

Northwest Public Health

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Public Health
Serves
the New Elderly



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Not Your Grandparents' Golden Years

According to the US Census Bureau, today's seniors are very different from previous generations. Americans are living longer and, in general, entering old age healthier. When—if—we become disabled, we're doing so far later in life than our parents and grandparents did.

As a result, there are more of us; there were 36 million Americans over 65 in 2000, and it's expected that there will be 72 million over 65 in 2030. The fastest growing age group in the country isn't toddlers or teenagers—it's people over the age of 85.

Although today's Americans are generally healthier when they reach their senior years than were previous generations, the fact is that living longer has consequences, as does the rising rate of obesity, which could neutralize the positive trends set by other health improvements.

A growing population of seniors and the usual consequences of aging—Alzheimer's disease, coronary heart disease, and stroke, to name a few—will mean, of course, a higher demand for health care and social services. By 2030, US health care costs are projected to increase by 25 percent. Faculty at the UW School of Public Health and Community Medicine are engaged in a number of research projects designed to contribute to healthy aging and lower health care costs. Our researchers are investigating a range of issues:

- Risk factors for coronary heart disease and stroke in the elderly
- Physical and cognitive functioning in the elderly
- Ways to delay or prevent dementia in older adults
- Genetic and environmental risk factors of Alzheimer's disease
- Health services for older adults
- Obesity in the elderly

Among our School's most visible efforts on behalf of our older citizens are those undertaken through the Health Promotion Research Center (HPRC). Some of the Center's work in improving fitness is described on page 20 in this issue of *Northwest Public Health*. HPRC is one of 33 Prevention Research Centers funded by the Centers for Disease Control and Prevention. These Centers are located in academic institutions across the country, and they collaborate with community-based partners to conduct research intended to decrease disease and disability.

In addition to managing several projects designed to increase physical activity among older adults—by increasing opportunities, removing barriers, and linking patients to community-based programs and support systems—the HPRC also studies minor depression among seniors through its PEARLS (Program to Encourage Active, Rewarding Lives for Seniors) project. Through structured behavioral therapy and “pleasant-event scheduling,” PEARLS eliminated depression for more than one-third of participants and reduced depressive symptoms by half for 43 percent of participants.

Although not directed at older adults, the Center's efforts to promote healthful behaviors in the workplace have implications for health in later life. For instance, were more employers to offer smoking cessation services, they would lower their health insurance costs and have a healthier workforce. And today's healthier workers would become tomorrow's healthier retirees.

This issue of *Northwest Public Health* covers an impressive array of articles on studies and projects geared to understanding and helping our aging population. Once again, I'm pleased to get a glimpse of the health-promoting initiatives under way throughout the Northwest region and to have the opportunity to highlight some of the research projects in our School contributing to those efforts.

A handwritten signature in dark ink, reading "Patricia W. Wahl". The signature is fluid and cursive, with the first name "Patricia" being the most prominent part.

Patricia W. Wahl, Dean
UW School of Public Health
and Community Medicine



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Patricia W. Wahl, PhD, Dean
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The mission of the journal is to provide a forum for practitioners, teachers, researchers, and policy makers in public health to exchange ideas, describe innovations, and discuss current issues.

The logo of the School of Public Health, designed by Marvin Oliver, is a symbol of physical and mental well-being.

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Couple walking. © Falk Bartels| Dreamstime.com.

US Army troops watch an atomic bomb test, 1951. National Archives and Records Administration.

Boy watching television. Library of Congress.

Sock hop. Urban Archives, Temple University Libraries, Philadelphia.

Civil rights march, Washington, DC. 1963. Library of Congress.

President and Mrs. Kennedy. 1963. By Victor Hugo King. Library of Congress.

Moon walk. NASA Kennedy Space Center (NASA-KSC).

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From the Editor



I started out in aging. That is, my first health policy job in Washington State (circa 1978) was in “long-term care,” a term often used synonymously with “aging.” Even though the field was led by some very independent and feisty elders—including a few of my own mentors at the time—we often approached long-term care as if all older adults needed long-term assistance with one problem or another, as if aging was a constant state of dependence on services and programs.

The main issue back then was how to break away from warehousing older people in institutions, such as nursing homes. Federal and state policy seemed to strongly favor nursing homes and to discourage in-home or in-community social and health services; nursing home use and cost could be controlled (build only so many beds, regulate price per day), while these non-institutional services were more amorphous (how many visits per week by a personal care attendant were really necessary?). Much lipservice was being given to family caregivers and social support systems, but that was just a sideshow to the debate over programs, services, buildings, and budgets.

We collectively voiced a vague anxiety about the distant future when Baby Boomers would reach retirement, overwhelming the ability of formal and informal care networks to support them. Now, that distant future is here, and vague anxiety is rapidly giving way to stark reality. Fortunately, we’ve learned a lot over the past 30 years about intergenerational relationships, about communities, about aging, and about health.

Today, it’s easier to see that “the elderly” represent various points on a continuum of assets, desires, and needs on which, in fact, we all fall. Who hasn’t needed help getting to the doctor’s office or the grocery store due to some malady or malfunction? Who shouldn’t watch their diet and exercise? Who isn’t better off contributing to the well-being of community through volunteer activities?

That’s the lens through which I read the articles in this issue of *Northwest Public Health*. For example, look over Northwest Region at a Glance; the health indicators are really the same indicators we might look at for any segment of the population. Likewise, both the Viewpoint from Klein (p. 4) and Piering’s article (p. 6) about expectations suggest that those entering retirement age have priorities similar to the generations before and after (family focus, purpose, choice).

The pieces by Lowe (p. 8), Knopf (p. 16), and Jones (p. 18) highlight the importance of community connections, including intergenerational relationships, in promoting quality of life. Articles by Johnson and Reischl (p. 10) and Snyder and Belza (p. 20) explore broad-based approaches to optimize both physical and mental health among the elderly—the former through community planning and zoning, the latter through a comprehensive health and wellness program. Still, we don’t ignore more traditional “public health” discussions about aging: Gray, Felton, and Wangsmo (p. 12) describe efforts to reduce transmission of noroviruses in care facilities; Graves, Saylor, and Shavings (p. 14) comment on the complex topic of elder abuse in Alaska Native cultures; and a series of short articles (p. 22) discusses seniors and public health preparedness activities.

I hope you enjoy this issue of *Northwest Public Health*. Let us know what you think.

Aaron Katz, Editor-in-Chief
Director, Packard-Gates Population Leadership Program
UW School of Public Health and Community Medicine

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The Changing Expectations of Aging

Denise Klein

It's convenient to divide our aging population into cohorts and then speculate about how the behavior and values of one cohort are different from those of another. From there, we move on to tease out the implications of these differences in terms of needs, desires, and demands for goods and services.

In my field, which includes a part of public health—the part where we concern ourselves with prevention, diet, exercise, and encouraging healthy behaviors—we struggle with program design challenges in part because we want to serve multiple cohorts and serve them efficiently with limited dollars. Many of our customers and potential customers are older than 85. Many are still in their 60s. For both groups, staying healthy is not only a major preoccupation of many individuals, but also a concern of funders, planners, and organizers. We are anxious not to spend precious health care dollars undoing harm that people have done to themselves through inactivity or unhealthy behaviors.

There isn't ever going to be a “dropping off a cliff” moment when all those turning 60 or 65 wake up and want something entirely new and different from what previous 60 or 65 year olds wanted. Nonetheless, all cultures constantly evolve, and each generation is shaped by birth rates and cohort

size, immigration patterns, each generation's own lived history, educational attainment, and changes in the economy ... not to mention genetics and personality.

Here are a few observations about how Baby Boomers may be different from previous generations and how these differences are likely to affect their health, social service, and long-term care needs and expectations.

There isn't ever going to be a “dropping off a cliff” moment when all those turning 60 or 65 wake up and want something entirely new and different from what previous 60 or 65 year olds wanted.

- Boomers are less conservative about their finances (for better and worse) and more likely to spend money on services that will help them age well.
- Shaped by a booming economy, many of these Boomers (despite lower savings rates) invested or have multiple pensions, so they may have quite a bit of disposable income.
- Others, less financially well-off, will have needs similar to those of older generations as they age and will be in the market for subsidized services and housing.
- Geared to a personal lifelong search for meaning and purpose beyond getting and spending, or perhaps motivated by the need for additional income, they may continue to work, postponing full-time retirement, for an indefinite period. They would like flexible schedules and interesting work opportunities, but they can be paid less or recruited as volunteers in some cases.
- Although not as devout about voting and expressing opinions on public policy issues as the preceding generations of elders, Boomers can probably be organized and motivated to participate politically—especially those who did so in their youth (and then put aside their activism for a focus on career).
- Boomers will not go gently into that good night. Their raging about aging predisposes them to exercise and watch what they eat so they can stave off the ravages of premature aging. This is a good thing and should lead to the realization of the promise of *compression of morbidity*—the phenomenon of remaining healthier for longer and experiencing a shorter period of disability near the end of our lives.

