annual conference and website that offers resources spanning many palliative care and hospice issues including advanced care planning, ‘having the conversation’, and POLST.

Best Practices Nationally

Access to Preventive Services

There are a number of evidence-based prevention programs that are being implemented for older adults throughout the U.S. One example is the Sickness Prevention Achieved through Regional Collaboration (SPARC). It was piloted in Atlanta, GA, and has increased the use of clinical preventive

services among older adults by increasing access points for their delivery and reducing logistical barriers. SPARC helps create partnerships between community organizations and health care providers to facilitate easy access to preventive services in one convenient place. For example, their initiative Vote & Vax, makes vaccines and appointments for cancer screenings available at polling places on election days (CDC, 2012).

Another prevention program, funded through the National Institutes of Health, is a fall prevention program specifically for older adults with visual impairments called “Osteopathic Medicine’s Balancing Act Program.” The program was developed in collaboration with the University of Maine’s Center on Aging, University of New England, and the Iris Network. It focuses on reducing falls through increasing balance abilities. The program requires only one training session from a trained facilitator and can be practiced by older adults at home with no equipment. The program also informs community programs about providing the best fall prevention information to older adults (Kahl, 2013).

Access to Medical Care

Community Health Workers

The Community Health Worker (CHW) model is gaining traction across the country. The Massachusetts Association of Community Health Workers (MACHW) is a state-wide professional organization for community health workers (CHWs) that is working to strengthen the professional identity of CHWs, foster leadership, and promote the integration of CHWs into health care, public health and human services ⁽³⁹⁾. Founded in March 2000, MACHW is recognized for its leadership nationally. Examples of Community Health Worker programs include:

- The Penn Center for Community Health Workers, which is a center that aims to improve health through the use of CHW. Their website provides a comprehensive array of CHW information including tools to begin a CHW program to a comprehensive list of CHW best practices ⁽⁴⁰⁾.
- The Northeastern Vermont Regional Hospital runs a program called Community Connections. They utilize CHWs to help people determine

what services they need and connects them to social and community services. The program serves a variety of populations (e.g., low income families, older adults, and children) with a variety of health conditions (e.g., diabetes, cardiovascular disease, and poor nutrition). They report positive effects on quality of life, health outcomes, and health care practice outcomes, including cost savings (Mirambeau, Wang, Ruggles, & Dunet, 2013).

- The Community Health Worker Pilot Project Grant (CHWPP) in rural Maine aims to support seniors living with chronic conditions by offering person-centered medical care through group and individual interventions and by coordinating services across the healthcare and social service systems (Spectrum Generations, 2014).

Oral Health Care

There are a number of national best practices that address issues of oral health in older adults. Fluoride varnish for older adults is becoming a national best practice (Morris, 2010). Smiles for Seniors is a free oral health screening and fluoride varnish program for area residents age 65 and

older sponsored through the Ottauquechee Health Foundation in Vermont. Licensed dental hygienists visit Bugbee Senior Center in White River Junction, VT and Thompson Senior Center in Woodstock, VT. The program offers a dry brushing, fluoride varnish, and screening for oral cancer (Bergin, 2015).

There are states that are addressing Medicaid coverage and provider participation through increased reimbursement rates and decreased administrative barriers for dental providers; however the focus has been on access for children. These same practices should translate to older adult coverage (Borchgrevink, Snyder, & Gehshan, 2008). The Association of State and Territorial Dental Directors has a healthy aging subcommittee, which is examining best practice for older adult care. Their recommendations, when released, will provide further options for consideration (N. Martin, personal communication September 9, 2015).

Health Care Workforce

Across the U.S., many states have recognized the impending workforce shortages facing the health care system and are implementing programs and policies that will help in recruiting and retaining workers in all health care sectors. Several states are

implementing programs to attract and retain primary care physicians. Krupa (2011) reported on a number of state initiatives to keep doctors practicing locally. For example, the Iowa Medical Society developed a targeted marketing campaign and created a database of doctors in residency programs nationwide with some connection to Iowa. Several states, including Kansas, Mississippi, and Alabama, offer loan repayment programs for doctors to practice locally, and Oklahoma offers state-funded scholarships and loans to medical students and residents who agree to practice in rural Oklahoma for a set amount of time.

The Patient Protection and Affordable Care Act (ACA), signed into law in March 2010, includes many provisions intended to strengthen the current and future primary care workforce. The ACA provides for funding for academic assistance and training programs for personal and home care aides; professional and post graduate training programs for doctors, nurses, and physician assistants; and medical residency training in community health centers. The ACA also invests in the development and evaluation of culturally competent curricula in provider training over the next five years, and loan repayment preference will be given to individuals who have cultural competency experience (National Conference

of State Legislators, 2011).

To help educate our workforce about geriatric issues, several universities have established Geriatric Education Centers. The University of New England's Maine Geriatric Education Center has established the Geriatric Health Literacy Learning Collaborative to provide education and training to health care professionals, students, and patients about the health care needs of an aging population (Metcalf, 2013).

The Dartmouth Centers for Health and Aging hosts a number of programs that conduct research in aging to improve the delivery of care, disseminate information about aging, and provide educational opportunities to professionals and community members ⁽⁴¹⁾.

Technology in Health Care

The Center for Technology and Aging at the University of California Berkeley issued a Framework for Understanding Technologies that Support Older Adults in Aging in Place (Ghosh, Linderman, Ratan, & Steinmetz, 2014). They recognize that successful aging includes empowering and supporting the whole person through telecommunications and Internet-based technologies. Their report identifies four categories of products and technologies that support connected aging: body, home environment,

community, and caregiving. Body refers to products that support monitoring and management of an older adult's physical and mental health status, such as weight scales, blood pressure cuffs, and body-worn sensors. Home environment refers to products that help monitor and maintain an older adult in the home. Sometimes referred to as "smart homes", this category includes monitoring for safety and activities of daily living as well as alerts generated if something is amiss. Community refers to technologies to help older adults maintain and strengthen their social ties to other individuals within their communities, such as social networking sites, video conferencing, and disease specific support sites. Technology-enabled caregiving products are typically websites and platforms that support informal and formal caregivers. Utilizing technology to keep older adults connected to their families, communities, and care providers holds much promise in supporting older adults to live and thrive in their communities.

Technology can greatly increase access to medical information and care. A number of communities have formed coalitions to address technology needs of older adults. One example is the San Diego Technology & Aging Coalition, which is a consortium of professionals and older adults. The

coalition grew out of the County of San Diego's 2010 Aging Summit that focused on technology and its importance in the lives of older adults. Their goal is to promote awareness of new technology, increase education and access, and advocate for quality products and services for older adults ⁽⁴²⁾.

Access to Mental Health Care

Innovative programs across the nation have gained attention as they integrate mental health care into primary care. In one example, Thresholds Psychiatric Rehabilitation Centers and the University of Illinois' College of Nursing partnered to offer integrated behavioral and physical health care at two Integrated Health Care clinics. The Integrated Health Care clinics offer integrated primary and mental health care through three service models: telehealth monitoring, home visits, and group visits (Davis, et al., 2011). Another example is a program housed within the Veterans Affairs West Haven Connecticut Healthcare System called Mental Health Primary Care (MHPC). MHPC is co-located within the West Haven VA primary care clinics and is designed to serve as an entrance for veterans to gain access to mental health services when accessing their primary care (Barber, Frantsve, Capelli, & Sanders, 2011).

Access to Palliative End of Life Care

A number of efforts are targeted at improving the connections among home health care, disease management, and hospice and palliative care. At Kaiser Bellflower in California, the hospice and palliative care teams work with staff members from disease management programs to improve end of life care. Further, teaching hospitals have begun to develop palliative care consultation teams, both to teach health-care professionals about end of life issues and to improve care delivery (Lynn & Adamson, 2003).

The Program of All-Inclusive Care for the Elderly (PACE) is a model of care delivery that provides geriatric and palliative care for vulnerable older citizens that require a nursing home level of care. Providence ElderPlace is a PACE organization in Portland, OR that has developed a unique approach to end of life care called the Supportive Care Program. The Supportive Care Program follows a palliative care model that includes collaboration with caregivers, recognizes three distinct phases of decline, and emphasizes individualized end of life care planning (Lee, 2008).

One notable initiative is the Respecting Choices program in Lacrosse, Wisconsin. This is

an evidence-based initiative acknowledged by the Institute on Medicine for its successful incorporation of advance care planning into a broader health care system. The program included four critical components: community engagement, advanced care planning facilitation skill development, systems to honor people's choices, and continuous quality improvement. Through this effort, 96% of Lacrosse residents who passed away had ADs in place, compared to the national average of 30%. Facilitators are trained and certified by Respecting Choices to conduct ACP in three distinct stages: when adults are relatively healthy, when they are beginning to suffer the effects of a chronic or life-limiting illness, and when they are near the end-of-life ⁽⁴³⁾.

A cultural assessment provides a systematic way of gathering and documenting information about the patient's cultural beliefs, meanings, values, patterns, and expressions as they relate to the patient's perception and response to an illness (Leininger & McFarland, 2002). An example of a cultural assessment to determine end of life preferences is the Kagawa-Singer & Blackhall's ABCD Cultural Assessment Model (2001).

Programmatic, Policy, and Research Implications

The Community Health Worker (CHW) Model is being tested in numerous states and is gaining traction in New Hampshire. The model has shown great promise in increasing access to health care, especially with ethnic and hard to reach populations. Yet, sustainable funding has not been established and most programs rely on short-term grant funding. New Hampshire can learn from the experience of other states to understand the efficacy and cost effectiveness of the CHW model specifically for the older adult population in order to advocate for Medicaid, Medicare, and other insurance funding for this service.

Despite the importance of good oral health on the health and wellbeing of older adults, there is not sufficient attention and resources paid to this issue. This is true both nationally and in New Hampshire. The NH Oral Health Coalition and the NH DHHS Oral Health Program should be supported in their missions of expanding research, funding, and programming for preventive and restorative dental care.

An adequate and well-trained health care workforce, across all sectors and positions, is critical

to assuring access to health care. Further work is needed to understand the training needs of these critical workforces and how to recruit and retain highly qualified health care workers, especially in more rural parts of the state. In addition, New Hampshire can do more to utilize the workforce potential offered through foreign trained medical professionals, both through direct recruiting and by assisting those who have already immigrated to the state to meet requirements to enter practice.

Technology holds great promise in increasing access to necessary health care services and supporting older adults to remain in their homes and communities. Further research is needed to understand how technology can be best utilized, how to best reach older adults with this technology, and how to finance the development and utilization of new technologies.

Advanced care planning is an important support as we age. Yet, formal mechanisms to engage in and document advanced care planning are not widely used by the general public. Understanding why these conversations are difficult and how to normalize discussions about death and dying is important. Further exploration of the success of programs such as Respecting Choices in Lacrosse, Wisconsin will be

helpful in understanding how to approach this issue from a population health perspective.