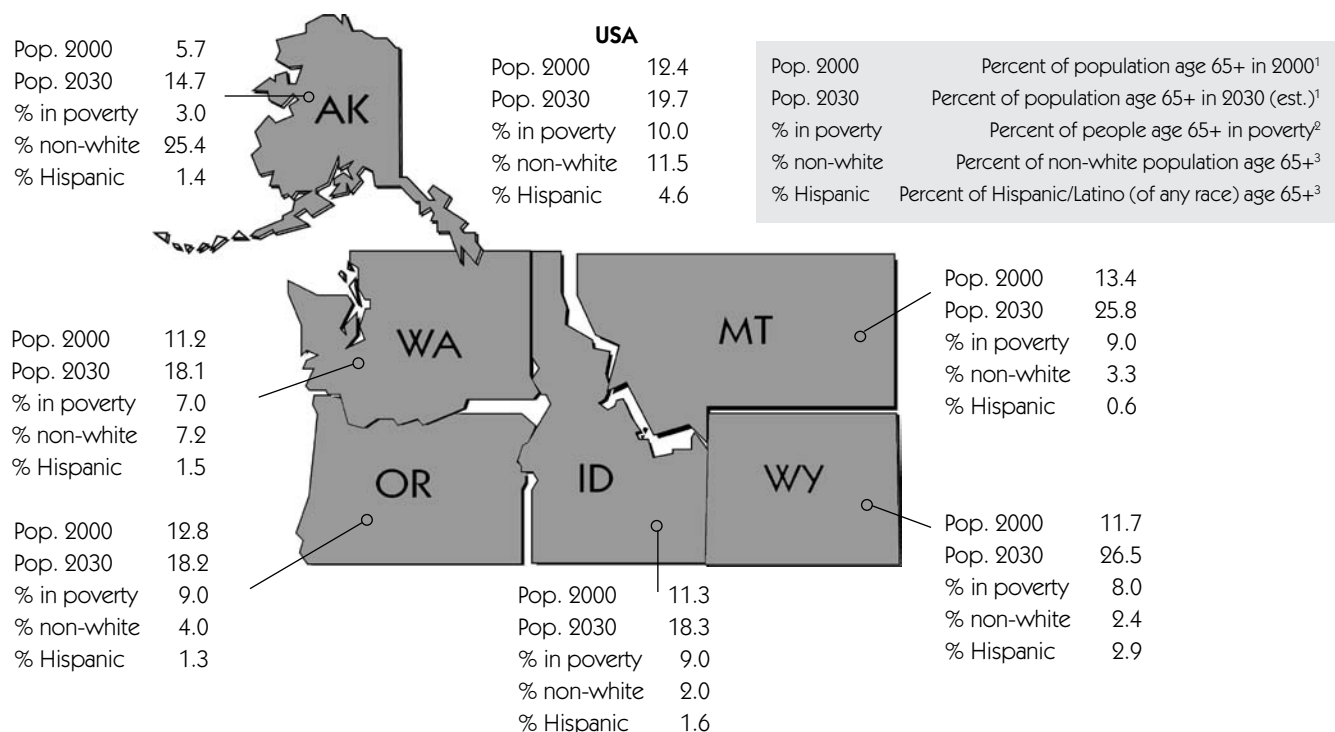
Most of my observations fall on the positive side of the ledger, reflecting a trait that I share with Boomers: a kind of unbridled optimism stemming perhaps from childhoods more financially and historically secure than those of our parents, as well as our young-adult ability to change what we wanted to change. We protested the Vietnam War, and it ended. We wanted to go to college and did so in unprecedented numbers. We got the jobs we aspired to, and many of us led organizations.

What will we do with, to, and for ourselves and others in retirement? That's the \$64,000 question. ■

Author

Denise Klein is executive director of Senior Services in Seattle, Washington.

Northwest Elders Selected Demographics



Sources: ¹US Census. www.census.gov/population/www/projections/projectionsagesex.html; ²2002 American Community Survey Profile, <http://www.census.gov/acs/www/Products/Profiles/Single/2002/ACS/index.htm>; ³Census 2000 Summary Tables: Race and Ethnicity Data for Population Age 65 and Over (<http://factfinder.census.gov/>).

Selected Health Indicators of People 65 and Older

	HEALTH STATUS				HEALTH BEHAVIOR				PREVENTIVE CARE & SCREENING			
	Physically unhealthy days (mean # of days in past month)	Disability ¹ (%)	Frequent mental distress ² (%)	Oral health: complete tooth loss (%)	No leisure-time physical activity (%)	Eating 5+ fruits/veggies a day (%)	Obesity ³ (%)	Current smoking (%)	Flu vaccine in past year (%)	Ever had pneumonia shot (%)	Up-to-date on select preventive services ⁴ (men) (%)	Up-to-date on select preventive services ⁴ (women) (%)
	2004	2004	2003-04	2004	2004	2003	2004	2004	2004	2004	2004	2004
AK	5.0	35.7	8.1	23.0	34.9	23.7	23.4	12.5	64.1	57.2	37.1	28.4
ID	5.6	36.0	6.2	22.5	29.4	26.8	20.1	7.4	66.2	60.1	33.8	25.9
MT	5.8	31.6	5.6	19.6	29.4	30.2	17.2	9.7	72.2	71.6	46.0	36.0
OR	5.4	40.2	6.3	17.8	24.2	34.0	17.7	9.1	71.0	69.4	39.5	36.7
WA	5.5	40.1	5.8	16.1	26.0	29.7	19.3	8.7	67.9	65.8	38.5	34.1
WY	5.9	35.6	5.5	21.8	30.6	31.4	20.2	9.8	73.8	70.7	40.0	32.8
USA	5.5	34.0	6.3	21.3	31.9	29.8	20.2	9.3	68.1	64.7	38.4	31.6

¹Defined as being limited in any way in any activities because of physical, mental, or emotional problems, or any health problem that requires use of special equipment;

²Defined as 14 or more days in the past month that respondents' mental health was not good because of stress, depression, and problems with emotions; ³A body mass index greater than or equal to 30 kg/m²; ⁴Includes recent flu vaccine, pneumonia shot, mammography (women only), sigmoidoscopy, and colonoscopy.

Source: The State of Aging and Health in America 2007. http://www.cdc.gov/Aging/pdf/saha_2007.pdf. This report draws on data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is a state-based telephone survey using self-reported data that has not been confirmed by a health care provider. The survey does not include people who do not have telephones or who live in institutions, such as nursing homes, and also may underrepresent people who have functional impairments.

Data researched and compiled by Maggie Jones.

Bracing for the Boomers

Buried in the demographic trends are implications for public health



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Pamela Piering

The “age wave” representing the graying Baby Boomers is about to change the landscape of health and human services. As the 76 million adults now aged 42–60 enter their retirement years, we know that they will reshape our thinking about aging and society. Boomers’ distinctive needs and preferences will affect the way they live into their elder years. Six key Boomer characteristics in particular influence how this generation relates to health and health care, and suggest ways for how health care and social services can relate effectively to them.

Eroding link between age and retirement

The oldest of the Baby Boomers will turn 65 in 2011. On average, these men and women can expect to live another 18 years, to 83, and many will live into their 90s. This might be one reason why increasingly, Boomers do not see 65 as the age of retirement. Financial security is another reason. In general, sources of retirement income for Boomers are less secure than those of previous generations. The combination of longer lives and a need for additional income means that many Boomers expect to work beyond the traditional retirement age of 65—but interestingly, research suggests they may seek more non-traditional jobs in the not-for-profit sector.

Chronic health challenges

Boomers face health challenges that include being overweight and living with chronic conditions such as diabetes and hypertension. Ethnic and racial minority Boomers face even more health challenges as disparities remain stubbornly endemic in health indicators and social determinants of health. In King County, Washington, African Americans and Native Americans, for example, have much higher death rates for heart disease, cancer, stroke, and accidents—four of the top ten leading causes of death. African Americans also have a higher diabetes death rate, and Native Americans have a higher rate of death from chronic liver disease.

Increased diversity

Boomers are more culturally, economically, and socially diverse than the generations who came of age in the 1940s and 1950s. These adults will seek health solutions that speak to their interests, backgrounds, and cultures.

A family focus

Nicknamed the “Sandwich Generation,” many Boomers are involved with their parents at one end of the spectrum and their children and grandchildren at the other. Nationally, 30 percent of Boomers have been or are currently responsible for an aging parent. As caregivers to their parents, Boomers want to support them in home-like settings. At the same time, Boomers are the head of more than 64 percent of households with four or more family members, and a substantial number of Boomers are raising grandchildren in their own homes or are otherwise involved in their day-to-day care.

Purposeful lives

Boomers seek purposeful living when it comes to meaningful employment and civic engagement. Close to one-third of Boomers say they expect to participate in community service after retirement. For those who were the social activists of the 1960s, involvement in socially responsible efforts, such as volunteering, environmental and social justice efforts, and community leadership, will be of interest.

Personal choices

Boomers want choices and ease of access to services at convenient times. This generation has a working knowledge of the Internet and is comfortable researching information about products and services. They want to be in control. As one marketer noted, “Ask them what they want, don’t tell them what you can give them.”

Implications for public health

So, what do these Boomer characteristics mean for public health and aging programs in the future?

Capitalize on technology

Because Boomers are comfortable with the Internet and online services, Web-based health education materials and resource links, “chat rooms” for caregivers and those who are isolated, and special self-management tools for chronic conditions will grow in popularity and use. The development of personal health records for the individual to track and manage health changes offers promise to those who want to take charge of their health. Tools such as www.sharedcareplan.org and www.networkofcare.org are expanding in this arena.

Resource databases, whether for housing, health care, caregiving, or general information, are becoming more useful and interactive. Check out www.seniorservices.org for a good example of what the aging network offers those seeking access to programs and services. A national CDC-funded pilot called Active Options is lining up local community physical activity inventories, with several communities already signed on, including King County, Washington (www.activeoptions.org). The Healthy Aging Partnership (www.4elders.org), bringing public health and aging partners together for community benefit, offers free articles on health topics, just right for community newsletters and local papers.

Put the Boomer in charge

Health-oriented programs for Boomers will need to focus on personal empowerment, motivational interviewing for behavioral change, and evidence-based “coaching” approaches. Significant research efforts by the UW Health Promotion Research Center over the past decade have demonstrated that self-management skills, goal setting, and follow-through are the keys to addressing chronic conditions for older populations. Here in Washington, and in 20 additional states, one of the UW-researched efforts, Project Enhance (*see article on p. 20*), is offered in a number of community and health settings. Another, the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS), brings relief from minor depression among isolated older adults through in-home problem solving using motivational interviewing and personal goal setting. PEARLS reduces depression scores for participants and is slowly expanding in Washington to both elders and Boomers as resources for implementation become available.