Recommendations

Better Coordinated Care

A number of promising practices are evolving that should be further developed to better coordinate medical, social, and mental health care for our most vulnerable older residents. These promising practices include the use of Community Health Workers; utilizing physician house calls; integrating care across all sectors; and taking a slower, more measured approach to working with older adults in the medical system. Health care should focus on population health and implement more evidence-based prevention programs to maintain the health of the population and help prevent long-term disabling conditions. Health care and health care organizations must be culturally competent to provide appropriate care to the state's growing minority and ethnic populations. Our approach to medical care for older adults must promote a focus on healthy aging and prevention in order to support older adults to live and thrive in their homes and communities.

Address Oral Health Care

New Hampshire should build upon the strategies outlined in the upcoming 2015 New Hampshire Oral Health Plan to address oral health care for older adults. Specifically, we should leverage the Tri-State Collaborative on Aging to educate congressional delegations about the importance of adding dental benefits to Medicare.

Access to Affordable and Effective Medical and Mental Health Services

Access to affordable and effective medical and mental health services must be a focus in order to support older adults to remain healthy in the community. Medical, mental health, and community-based care for older adults continues to be fragmented and siloed. Further efforts need to focus on integrating care across the medical, mental health, and social systems in order to assure that the physical and mental health needs of older adults is being appropriately addressed.

Increase Training for Health Care Providers

The Connecticut Health Foundation is advancing a policy agenda to promote and sustain the Community Health Worker Model. Their agenda

includes enacting legislation to establish a process for certifying CHWs, establish training programs, establishing a Medicaid payment rate, providing training for health care providers, and establishing a CHW task force. As the recently formed New Hampshire Community Health Worker Coalition forms its policy strategy, learning and adapting from Connecticut's work and policy agenda may provide a firm starting point for the coalition's work.

Increase Education about Palliative, End of Life, and Hospice Care

Palliative, end of life, and hospice care are critical components of the health-care system, yet they are often misunderstood and poorly utilized. Cultural beliefs and values can have a profound effect on one's views towards palliative, end of life, and hospice care, and programs must be culturally effective. Further education of the general public, medical professionals, and legislators about the benefits of palliative care and the importance of planning for end of life care is needed. Many communities have begun holding gatherings to start "the conversation" about end of life care. These efforts should be encouraged and supported. Efforts in this area will help to better manage end of life

care, control costs, improve quality of life, and honor individual choice.

Convene Technology and Aging Summit

New Hampshire should convene a summit on technology and aging to address the broad range of issues related to technology, aging in place, and access to health care. The creation of a taskforce on technology and aging could help to identify and promote technological developments that have the potential to support older adults to live and thrive in their homes and communities.

Recruit, Train, and Retrain Health Care Workers

Efforts need to be made to recruit, train and retain a broad range of health care workers, including physicians, nurses, home care workers, and direct support professionals. Efforts to provide a livable wage for home care workers should be supported. We need to work with employers, state policy-makers, and legislators to improve the recruitment, training, and retention of this critical workforce.

References

- Administration on Aging. (2014). Oral Health. Retrieved from: http://www.aoa.acl.gov/AoA_Programs/HPW/Oral_Health/index.aspx
- Barber, J. A., Frantsve, L. M., Capelli, S., & Sanders, K. A. (2011). Implementation and evaluation of an integrated care program in a VA Medical Center. *Psychological Services*, 8(4) 282-293. doi:10.1037/a0026158
- Bergin, D. (2015, August 4). Smiles for seniors: Ottawaquechee health foundation offers free oral health screenings and fluoride varnish for older adults. Retrieved from the Ottawaquechee Health Foundation: <http://www.ohfvt.org/smiles-for-seniors-ottaquechee-health-foundation-offers-free-oral-health-screenings-and-fluoride-varnish-for-older-adults/>
- Borchgrevink, A., Snyder, A., & Gehshan S. (2008). The effects of Medicaid reimbursement rates on access to dental care. *State Health Policy Monitor*. Retrieved from: <http://www.allhealth.org/briefingmaterials/nashp-medicaidreimbursement-1277.pdf>
- Center to Advance Palliative Care. (2011). Public opinion research on palliative care: A report based on research by public opinion strategies. Retrieved from: https://www.capc.org/media/filer_public/18/ab/18ab708c-f835-4380-921d-fbf729702e36/2011-public-opinion-research-on-palliative-care.pdf
- CDC. (2012). CDC focuses on need for older adults to receive clinical preventive services. Retrieved from: <http://www.cdc.gov/aging/pdf/cps-clinical-preventive-services.pdf>
- Coolen P. R. (2012). Cultural relevance in end-of-life care. *EthnoMed*. Retrieved from: <http://ethnomed.org/clinical/end-of-life/cultural-relevance-in-end-of-life-care/>

- Covert, S., Davie, L., & Fox, S. (2014). Tri-state roundtable on aging conference report. Maine Council on Aging; Endowment for Health.
- Davis, K. E., Brigell, E., Christiansen, K., Snyder, M., McDevitt, J., Forman, J., & Wilkniss, S. M. (2011). Integrated primary and mental health care services: An evolving partnership model. *Psychiatric Rehabilitation Journal*, 34(4), 317-320.
- DHHS. (2014, December 1). 2014 oral health survey of New Hampshire older adults. Retrieved from Oral Health Program: <http://www.dhhs.nh.gov/media/pr/2014/12-dec/12012014report.htm>
- Felderman, P. H., & Oberlink, M. R. (2003). The AdvantAge Initiative: Developing community indicators to promote the health and well-being of older people. *Family and Community Health*, 26(4), 268-274.
- Ghosh, R., Lindeman, D., Ratan, S., & Steinmetz, V. (2014). The new era of connected aging: A framework for understanding technologies that support older adults aging in place. Retrieved from Center for Technology and Aging: <http://www.techandaging.org/ConnectedAgingFramework.pdf>
- Home Care Assistance. (2012). Importance of palliative care for older adults. Retrieved from: <http://www.homecareassistance-toronto.com/blog/importance-palliative-care-older-adults/>
- Jones, A., Moss, A., & Harris-Kojetin, L. (2011). Use of Advance Directives in Long-Term Care populations . (National Center for Health Statistics Data Brief: No. 54). Retrieved from: <http://www.cdc.gov/nchs/data/databriefs/db54.pdf>
- Kahana, B., Dan, A., Kahana, E., & Kercher, K. (2004). The personal and social context of planning for end of life care. *Journal of American Geriatric Society*, 52(7), 1163-1167. doi:10.1111/j.1532-5415.2004.52316.x
- Kahl, E. (2013). Falls prevention program focus of \$380,000 grant. Retrieved from University of Maine: <http://umaine.edu/news/blog/2013/08/01/falls-prevention-program-focus-of-380000-grant/>
- Kash, B. A., May, M. L., & Tai-Seale, M. (2007). Community health worker training and certification programs in the United States: Findings from a national survey. *Health Policy*, 80(1), 32-42. doi: 10.1016/j.healthpol.2006.02.010
- Kagawa-Singer, M., & Blackhall, L. J. (2001). Negotiating cross-cultural issues at the end of life: "You got to go where he lives". *JAMA*, 286(23):2993-3001.
- Krupa, C. (2011). How states are keeping doctors from moving out. Retrieved from American Medical News: <http://www.amednews.com/article/20111219/profession/312199944/1/>
- Lee, M. (2008). The PACE program and end of life care. Retrieved from Catholic Health Association of the United States: <https://www.chausa.org/publications/health-progress/article/may-june-2008/the-pace-program-and-end-of-life-care>
- Leininger, M. M. & McFarland, M. R. (2002). *Transcultural Nursing: Concepts, Theories, Research, and Practice* (3rd Edition). New York, NY: McGraw-Hill.
- Li, F., Harmer, P., Fisher, K. J., McAuley, E., Chaumeton, N., Eckstrom, E., Wilson, N. L. (2005). Tai Chi and fall reductions in older adults: A randomized controlled trial. *Journal of Gerontology a Biological Medical Science*, 60(2). 187-194. doi: 10.1093/gerona/60.2.187
- Li, F., Harmer, P., Fitzgerald, K., Eckstrom, E., Stock, R., Galver, J., Maddalozzo, G., & Batya, S., S. (2012). Tai Chi and postural stability in patients with Parkinson's Disease. *New England Journal of Medicine*, 366(6), 511-519.

Chapter 5

Lynn, J., & Adamson, D. M. (2003). *Living well at the end of life*. Arlington: Rand.

Malley, P. (2012). Testimony related to New Hampshire HB 1217. Retrieved from Aging with Dignity: <http://agingwithdignity.org>

McCullough, D. (2008). *My mother, your mother: Embracing 'Slow Medicine': The compassionate approach to caring for your aging loved ones*. New York: Harper-Collins.

McGinn-Shapiro, M. (2008) Medicaid coverage of adult dental services. State Health Policy Monitor, 2(2), 1-6. Retrieved from: <http://nashp.org/sites/default/files/Adult%20Dental%20Monitor.pdf?q=files/Adult%20Dental%20Monitor.pdf>

Metcalf, J. A. (2013). Strategies to achieve the trip aim goals: Addressing health literacy challenges and employing effective communication techniques. Retrieved from University of New England: http://www.mainequalitycounts.org/image_upload/QC%202013_J.%20Metcalf_Health%20Literacy.pdf

Mirambeau, A. M., Wang, G., Ruggles, L., & Dunet, D. O. (2013). A cost analysis of a community health worker program in rural Vermont. *Journal of Community Health*, 38(6), 1050-1057. doi: 10.1007/s10900-013-9713-x

Morris, D. W. (2010). Making the case for fluoride varnishes. Retrieved from Modern Hygienist: <http://www.dentalproductsreport.com/hygiene/article/making-case-fluoride-varnishes>

National Council of State Legislators. (2011). Primary Care Workforce. Retrieved from: <http://www.ncsl.org/research/health/primary-care-workforce.aspx>

NH Citizens Health Initiative. (n.d.). About us. Retrieved from: <http://citizenshealthinitiative.org/about-us>

NH Citizens Health Initiative. (2008). Strategies to

Address the Issues of Access to New Hampshire's Primary Care Workforce: A Report to Governor John Lynch. Retrieved from: <http://citizenshealthinitiative.org/sites/citizenshealthinitiative.org/files/media/documents/NHCHIWorkforceReport.pdf>

NH Coalition for Direct Care Workforce. (2009). Strategies to invest in the future of the direct care workforce. Retrieved from: http://chhs.unh.edu/sites/chhs.unh.edu/files/media/strategies_to_invest_in_thefuture_of_the_direct_care_workforce.doc_-_2009_nhdcw_white_paper.pdf

NH Employment Security. (2014). NH employment projections by industry and occupation base year 2012 - Projected year 2022. Retrieved from NH Employment Security Economic and Labor Market Information Bureau: <http://www.nhes.nh.gov/elmi/products/documents/projections.pdf>

PHI National. (2013). America's direct-care workforce. Retrieved from: <http://phinational.org/sites/phinational.org/files/phi-facts-3.pdf>

Persky, T. (2015). Overlooked and underserved: Elders in need of mental health care. Retrieved from Mental Health Association of PA: <http://www.mhaging.org/info/olus.html>

Phillips, K., Fox, S., & Davie, L. (2012). Seniors Count community connections aging in place evaluation report. Retrieved from Center on Aging and Community Living: <http://chhs.unh.edu/sites/chhs.unh.edu/files/SCCC%20summative%20evaluation%20final.pdf>