Pay attention to words

Keep in mind that Boomers do not relate to traditional terms for older adults. They do not identify as elders, seniors, or as being in their golden years. Terms that connect aging to life experience resonate better with this group. Consider experience leaders, lifetime learning, active for life, and freedom years, which speak to aging as a part of the life process rather than a dead

end. Elderhostel, for example, has developed a new Road Scholar program aimed at the 50+ adult, and congregate meal sites are renaming themselves cafés in several parts of the nation.

Work in the local community

To reach the diverse communities of Boomers, public health programs serving the elderly must reach out to community groups. The good news is that local cosponsorship of healthy aging programs brings credibility to these programs in the Boomers’ social marketplace. Recent years have seen the development of strong ethnic agencies, special programs that effectively reach communities of color, and mutual assistance groups for recent immigrants and refugees. Gay, lesbian, bisexual, and transgender groups also have an increasing interest in the graying of their members. New health promotion programs must link with these partners to reach underserved groups.

Look across ages

Policy changes that would overcome the boundaries caused by categorical funding and encourage programs that benefit more than one generation merit involvement and investment by public health. Cross-generational programs, such as health buddies, youth mentors, and physical activity programs offered in recreational settings bring mutual benefits for the participants and offer an alternative to age-segregated programs (www.gu.org). Policy changes focused on the built environment, such as walkability improvements and zoning changes that permit a greater residential/commercial mix, hold a promise that Boomers may be able to remain living in active, multigenerational settings well into late life.

Promote civic engagement

Public health agencies and clinics might consider tapping Boomer retirees from health-related professions for new part-time careers in meeting critical public health needs. The US Environmental Protection Agency, for example, is developing volunteer environmental stewards in nonprofit organizations (www.epa.gov/aging).

The national organization Civic Ventures sponsors an initiative called Next Chapter that provides assistance to community groups across the country working to help people in the second half of life set a course, connect with peers, and find pathways to significant service. Personal health and wellness, continued learning, community connections, and finding a new meaning for life are the organization’s key focus areas (www.civiventures.org/nextchapter).

The ability to engage Boomers in improving their own health and that of the community is an important challenge ahead. Yes, the Boomers are coming, and they intend to continue leading, inspiring, and changing the world. ■

Author

Pamela Piering is director of Aging and Disability Services in the Seattle Human Services Department.

Caring About the Rural Elderly

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Sheryl Lowe

of home-canned goods so she doesn't have to go out. Her TV is her only companion.

Clallam County's CARE Partnership

Clallam County, on Washington State's Olympic Peninsula, has many older adults like Estelle. In fact, 25 percent of the county's population is 65 or older, and everything about the county is affected by its aging residents. Everyone, it seems, from the chamber of commerce, builders, and realtors, to local businesses, elected officials, and community activists, is worried about how to deal with the "aging" problem. As in other rural communities, the challenges of addressing the health needs of the county's isolated seniors are particularly daunting. Health and human service delivery systems are strained, and older adults cannot find primary care. Tribal elders of the five tribes in the county still experience poorer health outcomes than their non-native counterparts.

This is where the Community Advocates for Rural Elders (CARE) Partnership comes in. The Partnership's vision for the county is that aging will be embraced as a valuable asset and that older adults will be able to live independently in good health and well-being. The partnership brings diverse community partners together to develop age-friendly systems that provide quality, collaborative elder care.

The Partnership began as a conversation between the local Area Agency on Aging and the Clallam County Health and Human Services Department in 2003. The local public health

officer and the director of Health and Human Services met with a local tribe, the largest community mental health center, the largest hospital, and the county United Way to find ways to address some of the more pressing elder health issues.

In 2004, the Partnership received a \$950,000, five-and-a-half-year grant from The Robert Wood Johnson Foundation to assess and improve the county's long-term care and community support services systems for older adults. In pursuing this highly competitive national grant, the partnership argued persuasively that Clallam County's demographic bulge of elders would be the nationwide norm in 15 to 20 years as baby Boomers become senior citizens. Solutions developed in rural Washington State could have nationwide application.

The strategic planning process

The Partnership's work started with a community assessment, holding five listening circles in remote communities, conducting interviews with vulnerable elderly in their own homes, and surveying baby Boomers. Interviewers asked not "What do you need?" but "What are your preferences and concerns as you grow older?" and "What do you want your life to be like?" Individual service needs were observed and heard, of course. People did want accessible stores and restaurants, safer sidewalks, and more information about community services and opportunities. But the Partnership learned something even more valuable—that people wanted to be active, productive members of society whose lives had purpose and meaning.

The strategic plan that grew from these findings was much broader than originally anticipated. Prior to the assessment, the Partnership focused solely on improving the existing service delivery system. The assessment made it clear, however, that solutions outside of the system also needed to be developed, including advocacy to change things not in the Partnership's control, such as services to combat social isolation and elderly depression. Improving the local transit system was important but not the sole solution to meeting special mobility needs of elderly residents. Local services were available to tribes, but better information about how to access these services would not

address the underlying barriers tribal elders faced in receiving the services. Even more broadly, to create lasting change, ageism needed to be addressed in all areas of the local communities.

Community coalitions

In the past four years, the Partnership has grown to include more than 300 agency and individual members participating at different levels in the work. Members include representatives from local and tribal government, health care providers, residential care facilities, and the community college. The Partnership created a number of coalitions, a Senior Policy Council, and other working groups of providers, business people, older adults, caregivers, and concerned citizens to address these issues.

The Neighbor-Helping-Neighbor coalition developed a community watch program to help isolated elderly be prepared for emergencies. Interested community residents are trained in neighborhood organizing and receive technical assistance in establishing senior watch efforts in their own neighborhoods or communities. The coalition works closely with the local fire department and the county emergency management division.

Another coalition, focusing on early detection and treatment of elderly depression, created a countywide Peer Counseling/Gatekeeper Program that sends trained volunteers into older adults' homes to combat social isolation, identify mild to moderate depression, and make referrals to local mental health providers.

The tribal health coalition, in partnership with the local hospitals, home health, Senior Information and Assistance, and the health department, designed a chronic disease navigator project to help tribes develop disease-specific nutrition and physical activity programs, train tribal members and staff in disease self-management, and create links for tribes to the local aging network. The health department will work with each tribe to create memorandums of understanding on how the local public health jurisdiction will coordinate with and support tribal health jurisdictions.

The Senior Policy Council is made up of local older citizens who want to influence policies and decisions that affect them and other elders. After they received training in legislative advocacy and key aging issues, such as Medicare, prescription drugs, and long-term care, they mobilized other community members to help the Partnership create an Aging Agenda for the county.

Existing service delivery systems are currently being analyzed through a facilitated service delivery mapping process. Decision makers from partnership agencies have committed to making substantive changes in their systems to improve access for older adults. They have also committed

to creating protocols for collaboration across systems to ensure that elderly residents do not fall through the cracks when moving among systems.

Another group is developing and implementing a strategic communications plan to change the way the county views aging and the contributions of its older adult residents. The "Aging Is an Achievement, Not an Affliction" campaign will be launched in 2008.

How CARE differs from other partnerships

The Partnership goes beyond dealing with payment systems and frustrations with existing health and human service delivery systems. Through its collaborative work, it seeks to engage a growing number of community members and generate the kind of energy that makes change possible. The Partnership's goal is for the communities in Clallam County to own this effort and commit to sustaining the changes. The vision is that fragmented, duplicative silos of services will evolve into systems in which providers communicate with each other.

... to create lasting change, ageism needed to be addressed in all areas of the local communities.

Remember Estelle? This is the Partnership's vision for her three years from now. She has been identified by the trained mail carrier as being in need and is visited by another trained volunteer who helps her get mental health services, home-delivered meals, and health care. The nearest Neighbor-Helping-Neighbor chapter has been contacted, and Estelle agrees to open her curtains every morning as a sign she is all right. A local volunteer group has brought her wood stove up to county code. She receives energy assistance through the Community Action Program, and someone has brought and stacked a cord of wood outside her door for easy access. A volunteer driver takes her grocery shopping and to the local flea market she used to frequent.

Estelle no longer worries about someone putting her into a nursing home, and she rarely spends her days watching television. She feels connected and has the support she needs to remain independent in her own home thanks to a community that works together to care for its elderly citizens. ■

Author

Sheryl Lowe is executive director of the CARE Partnership. *The CARE Partnership is part of the Community Partnerships for Older Adults program funded by The Robert Wood Johnson Foundation to help communities develop leadership, innovative solutions, and options to meet the needs of older adults.*



Maintaining Mobility for an Aging Population

When physical or mental changes make it difficult to drive safely, many seniors find themselves isolated from the services they need and the activities that once filled their lives.

Nathan D. Johnson
Uwe Reischl

Many elderly people today face significant mobility challenges that will affect their ability to live fulfilling and healthy lives as they continue to age, especially if they live in suburban or rural areas where walking is difficult and public transportation options are limited.

Challenges of senior mobility

People over 65 are the fastest growing segment of the United States population. The US Census Bureau estimates that during the next 25 years, the number of people 65 and older will double. By 2030 more than 30 million senior drivers will be on our roads. The American Association of Retired Persons (AARP) estimates that by then one in five drivers will be older than 65. The public health challenge for this growing population and those around them is not one to be overlooked. Seniors, for example, have the highest automobile crash death rates per mile of all drivers except teenagers.

Driving cessation is often the only safe solution for elderly drivers, but its negative effects include reduced independence, reduced access to essential services, impaired ability to maintain a household, and reduced social interaction and community activity.

Not only does driving cessation affect seniors' functional ability to meet their own needs, it has a significant effect on their sense of self. The loss of driving can also lead to depression, obesity, alcoholism, and declining health in general. A study described in the March 2005 issue of the *Journal of Gerontology* reports that seniors who stopped driving experienced increased depressive symptoms, as defined by the Center for Epidemiologic Studies Depression Scale, at a rate nearly one and a half times that of their counterparts who still drive.

These negative psychological and physiological consequences are exacerbated by lack of sufficient transportation options. Public transit tends to be less available the further people live from city centers, and typically, few other consistent and reliable transportation options exist for the elderly.

Near-term solutions

The structural problems posed by the way our communities are designed cannot be overcome without time and concerted effort. In the near term, if we are to protect the health and well-being of our aging population, we need to focus on the issues we can make headway on now. These issues include planning for driving cessation, providing alternate transportation options, and reducing the transportation burden for the elderly by establishing more home-based services.

A number of organizations and programs have attempted to address the many issues surrounding driving cessation. Among them, the American Medical Association (AMA), National Highway Traffic Safety Administration (NHTSA), and AARP along with The Hartford Financial Services Group and the Massachusetts Institute of Technology (MIT) AgeLab have worked to address the issue of elderly driving assessment and cessation. AMA's *Physicians Guide to Assessing and Counseling Older Drivers* and NHTSA's *Model Driver Screening and Evaluation Program: Guidelines for Motor Vehicle Administrators* are useful assessment tools.

AARP/Hartford/MIT AgeLab's driving cessation initiative, *We Need to Talk...Family Conversations with Older Drivers*, focuses more on the family process of gently and respectfully easing the elder driver toward driving cessation through discussion and future planning. The planning involves identifying alternative ways

of transportation or means of acquiring the necessities of life while maintaining the everyday pleasures that affect quality of life. The discussion can include use of public transit, family assistance, Internet shopping, and perhaps moving to a more pedestrian-friendly, higher density community.

The success of this planning process will depend on the availability of alternative transportation options as well as on in-home services options. Few cities in America have public transit systems adequate to the task, and even then those are often restricted to the core of the city, leaving the transportation burden on families, volunteer organizations, and dedicated, but usually limited, transit organizations. To address these deficiencies, creative new approaches are needed to provide the necessities of life to “stranded” seniors.

The proliferation of Internet shopping combined with the increasing computer literacy of seniors will probably help close some of these gaps. However, home delivery of health care and social services has not seen the funding necessary for the same growth as Internet shopping. In the near term, social and health care service organizations will have to take a lead in fostering creative solutions to fill these needs.

Long-term planning

Restructuring health and social service delivery systems for the elderly is hard enough, but it pales in comparison to the difficulty of restructuring the mortar, brick, asphalt, and steel that make up the infrastructure of our cities.

American city design has been dominated by the functional need for and utility of cars. The neighborhood-based living that was common in small towns and older urban areas has all but disappeared in the wake of suburban sprawl. The result has been the erosion of pedestrian amenities in favor of wide spans of asphalt and distances that challenge even the hardest walkers. Local zoning laws frequently add to the problems of the mobility impaired. Zoning laws have been crafted to protect residences from the blight and noise of businesses, which has in turn served to isolate those who cannot drive an automobile.

New land-use approaches, however, can facilitate neighborhood-based living and minimize the dependence on cars. Policies are needed that allow mixed land use and higher density so that housing, stores, and services are more closely located and accessible. New zoning policies and land-use planning can lead to communities in which the services needed by older adults, such as clinics, shopping, social

centers, and assisted living facilities, are accessible by foot and public transportation.

The ideal of aging in place is to live in one’s own familiar environment safely and independently throughout one’s maturing years. The benefits provided by familiar surroundings, the advantages of maintaining contact with friends, as well as the overall reduced cost of living are generating increased public support for programs that facilitate aging in place.

Public health challenges

Because the loss of driving privileges by the elderly in the US often leads to social isolation, depression, obesity, alcoholism, and an accelerated decline in general health, providing convenient and safe transportation options poses an important public health challenge.

Issue	Challenge	Action Step
Aging in Place	<ul style="list-style-type: none"> • Residence located far from services. 	<ul style="list-style-type: none"> • Create mobility plan. • Consider moving to location that offers fewer transportation challenges.
Transportation	<ul style="list-style-type: none"> • Existing road and city designs make walking difficult. • Community transportation options are lacking. 	<ul style="list-style-type: none"> • Use walkability audits to identify and prioritize pedestrian improvements. • Make transit services more flexible and support volunteer driver programs.
Health Services	<ul style="list-style-type: none"> • Lack of transportation limits access to health care services. • Home-based services are not coordinated. • Community information about services is dispersed. • Poor diets and lack of physical activities increase health risks. 	<ul style="list-style-type: none"> • Improve access to medical transportation. • Integrate home-based services. • Create single point of entry for service information. • Develop active living programs for the elderly.
Planning and Zoning	<ul style="list-style-type: none"> • Community design to support aging has limited community support. • Zoning regulations discourage age-appropriate housing options. 	<ul style="list-style-type: none"> • Include older persons in the planning process. • Incorporate senior-friendly housing in zoning codes.

However, solutions will ultimately emerge only when adequate public resources are allocated in the development of transportation alternatives. This holds true at the local, state, and national levels.

To give safe transportation for seniors the priority it warrants will clearly require leadership, activism, and consensus building, both political and institutional. Public health professionals have an obligation to provide input into the community planning process. This can be done at the local level, similar to the efforts currently underway by public health professionals to influence local design that promotes physical activities among children to reduce America’s obesity epidemic. The federal government can support, assist, and inform, but meeting the mobility needs of a community, especially the needs of the elderly, must first and foremost be a priority of state and local leaders.



Authors

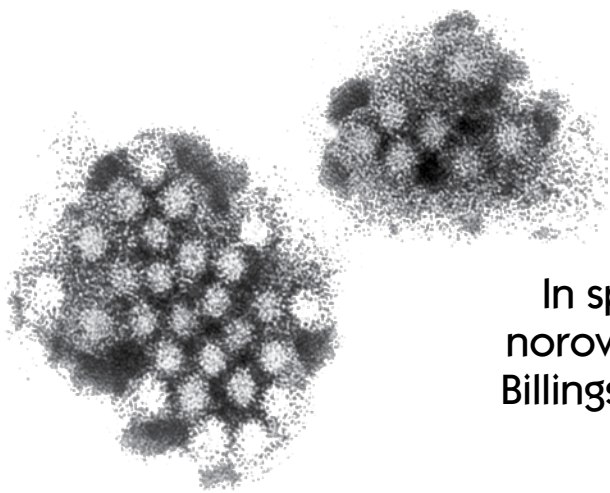
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Resources

AARP/Hartford/MIT AgeLab. *We Need to Talk... Family Conversations with Older Drivers*. www.thehartford.com/talkwitholderdrivers/brochure/brochure.htm.

Active Living by Design. www.activelivingbydesign.org/.

MIT AgeLab. web.mit.edu/agelab/.



Quelling a Norovirus Outbreak

In spring 2006, the largest reported outbreak of norovirus sickened more than 1,100 people in the Billings area, particularly in long-term care facilities.

Christine L. Gray
John Felton
Ellen Wangsmo

Noroviruses cause acute gastroenteritis in humans. Symptoms typically last 24 to 60 hours and include severe diarrhea, vomiting, fatigue, fever, muscle ache, and headache. A sudden attack of diarrhea and vomiting is nobody's idea of a good time, particularly when victims report feeling worse than they have ever felt in their entire life. But among older adults, many of whom are already physically compromised, the symptoms can be especially debilitating.

Literature on noroviruses suggests that no serious long-term consequences result from them; however, long-term effects can be substantial. For some older adults, in particular, a case of norovirus might require a much longer recovery period than for their younger counterparts and may even mean the end of independent living. Local clinicians in Billings, Montana, surmise that the greater morbidity seen in the elderly is largely related to the effects of dehydration resulting from extensive vomiting and diarrhea.

A key clinical characteristic of noroviruses is their transmissibility. As few as 100 particles are needed to cause infection, which is spread primarily through the fecal-oral route. The viruses can also spread via fomite contamination or aerosolized vomit. Unfortunately, noroviruses spread easily through nursing homes and other long-term care facilities. Close contact and susceptibility to infection make their residents particularly vulnerable to norovirus infection.

Challenges beyond public health

During the spring 2006 norovirus outbreak in Billings, 1,178 cases of gastrointestinal illness were reported to Yellowstone City-County Health Department and assumed to be norovirus. Of the 102 laboratory tests performed, 80 were confirmed norovirus cases. Six care facilities and two restaurants were connected with the spread of the virus. As the outbreak progressed, laboratory testing confirmed that cases from nearly all the facilities and restaurants involved had the same norovirus strain (genotype II).

Early identification and swift intervention are crucial for preventing further transmission of noroviruses. Interventions include mass media messaging to the public as well as targeted outreach to providers and facilities about handwashing and cleaning practices.

In addition to the clinical and epidemiologic challenges typically confronted with any outbreak of infectious disease, this outbreak had economic, policy, and social consequences that affected the response. The staffing and publicity concerns of the involved restaurant and long-term care facilities, in particular, complicated the community response and facilitated the spread of the disease.

SICK WORKERS. The wage level for the majority of employees in restaurants and long-term care facilities is at or near minimum wage. Workers typically live from paycheck to paycheck. Like many service businesses, care facilities and restaurants are rarely able to provide paid sick leave and vacation benefits for their employees. As a result, workers come to work even when they are ill.

In addition to individuals' need to work, the absence of ill workers also affects fellow workers. Montana, in general, and Billings, in particular, have low unemployment rates. Many vacancies exist for minimum-wage jobs, resulting in chronic short-staffing conditions. Calling in sick generates an additional burden on already overextended co-workers, creating another disincentive for employees to stay home when sick.

CROSS-SITE INFECTIONS. Although the linkage to an outbreak is difficult to quantify, direct care, housekeeping, and dietary staff often work at more than one long-term care facility, creating the opportunity to transmit the virus from site to site. Similarly, a single company might own or operate multiple care facilities, again creating opportunities for staff to carry the viruses from one site to the next.