Ragovin, H. (2014, August 12). Dental woes of an aging population. Tufts Dental Medicine. Retrieved from: <http://now.tufts.edu/articles/dental-woes-aging-population>

Rollins, N. (2015). Data compiled from the American

Community Survey 2012 5-year sample of people living in New Hampshire, age 75+. Institute on Disability, Durham, NH

SAMSHA. (2013). Report to Congress on the nation's substance abuse and mental health workforce issues. Retrieved from U.S. Department of Health and Human Services: <http://store.samhsa.gov/shin/content//PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>

Seniors Count NH. (2015). Our seniors are falling through the cracks. Retrieved from Easter Seals NH: <http://www.easterseals.com/nh/our-programs/senior-services/SeniorsCount.html>

Spectrum Generations. (2014). Spectrum Generations awarded community health worker grant. Retrieved from: http://www.spectrumgenerations.org/chw_grant

Spitzer, W. J., Davidson, K. W., & Allen, G. (2013). Future trends in health and health care: Implications for social work practice in an aging society. *Social Work in Health Care*, 52(10), 959-986. doi:10.1080/00981389.2013.834028

Thorpe, J. M., Thorpe, C. T., Kennelty, K. A., & Pandhi, N. (2011). Patterns of perceived barriers to medical care in older adults: a latent class analysis. *BMC Health Services Research*, 11, 181. doi: 10.1186/1472-6963-11-181

Tinetti, M., Baker, D., McAvay, G., Claus, E., Garrett, P., Gottschalk, M., & ... Horwitz, R. (1994). A multifactorial intervention to reduce the risk of falling among elderly people living in the community. *New England Journal of Medicine*, 331(13), 821-827.

Verhagen, I., Steunenbergh, B., De Wit, N. J., & Wynand J. G. R. (2014). Community health worker interventions to improve access to health care services for older adults from ethnic minorities: A systemic review. *BMC Health Services Research*, 14,

497- 504. doi: 10.1186/s12913-014-0497-1

Viswanathan, M., Kraschnewski, J. L., Nishikawa, B., Morgan, L. C., Honeycutt, A. A., Thieda, P. . . . Jonas, D. E. (2010). Outcomes and costs of community health worker interventions: A systematic review. *Med Care*, 48(9), 792-808. doi: 10.1097/MLR.0b013e3181e35b51

World Health Organization (WHO). (2015). Definition of palliative care. Retrieved from: <http://www.who.int/cancer/palliative/definition/en/#>

World Health Organization (WHO). (n.d.). WHO definition of health. Retrieved from: <http://who.int/about/definition/en/print.html>

Written Directives for Medical Decision Making for Adults Without Capacity to Make Health Care Decisions, N.H. Rev. Stat. Ann § 137-J (2015).

Website Links

(25) MapNH: <http://citizenshealthinitiative.org/mapnh-health>

(26) Accountable Care Project: <http://citizenshealthinitiative.org/accountable-care-project>

(27) NH Falls Reduction Task Force: <http://www.nhfallstaskforce.org/wordpress/>

(28) American Academy of Home Care Medicine: <http://www.aahcm.org>

(29) Better Choices, Better Health Workshop: <http://www.snhahec.org/BetterChoicesBetterHealth.cfm>

(30) Patient Aligned Care Team: www.manchester.va.gov/features/HPDP.asp

(31) NH AHEC: <http://nhahec.org/>

(32) New Hampshire J-1 Visa Waiver Program: <https://www.raonline.org/funding/3413>

(33) Referral Education Assistance and Prevention (REAP) Program: <http://www.smhc-nh.org/services/reap/>

(34) NAMI NH: <http://www.naminh.org/>

(35) A New Perspective on living: http://www.dartmouth-hitchcock.org/palliative_care/new_perspective.html

(36) Project Enable: <http://promotingexcellence.org/dartmouth/index.html>

(37) POLST: <http://www.healthynh.com/provider-orders-for-life-sustaining-treatment-polst.html>

(38) NH Hospice and Palliative Care Organization: <http://www.nhhpc.org/>

(39) Massachusetts Association of Community Health Workers: <http://www.machw.org>

(40) Penn Center for Community Health Workers: <http://chw.upenn.edu/collaborate>

(41) Dartmouth Centers for Health and Aging: <http://prc.dartmouth.edu/car/>

(42) San Diego Technology and Aging Coalition: <http://www.agetechsd.org/>

(43) Respecting Choices: www.respectingchoices.org



ADVOCATES FOR ELDER ISSUES ARE EFFECTIVE

THE ELDER HEALTH ADVISORY COMMITTEE DEFINED THIS DOMAIN AS “CULTURAL VIEWS OF ELDERS ARE POSITIVE AND REALISTIC; LAWS ARE ELDER FRIENDLY; AND AGING ISSUES ARE A COMMUNITY-WIDE PRIORITY.”

Success across the other five Elder Health domain areas will rely heavily on the activation of effective advocacy for elder issues. Advocacy helps inform and educate policy makers, allows individuals to have their voices heard, builds stronger communities, and allows people to live more fulfilling lives. Successful advocacy helps build and maintain social movements. The hallmark of successful social movements is that they are broad based, have support from constituents who are representative of the vulnerable population, and garner support from individuals and/or organizations focused on the same specific political or social issue.

While each generation of Americans face a different set of economic, political, and social conditions, the “Traditional” generation (1922–1945) and the “Baby Boomers” (1946–1964) witnessed and participated in some of the greatest social changes in the country’s history, including the Civil Rights, Anti-War, Disability Rights, Women’s

Rights, and LGBT Rights movements. Despite these revolutionary civil rights movements, advocacy related to seniors’ issues has not kept pace with the changes needed for our aging population. As the baby boom generation ages, the time is right for the development of a social movement to support the rights of older adults. However, without a strong grassroots advocacy network for older adults, a social movement will never get off the ground, making reform less likely. The need for strong advocacy related to aging issues is of particular importance for New Hampshire, because it is one of the oldest and fastest aging states in the nation (US Census, 2014).