CONCERNS ABOUT BAD PUBLICITY. Another key challenge is created when outbreaks are focused in restaurants. No establishment wants negative publicity, but public education was crucial because

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The image above is an electron micrograph of norovirus, with 27-32nm-sized viral particles. Centers for Disease Control and Prevention.

the buffet restaurant linked to the norovirus outbreak catered to seniors, providing another opportunity for rapid spread of virulent norovirus among this vulnerable population. Many seniors, for example, would enjoy a meal at the buffet and then make either direct or indirect contact with institutionalized peers, unwittingly carrying the norovirus with them.

Key intervention: Communication

To address these challenges, the Department communicated both internally among staff and externally with partner organizations, including the local hospitals, affected facilities and workers, the media, and the public in general.

Internal communication occurred primarily through an e-mail listserv, which also provided documentation of the ongoing management of the outbreak. The Department held face-to-face meetings on an as-needed basis—during peak times, two meetings a day was standard practice. E-mail allowed for rapid information sharing, but no central database existed that multiple people could access simultaneously. The Department is taking measures to create a dynamic database that can be updated as an outbreak progresses.

External communication efforts were particularly challenging. Department staff, especially public health nurses, were in constant communication with the hospitals during the outbreak. Phone calls were the most common form of contact, followed by facility site visits to interview patients and perform chart reviews. The hospitals and their affiliated providers received Health Alert Network messages, via e-mail or fax, with current recommendations and updates. Hospital staff members were also present at the meetings of the partners' Unified Health Command.

Public health nurses and sanitarians conducted site visits to the care facilities. The nurses met with the directors of nursing and reviewed charts while the sanitarians inspected the kitchen and laundry areas and reviewed cleaning procedures. Sanitarians performed the same functions at restaurants.

The long-term care facilities were often reluctant to let the Department know of new cases of norovirus because of potential negative media attention. To increase communication, Department staff stressed that reporting the outbreak was in the facilities' best interest, as timely reporting allowed for quicker identification of potential sources and quicker implementation of interventions, which resulted in fewer cases.

To reinforce **health and hygiene messages**, sanitarians worked with restaurants to educate them on the spread of norovirus and additional precautions they could take. They placed emphasis on handwashing, cleaning practices,

and not allowing sick employees to come to work. Individuals who became ill were encouraged to call the Department's hotline and speak with staff to complete a case report form. Groups that had eaten at the buffet restaurant provided a contact list, and staff contacted group members directly. The Department distributed handwashing reminders and posted them at area restaurants as well as other large gathering sites such as conference and concert facilities.

The media played a key role in quelling the outbreak by conveying prevention messages and providing contact information to the public on how to report cases. During the spring 2006 outbreak, a total of 40 stories ran on norovirus, including 19 newspaper articles, 16 television stories, and 5 radio stories.

Fortunately, prior to the outbreak, Department staff had already spent time establishing a strong and credible relationship with the media. When misinformation appeared in stories or when additional information needed to reach the public, staff members were able to follow up and communicate the correct information via multiple media outlets. Staff members also monitored the newspaper's online blogs for potential rumors and to track the public's view of the Department's management of the outbreak.

Looking forward

As a follow-up to the outbreak, the Department facilitated a community meeting involving infectious disease specialists, the local media, hospital representatives, and long-term care facility medical, nursing, and administrative leaders in a successful and positively received effort to help all constituencies understand each other's perspectives and concerns.

Despite the multiple news stories focused on the outbreak, a portion of the population remained unaware of it, as evidenced by anecdotal information gathered through contact with community members. The Department is working on new ways to reach populations that might not use traditional media such as newspapers and local television stations. Information on norovirus, prevention methods, and cleaning recommendations remain available on the Department's Web site (www.ycchd.org).

Noroviruses are not likely to be eradicated through any preventive measures, and the likelihood exists that the viruses will always be present in the community. Local public health agencies play a key role in identifying the initiation, sources, and extent of an outbreak. And just as important is their role in educating the public with clinical guidelines to reduce further infection, as well as working with relevant stakeholders—many of whom have disparate or competing interests—to develop an effective community response. ■

Authors

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The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

Interpreting Elder Abuse Among Alaska Natives

Kathleen Graves
Brian Saylor
Louise Shavings

When we hear about elder abuse, we usually think of a phone scammer defrauding vulnerable elders or a caretaker physically mistreating a bedridden senior. Public health care workers are less likely to hear stories such as these when working with elderly Alaska Native people. This does not suggest that there is an absence of abuse but instead means that Alaska Natives may be reluctant to address the issue.

Key informants reveal views

Because elderly Alaska Natives report little abuse to health officials, little is known about the scope and nature of abuse and neglect among Alaska Natives. In order to understand elderly Alaska Natives' view of abuse, the authors interviewed 15 recognized Alaska Native Elders from each of the five major ethnic groups (Tlingit/Tsimshian/Haida, Aleut/Alutiiq, Yupik/Cupik, Inupiat, Athabascan) about abuse of elderly Alaska Native people. (The status of an Alaska Native Elder is not solely a function of age, and not all elderly Alaska Natives are viewed as Elders.) Additional recognized Elders served as cultural consultants and assisted the researchers in every phase of the research process. The interviews, conducted with the assistance of the cultural consultants, revealed a number of key points.

The value of balance and harmony in Alaska Native culture.

Traditionally, many Alaska Native communities had restorative justice systems, which have been severely disrupted by the dismantling of traditional structures, languages, ceremonies, spiritual beliefs, and values. These Native systems moderated unacceptable social behaviors through shunning, banishment, counseling, and rewarding positive behaviors.

The systems promoted a balanced, harmonious, and interconnected relationship with others and with the natural environment. In this traditional framework, disrespect exists when there is a lack of balance, harmony, and connection with others and with the natural world. From the elderly's point of view, abuse is equivalent to disrespect, and the importance of reporting it is secondary to the concern with maintaining balance and harmony.

Elders refer to abuse as a lack of respect.

The use of the term *abuse* seemed to offend the Elders, making it more difficult to talk about. They preferred terms such as *respect* and *disrespect* rather than abuse. Emotional disrespect was one of the most common types of disrespect mentioned.

The elderly are reluctant to report abuse.

Elders reported a reluctance to report abuse by a family member to law enforcement for fear of compromising the longevity of the group, a possible outbreak of suicide among at-risk youth, and the withholding of financial or personal support.

The elderly believe that they are disrespected by non-Natives.

One of the most widespread forms of disrespect experienced by Alaska Native elderly involves the disrespect of lifestyles and traditions by the non-Natives who come into their communities. Some Elders reported that health care professionals treat them in a disrespectful manner by assuming that the elderly do not understand their own bodies.

The elderly perceive a loss of respect by some younger Alaska Natives.

As younger Alaska Natives adopt non-Native ways, the traditions that protected Alaska Natives in the past are threatened. The Elders reported a belief that Native youth sometimes don't value traditional wisdom and therefore treat the elderly as though they lack intelligence.

Emotional needs of the elderly are sometimes neglected by families and service agencies.

The Elders frequently mentioned that nursing staff and family members ignore elderly Alaska Natives' physical and emotional needs. Some Elders mentioned the emotional abuse caused by families who place their elderly in extended care facilities and don't visit them. When caregivers, family members, and friends, either consciously or unconsciously, communicate to the elderly that they are a burden, the elderly are emotionally injured.

The elderly are overburdened with caregiving responsibilities.

Many Elders reported that elderly Native Alaskans are providing full-time care for their grandchildren and great-grandchildren, while

the parents are unavailable due to substance abuse or lack of parenting skills. A common intergenerational practice is for extended family members to care for young children for short periods of time. This traditional arrangement for short-term care appears to have expanded to extensive caregiving responsibilities. When the elderly are overburdened with caring for youth, they may experience physical, emotional, and financial strain.

Elderly Alaska Natives experience financial exploitation.

Financial abuse of Alaska Native elderly by family members was the most frequently mentioned form of disrespect. The elderly are at risk for financial disrespect from those in control of their finances. Family members may take advantage of the elderly who depend on the younger generation to care for them.

Recommendations for health care workers

Health care workers encountering elderly Alaska Native patients whom they suspect are suffering abuse can feel frustrated when attempting to elicit information. Patients avoid eye contact, do not talk about themselves, and may even deny being in an abusive situation, despite the worker's strong suspicion that they are being abused. Health care professionals should always take the time to look beyond the initial silence displayed by the Alaska Native elderly when abuse is suspected.

Become informed about Alaska Native cultural communication practices.

Understand and communicate respect for protocols, values, and ways of life. When uninformed health care providers visit an Alaska Native in his or her home or community, they may unknowingly violate cultural communication practices and disrespect the elderly Native. An elderly person who does not feel respected will give superficial information or not respond at all. Begin the visit by asking for advice from the elderly client about the appropriate Native protocols in the situation. If the client is not comfortable explaining the protocols, he or she might refer you to someone who can explain them. Allow yourself to be corrected and ask the elderly to teach you the proper ways of respect. In some Alaska Native cultures, offering a small gift, such as a jar of salmon or jam, will help to communicate respect to the elderly client.

Slow down your pace of speech to match the pace of the patient.

Health care workers need to understand Alaska Native communication patterns. Many Alaska Native elderly have a slower cadence in their speech. Rushing the elderly who speak slowly

may lead them to withdraw instead of opening up. Mirroring the cadence of the elderly person is one way to increase communication as well as show respect. Health care professionals also need to be sensitive to nonverbal communication patterns. Because health care providers are held in high regard, it is customary, for example, for the elderly person not to look directly at health care providers while listening intently to what they are saying.

Listen more than talk.

Health care workers should listen more than talk, giving the elderly total attention. It is vital to allow the elderly ample time to express themselves without interruptions. When Native people are silent, they may be showing respect rather than incomprehension. And finally, keep in mind that the elderly often speak indirectly, in metaphors and stories.

Understand local reluctance to implicate relatives.

Be aware that Alaska Native elderly do not always trust non-Natives. They may be reluctant to implicate others, particularly family members, in reports of neglect or abuse that may result in jail time or fines for the perpetrator and may threaten individual or community activities such as subsistence hunting, fishing, and gathering.

Avoid addressing individual issues and take a family or community systems approach.

Prevention and intervention of elder abuse requires a focus not only on the individual but also on the family or community. Develop and strengthen community networks that can raise awareness and provide outreach, detection, and encouragement to report abuse. Although urban areas have a variety of programs and systems in place to address the needs of the elderly, health care workers in rural areas need to engage the village-based elders' councils to organize forums to focus on elder priorities.

Each group of Native Americans has its own cultural values and communication protocols. However, many of the suggestions for improved communications with elderly Alaska Native people could be considered by health care workers as a starting place for better understanding the health issues of other Native Americans. Health care workers who have Native American patients should take the time to learn their values and protocols. Without this understanding communication may be incomplete, and the quality of care may be compromised.

With an awareness of the cultural aspects related to defining and describing abuse, as well as to communicating about it, health care workers and community advocates can work together with Alaska Native elderly and their communities. As in most areas of life, respect is the key. ■

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Find sources for this article online at www.nwpublichealth.org.

Partnering for Healthy Aging in a Small Town

Amelia Knopf

In 2011 the first baby Boomers will turn 65, marking the beginning of a significant shift in the population demographics of the United States. Contrary to romanticized notions of older people packing up their homes and moving to sunny retirement communities, people between ages 65 and 85 are the least likely to relocate. In a 2003 national survey by the AdvantAge Initiative, 93 percent of older adults said that they want to stay in their communities. As the older population grows over the next 20 years, communities are likely to face an increase in demand for elder-friendly features.

Mutual benefits of elder-friendly communities

According to Mia Oberlink, national project director of the AdvantAge Initiative, perhaps one of the biggest challenges older adults face is “redefining old age and the older years.” People have outdated ideas about what it means to be old. In order to adequately meet the multifaceted needs of older adults, we will need to change our conception of old age. We can start by recognizing that older adults aren’t merely potential burdens. Research suggests that older adults can be invaluable assets to their communities. Older adults have the time, life experience, and skills to serve as active volunteers in their communities. One national study found that 35 percent of adults aged 65 and older engage in regular volunteer work, and 86 percent donate money or goods to charity.

In addition, although many older adults face unique age-related challenges, the solutions to those challenges can benefit the entire community. For example, older adults who are facing limited mobility can benefit significantly from access to public transportation, improved sidewalks, and traffic signals that allow sufficient time to cross busy streets. However, the same community improvements will also benefit working adults and parents walking with young children.

The AdvantAge Initiative

Local communities that want to assess their elder-friendliness have an example to follow from the AdvantAge Initiative. Developed by the Visiting Nurse Service of New York’s Center for Home Care Policy and Research, the AdvantAge

Initiative’s basic tenet is that healthy environments foster healthy people. Researchers in aging at the Center wanted to know how well communities are meeting the needs of older adults and what makes a community elder-friendly.

The project began with the goal of producing two products: a model of an elder-friendly community and a set of objective indicators that local agencies could use to measure and improve their capacity to meet the needs of older adults. The AdvantAge Initiative initially conducted qualitative research in four major US cities to inform and develop the elder-friendly community model (see *Figure 1*) and the corresponding 33 indicators (www.vnsny.org/advantage/indicators.pdf). AdvantAge identified four domains in which communities can make a difference in the lives of older residents: basic needs, social and civic engagement, physical and mental health and well-being, and independence for the frail and disabled.

After the model was developed, the AdvantAge Initiative sought to measure the elder-friendliness of 10 geographically and demographically diverse communities across the US. Researchers typically turn to statistical data that reflects elders’ health outcomes and use of health care services to assess the status of older people in a particular region. The AdvantAge Initiative, however, went directly to the elderly. The researchers developed a survey that addressed the 33 indicators of an elder-friendly community and administered it to older adults in the 10 pilot communities.

The results of the local surveys reflected the unique needs of each participating community, making it difficult to compare them. Therefore, the AdvantAge Initiative administered a national survey and compared the 10 communities to the resulting national average of elders’ needs.

In each of the 10 pilot communities, local project leaders organized a community task force. Each task force was charged with using data from the surveys to raise community awareness about aging issues, set priorities, design action plans, allocate resources, and monitor progress on implementing the plans.

AdvantAge at work in Puyallup

Puyallup, a growing western Washington town with a population around 38,000, was one of

the 10 pilot AdvantAge Initiative communities between 2001 and 2007. Approximately 11 percent of Puyallup's residents are 65 and older. The Puyallup AdvantAge Initiative task force included employees from a local hospital, the health department, the Area Agency on Aging, University of Washington Tacoma, Pierce College, a local senior center, an assisted living facility, and the city of Puyallup.

After conducting surveys with 514 older adults, the Puyallup project leaders identified seven areas that needed improvement: access to information and assistance, participation in physical activity, opportunities to volunteer, affordable housing, gaps in meeting health care needs, transportation and pedestrian safety, and employment opportunities. The Puyallup task force developed action plans for three of these issues to advance elder-friendly changes—access to assistance, physical activity, and pedestrian safety.

FINDING ASSISTANCE. Although Puyallup has a Senior Information and Assistance service, the community survey showed that one in five older people did not know whom to contact if they needed assistance. The AdvantAge Initiative Puyallup task force worked with local network partners to help the Area Agency on Aging develop a campaign to increase seniors' awareness of the availability of Senior Information and Assistance. After considerable outreach efforts, Senior Information and Assistance noted a 250 percent increase in the number of community members requesting help.

INCREASING EXERCISE. One-fourth of Puyallup seniors reported that they seldom or never exercise. Some groups, such as people who were isolated or had chronic illnesses or low incomes, were even less likely to exercise. Residents cited a number of barriers to exercise, including physical disabilities, safety concerns, and lack of sidewalks, and many did not have complete information about opportunities for physical activity. The local health department, a hospital, the city parks and recreation department, and a nonprofit organization joined the task force in creating a guide to free and low-cost exercise programs for seniors (Pierce County Washington STAY FIT! Guide 2006, www.nwoi.org/links.htm). They also established a biweekly walking group, the Puyallup Pacers for seniors of all abilities. Five to 10 Pacers meet biweekly at the Puyallup Activity Center and walk for an hour. The Center also hosts bi-monthly off-site walking events at which 20 Pacers get together and exercise at local parks and beaches.

PEDESTRIAN SAFETY. Survey analysis revealed that seniors found transportation and pedestrian safety to be a significant problem in their neighborhoods. Seniors noted heavy traffic, poor street lighting,

limited public transportation, and pedestrian signals that changed too quickly. Using data from the survey and from follow-up focus groups, the city was able to secure grant funding from the Washington Traffic Safety Committee to make elder-friendly street improvements near a senior center and a post office used by a large number of older adults.

Although the national AdvantAge Initiative received \$2.5 million in funding from private, state, and national donors, Oberlink is quick to point out that other communities can assess the needs of their elders in affordable ways. She offers this advice to communities who want to appraise their capacity to meet the needs of older adults, "When you go out to learn about your communities, don't just seek facts and figures; involve the community in learning about itself. That way, you can move people from passive respondents to active participants in community improvement."

Dr. David Hanson, project coordinator for Puyallup AdvantAge, advises that "the importance of community assessment cannot be underestimated." He suggests that public health organizations, Agencies on Aging, and cities work together to share the labor and cost of community assessment. He cited the Puyallup assessment as pivotal in understanding "what was working for seniors and what really was not working at all."

When we make efforts to identify and address seniors' needs, the entire community benefits, from improved traffic safety to increased volunteer contributions of older adults who have life experience, skills, and wisdom to offer. ■

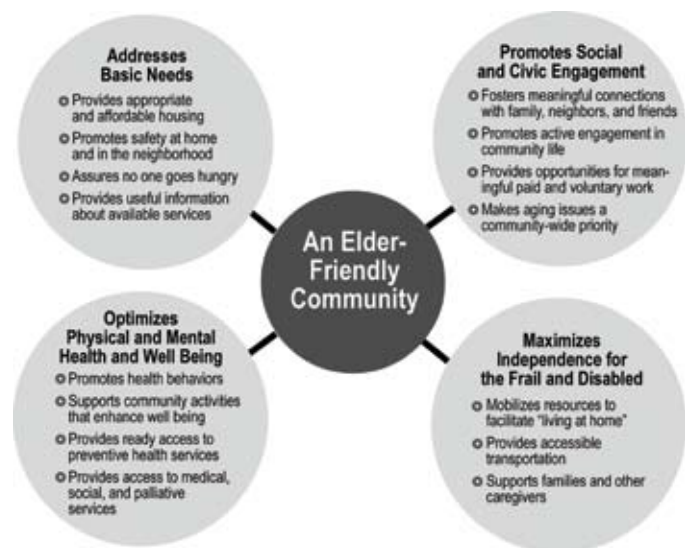


Figure 1. The four components of the AdvantAge Initiative model.

Author

Amelia Knopf is an MPH student in the Community-Oriented Public Health Practice Program at the UW School of Public Health and Community Medicine.

Resources

The AdvantAge Initiative Toolkit. www.vnsny.org/advantage/resources.html#tool.

Feldman PH and Oberlink MR. Developing community indicators to promote the health and well-being of older people. *Fam Community Health*. 2003;26(4):268-274.

Hanson D and Emler CA. Assessing a community's elder friendliness: a case example of the AdvantAge Initiative. *Fam Community Health*. 2006;29(4):266-278.

Walking the Talk, Together

Cross-generational programs involve Asian elders in their community and build valuable relationships among seniors and youth.