Despite pervasive age discrimination, older adults have not engaged in a collective action that could be labeled as a rights-based movement. Rather, advocacy efforts have been led by service providers and professionals and have, therefore, focused on obtaining benefits and services. While

this has resulted in advances in entitlement programs and aging-related services, it has failed to create a constituency for protecting or enhancing older adults' rights (Vliet, 2011).

As New Hampshire moves forward to build an effective advocacy movement around elder issues, the key factors that were identified by Rother (2004) as contributing to the lack of advocacy for older adults should be considered. These factors include the increasing diversity of the older adult population; difficulty in unifying interest groups; lack of leadership to build grassroots advocacy; underutilization of think tanks, technology, and communication tools; lack of cross-generational solidarity; and difficulty building support across the political landscape. The lack of a strong and cohesive advocacy network to address aging issues in New Hampshire continues to be a significant barrier to creating change in this arena.

Key Concepts in Creating an Effective Advocacy Network

Recent research by the Frameworks Institute indicates that the American public draws on a complex set of cultural models to make sense of

adult aging and the role that older Americans play in our society. They identified a set of key assumptions in mainstream American culture regarding how we view aging. These assumptions include the public's vision of what aging should be like, as opposed to the reality of aging; stereotypes of aging as a singular category of "old people"; the notion that individuals should be held responsible for their lifestyle choices, such as planning for retirement or choices leading to poor health; the belief that government programs (such as Social Security) are inefficient and ineffective; and cognitive holes in our understanding of how rapidly the country is aging and how ageism and discrimination limits our ability to address aging as a social issue (Lindland, Fond, Haydon, & Kendall-Taylor, 2015). Any effort to create an effective advocacy network must consider how to navigate these key assumptions and perceptions.

Successful social movements stimulate the emergence of new stories, which often lead to legal and public policy changes. Lawmaking becomes a way to institutionalize the changes promoted through a social movement (Guinier & Torres, 2014). In contrast to the successful social movements noted above, the legal field has not played as significant a role in shaping the field of gerontology

(Kohn, 2012). This has created an environment where governmental treatment of older adults has been framed primarily as a social welfare concern and in which the implications of such treatment for older adults' civil rights are underappreciated or unrecognized. Kohn (2012) recommends incorporating a civil rights (i.e., the rights individuals have by virtue of their membership in a particular group) perspective in order to improve aging-related laws and policies. By recognizing aging concerns as civil rights issues and publicly labeling them as such, the potential exists to change how governments and societies treat older adults.

The Current Landscape in New Hampshire

There are a number of advocacy initiatives that have been developed in New Hampshire, with a goal of increasing advocacy efforts related to older adult issues. The New Hampshire Senior Leadership Series is a collaboration among AARP, the UNH Center on Aging and Community Living, and the Dartmouth Centers for Health and Aging. The purpose of the Senior Leadership Series is to provide support and training to interested New Hampshire

community leaders in the advocacy and leadership skills necessary to promote livable communities, including community-based systems of support for New Hampshire citizens as they age. The envisioned benefit of the series is a stronger, more unified grassroots advocacy system to improve the lives of older adults in the Granite State. Participants receive training on a wide variety of educational and community topics from respected leaders in community organizing, leadership development, and best practices in older adult advocacy. Topics covered include aging demographics, service delivery and financing mechanisms, community organizing, the legislative process, and healthy aging. Participants are also tasked with working on a group project that incorporates one area of aging they are particularly interested in (e.g., housing, employment, fraud/scams, etc.) (Davie, Fox, & Rataj, 2015). The series' organizers also created an "alumni network" to keep graduates connected, and to form the beginning of a community-level advocacy network.

The State Committee on Aging (SCOA) is a Governor-appointed committee that identifies concerns of older citizens and makes recommendations to the Commissioner of Health and Human Services regarding policy and

Chapter 6

procedures to best protect the well-being, rights and quality of life of older New Hampshire citizens. There are 18 members who serve as advocates for New Hampshire's older adults by identifying needs, facilitating participation of older adults in the public process, developing the State Plan on Aging and monitoring implementation progress, collaborating with other elder issue interest groups, and advising the DHHS on elder issues. In addition, local Committees on Aging are established in many communities to allow for broader input. While there are local Committees on Aging in each of the ten regions of the state, there is great variability in how active and engaged they are.

There are a number of organizations, associations, and groups in New Hampshire that advocate for senior issues; however, they often support a specific agenda or narrow cause. Currently there is not a state-wide, multi-issue effort to bring these various constituencies together to advocate on common issues related to older adults.

NH AARP represents the needs of all older adult members in New Hampshire and is one of the largest lobbying and advocacy forces focusing on aging issues. They have been strong advocates for a variety of aging issues such as economic security;

health care; access to affordable, quality long-term care; creating and maintaining livable communities; and consumer protections (AARP, 2015). NH AARP has been a strong voice for New Hampshire seniors around these issues, as well as promoting the national organization's agenda around political organizing and protection of Social Security and Medicare.

The Elder Rights Coalition (ERC) is a volunteer effort of organizations, associations, and individuals who are interested in assuring the rights of older adults (Elder Rights Coalition, 2015). The ERC supports responsible social policy and its enforcement, guaranteeing the rights and choices of every older person in New Hampshire to a full range of quality living, support, and care options that enable all to live in dignity as respected members of society. The ERC monitors legislation related to aging issues during each legislative session and keeps its members and the interested public informed of the status of pertinent bills.

In addition to the organizations listed above, there are a number of other organizations in New Hampshire that support aging issues or could be tapped to develop partnerships to strengthen advocacy around these issues. These include:

- Granite State Organizing Project (GSOP) is a non-profit, non-partisan organization rooted in faith and democratic values, and includes 28 religious, labor, and community organizations. GSOP mobilizes on issue oriented actions and builds strong relationships and communities in the Manchester, Nashua, and Goffstown areas of New Hampshire ⁽⁴⁴⁾.
- New Hampshire Citizens Alliance for Action (NHCAA) works to engage grassroots activists in lobbying the state legislature to ensure consumer and community concerns are addressed by public policy. NHCAA tackles issues such as: affordable health care for all, ensuring equal pay for equal work, and establishing a livable wage. NHCAA is an affiliate of USAction, which brings together citizen organizations from across the country to form a strong national, progressive voice ⁽⁴⁵⁾.
- New Hampshire Public Health Association (NHPHA) is non-profit organization that aims to strengthen the state’s public health system to improve health, prevent disease, and reduce costs for all. NHPHA brings people interested in public health together and provides a forum for the exchange of public health information. NHPHA helps to identify public health problems within the state and educates members of the New Hampshire governing body on matters pertaining to public health ⁽⁴⁶⁾.
- EngAGING NH is a non-profit, grassroots organization that serves as a citizen voice for the aging experience. EngAGING NH defines its mission as promoting “citizen leadership and the active involvement of New Hampshire’s older adults in the development of communities and public policies that support individuals as they age.” EngAGING NH works to empower older adults by providing education and information on key public issues to support advocacy for change⁽⁴⁷⁾.
- The Alliance for Retired Americans (ARA) is a national organization that advocates a progressive political and social agenda that respects work and strengthens families. The ARA works to ensure social and economic justice and full civil rights for all citizens so that they may enjoy lives of dignity, personal and family

fulfillment, and security. The New Hampshire organization often coordinates their efforts with the New Hampshire Citizens Alliance ⁽⁴⁸⁾.

- Healthy Eating Active Living (HEAL) is a network of state and community partners dedicated to advancing population-based approaches to reduce the prevalence of obesity and chronic disease in New Hampshire. HEAL aims to improve access to healthy foods and opportunities for physical activity. HEAL has brought together network partners representing health, land use, transportation, education, food systems, economic development, housing, environment, policy makers, business, and industry professional groups to achieve long-term sustained change ⁽⁴⁹⁾.
- New Hampshire Voices for Health works with health care advocates, consumers, and policy makers to advance change in public policy and health care systems. Their mission is to achieve quality, affordable healthcare for all. They have a network of more than 50 organizational members representing more than 400,000 constituents ⁽⁵⁰⁾.

There are many organizations that can be mobilized to aid in the creation of a grassroots advocacy network for older adults in New Hampshire. Creative partnerships that build on the common interests of these various groups could greatly enhance the strength of an advocacy network for aging issues.

Best Practices Nationally

A number of grassroots advocacy organizations focusing on aging issues particular to a specific state have surfaced around the nation. For example, the Joint Public Affairs Committee for Older Adults (JPAC) is a senior-driven grassroots group, drawn from over 200 senior and community groups throughout metropolitan New York City. It mobilizes older adults to speak out on critical issues and effect positive social change. JPAC founded a ten week leadership training course, the Institute for Senior Action, which integrates education on effective advocacy and critical aging policy issues with practical grassroots application. The Institute for Senior Action serves as a vehicle for recent retirees and others to become more involved in social action. The Institute has trained more than 265 participants

who have returned to their communities to act as leaders and advocates in communities throughout New York City (Epstein, West, & Riegel, 2000).

Another example is the California Senior Leaders Program (CSLP), which is grounded in concerns with ageism, and the often invisible volunteer and community advocate roles of California's rapidly growing older adult population. CSLP recognizes a diverse array of California's older activists for their impact and continuity of their work at a two-day honoring and training event for these "Senior Leaders." CSLP also formed the action-focused organization California Senior Leaders Alliance (CSLA). CSLA is completely constituent run and was formed as a state-wide aging network focusing on three key areas: healthcare access, transportation, and elder economic security. CSLA hosts an annual meeting in the state capital as an opportunity to meet with legislators, provide education, and advocate for a bill related to priority issues. A subgroup of CSLA collaborates as a Steering Committee, which coordinates the implementation of CSLA's action steps (Martinon, Minkler, & Garcia, 2013).

Caring Across Generations is a national movement that utilizes social action, social media

and storytelling to spark connections across generations and to strengthen family and caregiving relationships. The movement is built on four major program areas: culture change work; local, state and federal policy advocacy; online campaigning; and field activities and civic engagement. They provide a great example of how to mobilize across generations to build momentum to create social change⁽⁵¹⁾.

The FrameWorks Institute is working collaboratively with a coalition of eight of the nation's leading aging-focused organizations to address perceptions of aging and to better understand older adults' needs and contributions to society. This coalition includes: AARP, the American Federation for Aging Research, the American Geriatrics Society, the American Society on Aging, The Gerontological Society of America, Grantmakers in Aging, the National Council on Aging, and the National Hispanic Council on Aging (Lindland, 2015). The coalition is working to address public perceptions to develop a more accurate understanding of today's older adults⁽⁵²⁾.

Another national initiative that is working to change the public perception of aging is Dr. Bill Thomas' Age of Disruption 2015 Tour. The tour is visiting cities across the country in order to connect

pro-aging advocates to each other and to new ideas and approaches that can “disrupt aging” and yield lasting change ⁽⁵³⁾.