Maggie Jones

On any Thursday evening in Seattle's International District (ID) during the summer months, you may see a group of 10 to 20 Asian elders walking together with a few young people walking alongside. This walking group is just one component of the International District Housing Alliance's Intergenerational Leadership Program, which focuses on engaging elders in their community.

The International District Housing Alliance (IDHA), created in the 1970s in Seattle to organize low-income residents of the ID, first focused on issues of housing and development. Today, IDHA houses many community organizing programs, one of which is an Intergenerational Leadership Program. The Program started in 2002 and grew out of the desire to strengthen community leadership for both youth and elders in the International District neighborhood.

The elderly are frequently left out of decision-making processes, although they comprise almost 30 percent of the neighborhood, according to the 2000 Census. As Hoa Tang, IDHA's intergenerational program coordinator, said, "The

Elders are so much more creative and capable than we assume or allow them to be.

elders thought that they could not participate in decision making because they do not speak English. But they need to be heard because they have a lot of knowledge to share." At the same time, IDHA leaders realized that many of the 14- to 21-year-old youths who participated in their youth leadership program had bicultural and bilingual skills that could be an asset in engaging elders in the neighborhood.

The Intergenerational Leadership Program's philosophy is that you need to build knowledge and community relationships to build community leadership. The Program's philosophy is based on three models:

- Youth development, which focuses on empowering youth
- Community building, which recognizes that relationships on which to build already exist in the community

- Asset-based community development, which focuses on the strengths that people have and how those strengths can be used in community development

At the onset of the Program, IDHA's goal was to engage elders and youth in advocacy work around environmental issues. However, Program leaders quickly realized that they could not push only their own agenda if they were to be successful in community organizing. To engage and organize the youth and elders, IDHA first had to build trust, and second, it needed to let the participants have a say in the Program design and activities.

Program components

Starting with input from the elders, IDHA focused on four program components.

EDUCATIONAL DEVELOPMENT. The elders' first request was for English as a Second Language (ESL) and citizenship classes. Youth tutors facilitate the classes, which meet once a week. Classes often incorporate health and safety topics (for example, calling 911, talking to the doctor, and riding the bus) into the language lessons. The citizenship classes teach elders about civics, advocacy, and how to be involved in the political process. Although both classes are facilitated by youth tutors, the classes encourage an exchange of knowledge between youth and elders, encouraging both to be teachers. The ESL class has been well attended and has helped to build trust with the elders who attend. The trust established by these classes provided a platform for the relationship-building component of the program.

RELATIONSHIP BUILDING. Important parts of the Intergenerational Leadership Program are social and community service activities that emphasize relationships, because, as Joyce Pisnanont, IDHA's director of Community Building Programs, said, "You have to have fun to be successful with community building." On Friday nights at a community center in the neighborhood, youth and elders get together to play games such as ping pong and Chinese chess. The Program also offers other activities such as neighborhood clean ups, holiday dinners, weekend camping trips, day hikes, and dance and tai chi classes. The emphasis on relationships is important to health because it promotes positive mental health and encourages the development of a social support system. For

example, elders have called youth to invite them out for an afternoon snack of dim sum or to ask for help in going to a doctor's appointment.

LEADERSHIP DEVELOPMENT. During the school year, IDHA holds weekly leadership development workshops in which bilingual, bicultural youth leaders help elders develop skills in public speaking, facilitating workshops, neighborhood organizing, and community education strategies. Resident elders also help youth develop multicultural skills and culturally appropriate outreach techniques as they work together on public awareness campaigns.

One year, for example, a group of about 15 elders and 4 youths focused on a recycling education campaign, which was prompted by Seattle's new recycling policies. The city had sent notices to homeowners that said they would be fined for noncompliance. This policy worried Seattle Public Utilities (a major program partner) and the staff at IDHA, since they knew that many ID residents spoke limited or no English. To inform their neighbors, the group worked with Seattle Public Utilities to develop and practice their education messages in the workshops. When they were ready, the youths and elders went door-to-door to tell residents about the city's new policies and what actions they needed to take.

WALKING GROUPS. The leadership development workshops meet only during the school year, so during summer months, IDHA sponsors a walking group. This group is very popular with elders in the neighborhood because it helps address their concerns about their physical health as well as public safety. During the walks, a youth coordinator tells the elders about the neighborhood—helping them learn street names and sharing with them the history of the area. Sometimes the elders invite their friends from other areas around Seattle to join the walking group. They also encourage other resident elders they encounter along the way to join their walk through the neighborhood.

In 2006, through its three components, the Intergenerational Leadership Program reached 101 youths and 110 elders. It was the first year in which the elders' participation was higher than the youths'. At any given time, 30 to 40 participants are participating in different components of the Program. Although IDHA has done no active recruiting for the Program since 2005, participation grows each year. Recruitment happens mostly through word of mouth and the visibility of the walking group in the neighborhood.

Successes and challenges

According to Pisananont, the greatest success of the program is the level of engagement that youths and elders feel. The Program has also helped

develop stronger leaders, and some elders have started to speak at city council meetings and conferences so that their stories can be heard. Pisananont said that the willingness to participate in events, such as conferences, also reinforces their commitment to each other. One elder, for example, said, "This young girl asked me to do it, and I don't want to let her down."

Although the Intergenerational Leadership Program benefits more than 200 participants a year, one of the biggest challenges the Program faces is funding. Health-related funders tend to focus strictly on health rather than social determinants of health, a distinction that makes programs such as this one difficult to fund. As a result, the little funding the Program receives is through youth development funds that support intergenerational programming.

A number of administrative challenges also exist when providing services to elders. Such programs can be time consuming because of the time it takes to develop and maintain genuine relationships. In addition, program coordinators often must call participating elders before every activity so that they remember to come, which could be up to five times a week depending on how many activities they are involved in. Finally, logistics are a challenge—particularly with the field trips—to ensure that elders can participate safely in the activities.

Implications for public health

Although this Program was designed for a specific population with specific needs, it provides some lessons for the broader public health community.

Elders are so much more creative and capable than we assume or allow them to be. When designing programs to serve elders, remember that they know what they want and need. Be prepared to listen to them and be willing to take risks to meet their needs. If they have more involvement in the decision making, they will have more investment in the program.

Even if the program doesn't work out exactly as envisioned, it may be possible to incorporate the content in other ways that meet the needs of the target population.

Most importantly, to keep people of any age engaged in a program, everyone has to have fun. ■

Author

Maggie Jones, MPH, is a research project manager at the Center for Community Health and Evaluation, which is part of Group Health Center for Health Studies, in Seattle, Washington.

Resource

International District Housing Alliance. www.apialliance.org/idha/.

Enhancing Healthy Aging

Exercising and changing health behaviors are easier said than done. One health wellness program demonstrates how to make doing them easier.

The physical and emotional benefits of exercise are increasingly well-known, but just 20 percent of older adults are engaged in regular leisure-

time physical activity, a rate that has not budged since the mid-1990s. Older adults—even the most frail—can improve their health and maintain their independence by incorporating daily physical activity into their lives. To do this, though, they need access to enjoyable physical activity opportunities designed specifically for them and that are proven to be effective. Many older adults know they want to become more active but don't know how. Project Enhance programs offer a great opportunity to insert exercise to their day.

Project Enhance (www.projectenhance.org), is an initiative of the private, nonprofit Senior Services in King County, Washington. The initiative packages a number of health-enhancement components to form a comprehensive health and wellness program that addresses the wellness needs of older adults ranging from those who live with physical challenges to those who are ready to take a challenging exercise class. Two of its key evidence-based programs—EnhanceFitness, a group physical activity class, and EnhanceWellness, a participant-centered behavior change program—are based on studies conducted in the early 1990s through the University of Washington Health Promotion Research Center in partnership with Senior Services, PacifiCare, and Group Health Cooperative in Seattle, Washington.

Although organizations can choose to adopt one or the other program, the EnhanceWellness and EnhanceFitness programs work best together, reinforcing each other as a wellness package. They are easy to implement, attract new people to community sites, and empower participants to sustain independent lives. Most importantly, they result in measurable improvements in the health and well-being of older adults.

In the past 10 years, Project Enhance has received funding not only from local resources

such as the Seattle/King County Area Agency on Aging but also from regional and national resources, such as The Robert Wood Johnson Foundation and the CDC Arthritis Program. This funding is supplemented by income from program sales. The operating cost of each program is low. Typically, a class fee (\$2.60/class) is charged for EnhanceFitness, which covers the cost of the instructor's salary. EnhanceWellness services are provided on a donation basis with program operational costs covered by a variety of funders.

Dissemination of the EnhanceWellness and EnhanceFitness programs started in 1997 at four senior centers in King County. Today, the programs have expanded to nearly 200 sites in 21 states. Program participation has increased from 80 to more than 4,000 participants. Program retention is very good; more than half of the EnhanceFitness participants have remained in the program for more than one year, and EnhanceWellness has a 75 percent graduation rate for its six-month period of enrollment.

Increasing activity

EnhanceFitness helps even near-frail older adults become more active, energized, and socially connected. The program includes exercises to improve flexibility, balance, cardiovascular capacity, and strength. Certified fitness instructors receive special EnhanceFitness training, giving them the expertise they need to lead the three one-hour classes each week. EnhanceFitness participants complete physical function tests upon enrollment and every four months thereafter. Project Enhance collects and analyzes outcomes data and provides individualized site reports annually.

Although originally offered only in senior centers, EnhanceFitness is also now available in residential settings, YMCAs, recreation centers, and other community settings—any facility that has appropriate space for an exercise class and where older adults are comfortable going. For example, a current study using EnhanceFitness as the intervention is being conducted at meal sites in Oregon managed by Loaves and Fishes, Inc.



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Susan Snyder
Basia Belza

In Seattle, the local Area Agency on Aging and Group Health Cooperative support management of sites and instructor training. In addition, Group Health provides EnhanceFitness as a benefit to its Medicare enrollees.