Programmatic, Policy, and Research Implications

An effective grassroots advocacy network is imperative in order to strengthen policies and programs related to long-term services and supports for older adults, as well as to advance policies to create more elder-friendly communities. Currently, the grassroots advocacy capacity in New Hampshire is weak. It will be important to understand what has hindered the development of a cohesive and strong advocacy network for older adults. The baby boomers are more diverse, better educated, and more interested in person-centered choice and control than previous generations. In order to successfully engage older adults, it is important to better understand how this generation can be engaged in advocacy interests as they age.

New Hampshire aging advocates must expand their reach outside of the aging service network. While the needs of a vulnerable population are not going away, not all older adults are vulnerable, nor

are they united on any particular prescription for social reform. The messaging around the needs of an aging population must be expanded to include other audiences such as journalists, business leaders, and other opinion leaders who can help incorporate a broader view of aging in the context of the entire community’s needs.

Recommendations

Address Stereotypes and Cultural Views

In order to impact change around aging-related issues, society’s view of aging needs to change, including stereotypes, stigma, and our fear of aging and dying. Cultural views of older adults that are positive and realistic must be promoted. In order to frame a positive image of aging, a comprehensive communication and public engagement campaign is needed. New Hampshire can build on the work of national groups that are working to redefine aging, such as the Frameworks Institute and the Age of Disruption 2015 Tour noted above.

Promote Advocacy

A grassroots advocacy movement is needed in order to make aging issues a community-wide priority. The movement should engage community members across generations; promote collaboration across organizations, businesses, and community leaders; educate the public about aging issues; and utilize technology to reach the largest possible constituency. Any advocacy movement should utilize and build upon the many advocacy groups that are already working in New Hampshire, such as the Elder Rights Coalition, SCOA, and EngAGING NH, in order to build a more cohesive and coordinated state-wide advocacy network.

Create Social Change

Efforts to create social change in relation to aging should utilize a civil rights perspective in order to impact aging-related laws and public policies. The framing of issues related to aging as civil rights creates a greater potential to change how government, business, and society treat older adults. Efforts should be supported that can work toward the development and passage of aging friendly laws.

Build State-Wide Advocacy Network

Finally, a more strategic approach is needed to build an effective, state-wide advocacy network. Building on the success of the New Hampshire Senior Leadership Series to establish a large network of educated and passionate advocates is a critical step in creating a strong network of leaders to fight for aging related issues, policy changes, and adequate public funding for services.

References

AARP. (2015). AARP. Retrieved from: <http://states.aarp.org/region/new-hampshire/>

Davie, L., Fox, S., & Rataj, A. (2015). Building an aging advocacy network: Findings from the New Hampshire Senior Leadership Series. Retrieved from Center on Aging and Community Living: http://chhs.unh.edu/sites/chhs.unh.edu/files/departments/center_on_aging_and_community_living/cacl_senior_leadership_brief_3_12_15.pdf

Elder Rights Coalition. (2015). Mission. Retrieved from: <http://www.ercnh.org/>

Epstein, D., West, A., & Riegel, D. (2000). The Institute for Senior Action: Training senior leaders for advocacy. *Journal of Gerontological Social Work*, 33(4), 91-99.

Guinier, L., & Torres, G. (2014). Changing the wind: Notes toward a demosprudence of law and social movements. *Yale Law Journal*, 123(8), 2740-2804.

Kohn, N. (2012). A Civil Rights Approach to Elder Law. In Israel Doran, Editor, & Ann M. Soden, Editor (Eds.), *Beyond elder law* (19-34). London: Springer.

Martino, M., Minkler, M., & Garcia, A. (2013). Honoring, training, and building a state-wide network of elder activists: The California Senior Leaders Program. *Journal of Community Practice*, 21(4), 327-355.

Lindland, E., Fond, M., Haydon, A., & Kendall-Taylor, N. (2015) Frameworks Institute. Retrieved from Gauging Aging: Mapping the gaps between expert and public understandings of aging in America: http://www.frameworksinstitute.org/assets/files/aging_mtg.pdf

Rother, J. (2004). Why haven't we been more successful advocates for elders? *Generations*, 28(1), 55-58.

U.S. Census (2014). New Hampshire quick facts. Retrieved from: <http://quickfacts.census.gov/qfd/states/33000.html>

Vliet, W. (2011). Intergenerational cities: A framework for policies and programs. *Journal of Intergenerational Relationships*, 9(4), 348-365. doi:10.1080/15350770.2011.619920

Websites

- (44) Granite State Organizing Project: http://granitestateorganizing.org/About_Granite_State_Organizing_Project.php
- (45) NH Citizens Alliance for Action: <http://www.nhcaforaction.org/about-.html>
- (46) NH Public Health Association: <http://nhpha.org/about>
- (47) EngAGING NH: <http://www.engagingnh.org/>
- (48) Alliance for Retired Americans: <http://retiredamericans.org/>
- (49) Healthy Eating Active Living: <http://www.healnh.org/index.php/about-heal>
- (50) New Hampshire Voices for Health: <http://www.nhvoicesforhealth.org/>
- (51) Caring Across Generations: <http://www.caringacross.org/>
- (52) Frameworks Institute: <http://www.frameworksinstitute.org/aging.html>
- (53) Age of Disruption: <http://changingaging.org/blog/category/age-of-disruption/>

Prepared by:
Susan Fox, PhD
Laura Davie, MA
Alison Rataj, MSW

© 2015 UNH Center on Aging and Community Living

Center on Aging and Community Living
University of New Hampshire
56 Old Suncook Road, Suite 2
Concord, NH 03301

www.chhs.unh.edu/cacl