Beyond exercise

The six-month-long EnhanceWellness program is designed for individuals who want to make health behavior changes but need support and skill-building to do so. Typically, when individuals join the program, a nurse and social worker, sometimes complemented by trained volunteer health mentors, work with each individual to develop a personalized health action plan based on what the individual wants and is ready to work on. Health plan goals include such things as attending a group physical activity class, walking, and attending a support group on weight loss or on management of chronic conditions.

Participants complete tests measuring different health behaviors such as physical activity and social connection when they enroll in the program and when they graduate so that they have written documentation of progress made. Their physician is informed of their enrollment in the program and of their chosen goals so that the physician also can support their patient in their changes.

Staff who are trained in motivational interviewing contact program participants regularly to provide support as the participants work on their health plan. The social worker also conducts support groups for participants and other community members. Popular topic areas include transitions, living a healthy life, depression management, and weight management. Groups are provided whenever several participants need to work on similar issues and could benefit from their peers' experiences.

Research has shown that people participating in EnhanceWellness can decrease the length of hospital stays, lower their use of psychoactive drugs, alleviate symptoms of mood disorders, and develop a sense of greater self-efficacy.

EnhanceWellness has found that robust partnerships with health care systems and providers are crucial. EnhanceWellness staff complement the work of health care providers by being available for participants as they make difficult health behavior changes and guiding them through the ups and downs of such changes. Most providers don't have the time to do this and appreciate the support that community providers can give their patients.

Project Enhance works

Project Enhance is regularly evaluated for effectiveness and reach. The University of Washington Health Promotion Research

Center, for example, has conducted three formal evaluations of the EnhanceFitness and EnhanceWellness programs. As new research regarding each program, or healthy aging in general, becomes known, program curricula are revised.

The success of Project Enhance is measured by its positive participant outcomes. The research indicates that EnhanceWellness participants have had a 72 percent decrease in hospital days, 35 percent decrease in psychoactive drugs, and 11 percent decrease in depression. EnhanceFitness participants have had a 52 percent decrease in depression and a 35 percent improvement in physical functioning, as reflected in an index score of various physical function measures.

The size of the US aging population is increasing dramatically, and it will be critically important to offer proven programs that maintain older adults' physical, emotional, and mental health. Project Enhance programs connect participants to their peers in a community setting, which may be the one thing that gets them out of their homes and socializing with others. Participants then begin to take part in other activities in the senior or community center, either as participants or as volunteers. They become healthier, more confident, and more active members of their community.

Project Enhance programs are easy to implement, attract new people to community sites, and empower participants to sustain healthy and independent lives. Most importantly, they result in measurable improvements in the health and well-being of the older adult program participants. As one participant stated after enrolling in both EnhanceFitness and EnhanceWellness, "I honestly feel 20 years younger! I am so much more flexible and able to move more easily. I carry my own groceries to the car and unload them myself. I can reach the top shelf in my cupboard. I have more energy. And as a result, my whole outlook on life is brighter." ■

Project Enhance Packaged for Use

Project Enhance has a turnkey package providing all the tools needed to successfully implement both EnhanceFitness and EnhanceWellness, including training and other workshops, instructor and administrator training manuals, instructor listserv, tracking and measurement forms, and ongoing program evaluation. Experienced Project Enhance administrators provide technical assistance to on-site instructors and program and administrative staff.

Find information about the programs, their current locations, and how to implement them at www.projectenhance.org or call 206-727-6219.

Authors

Susan Snyder is director of Project Enhance with Senior Services (Seattle). Basia Belza, PhD, RN, is a professor of Biobehavioral Nursing and Health Systems in the UW School of Nursing.

Resources

The Pocket Guide to Staying Healthy at 50+. Agency for Healthcare Research and Quality. www.ahrq.gov/ppip/50plus/.

Regional Preparedness Efforts for Seniors

Seniors Reaching Out to Seniors

Idelle Badt
Cynthia Dold
Carlos Dominguez
Nathan D. Johnson

Eastern Montana doesn't have taxi cabs, shopping malls, or coffee chains on every corner. It does have something more important—friendly, fiercely independent people who take care of their neighbors and don't hesitate to help wherever they are needed. Taking that friendly, independent spirit into account, the Retired and Senior Volunteer Program (RSVP) of the Richland County Health Department located in Sidney, Montana, created a program called Seniors Outreaching to Seniors (SOS).

Although eastern Montana is more rural than much of the United States, it shares one thing in common with the rest of the country—an aging population with Baby Boomer children assuming the role of caregiver.

The intention of SOS is to give Baby Boomers and their parents a sense of security by connecting them to their community. Volunteers make regular contact with seniors, thus enabling them to live independently in their own homes as long as possible. SOS relies heavily on the use of the telephone for communication so people of all abilities are able to volunteer, even housebound individuals.

Getting started

Initially, SOS focused solely on disaster preparedness. Through collaboration with other agencies that serve the senior population in Richland County (Richland County Ambulance Service, Sidney Health Center, four senior citizen centers, and three assisted living facilities) and in talking to the seniors themselves, health department staff concluded that the program had to expand if it was to achieve the project goal of enabling seniors to live independently in their own homes.

Of the seniors surveyed, the overwhelming majority stated that they felt alone. Many of them were widows and had no children living in the vicinity of Richland County. Many of the seniors contacted were too proud to confess to their friends that they were lonely. They didn't want to bother anyone with their problems.

After assessing the feedback, SOS coordinators decided that a three-pronged approach would be the best way to accomplish the goal of allowing seniors to live independently in their own homes: disaster preparedness, outreach through phone calling, and home safety inspections.

Disaster preparedness

RSVP is working with local Disaster and Emergency Service emergency preparedness coordinators to create a database of people who would need additional services in case of an emergency. This database allows SOS volunteers and first responders to react in the most effective way during a disaster.

All three agencies are collaborating on developing a rating system, based on the SOS database, to determine who would need the most help during an emergency, which will enable volunteers and first responders to respond based on seniors' physical conditions and needs.

Likely disaster scenarios in eastern Montana are severe snowstorms and electrical outages. During either of these events, SOS volunteers would call people on their lists to make sure they have heat, food, medicine, and other necessary supplies.

Everyone who signs up to participate in the SOS program receives a "File of Life" kit free of charge. The File of Life enables local emergency medical technicians (EMTs) to obtain a quick medical history of a patient when he or she is unable to offer one. The kit consists of a card that is kept in a red plastic pocket labeled File of Life. It lists the patient's name, emergency medical contacts, insurance policy, social security number, health problems, medications and dosages, allergies, recent surgeries, religion, and a preferred doctor's name. The pocket is held to the outside of the refrigerator by a magnet; a smaller version is also available to fit in a purse or wallet. People who fill out their File of Life cards are put into the SOS database, which is used in the event of a disaster to determine how much help they would need.

Josh King, director of the Richland County Ambulance Service, has worked closely with RSVP in the implementation of File of Life kits in the SOS program. He has trained all of his EMTs to look automatically on people's refrigerators for the red File of Life magnets when they are dispatched to a home. He has also made it his mission to educate the public about the importance of making sure their loved ones have File of Life kits and to alert the EMTs to that fact when they arrive on a call.

The local Emergency Medical Services (EMS) in Richland County holds quarterly tabletop exercises, and plans are underway to add the rating

system to a tabletop to test its effectiveness in the event of an evacuation of SOS participants.

Outreach through phone calling

The Richland County Health Department has many programs that work with senior citizens in Richland County. In the past, the Fire and Fall Program, which is no longer active, performed installations and checks of fire alarms, along with checks for fall hazards in senior citizens' homes. Through casual conversation one day, the Fire and Fall coordinator remarked that most of the senior citizens who requested smoke alarm checks and installations were desperate for socialization. Many times, clients would beg them to stay and visit after their inspection was done. Outreach through phone calling was born. This service is available to anyone who wants to socialize and make new friends. It involves weekly or monthly phone calls by volunteers. If senior citizens are housebound or have mobility issues, this is a way for them to give and receive social interaction. Additionally, health department staff members can check in on seniors to see if they need anything.

During Public Health Week this year, the Department placed a flyer seeking SOS volunteers in both of the local papers. The first person to call and volunteer was a woman residing at Sidney Health Center's Extended Care, a long-term care facility. She said that although she was a resident of Extended Care, she had a telephone in her room, and she wanted to volunteer to make phone calls to people. This was a great indication to us that no matter what the level of physical ability, anyone can enhance another person's life.

Home safety inspections

The third component of SOS is home safety inspections. Although the Richland County Health Department no longer has a Fire and Fall Program, SOS has assimilated some of Fire and Fall's components. Volunteers perform quick assessments of the inside and outside of homes to determine whether there are any obvious hazards that could easily be fixed. The volunteers look for such things as properly placed smoke detectors with working batteries, rugs that could be tripping hazards, and banisters on stairwells.

RSVP's goal is to have 300 participants and volunteers enrolled in SOS by June 2008. Coordinators are confident that SOS will make a major difference in the lives of senior citizens and their ability to remain independent in their own homes as long as possible. ■

Author

Idelle Badt is director of the Retired and Senior Volunteer Program in Sidney, Montana.

Puget Sound Windstorm 2006 Teaches Lessons

On the evening of Thursday, December 14, 2006, western Washington experienced one of the most powerful windstorms in the region's history. The storm brought torrential rainfall and winds measuring 90 mph along the coast and 70 mph in the Puget Sound region. More than one million people lost power, and road access was limited in some areas. The effects of the storm extended over a period of days and in some cases lasted more than a week. The power outage had a huge effect on the regional health care system, as hospitals were swamped with people who needed power, light and warmth. Some nursing homes had to rely on alternative power sources, which were frequently inadequate, for their daily operations; as a result providing heat, laundry, and even food became a challenge.

Friday morning, Public Health - Seattle & King County (Public Health) activated its Emergency Operations Center (EOC) to manage the health and medical needs of the region, with support from the King County Healthcare Coalition. The King County Healthcare Coalition is a network of health care organizations and medical providers with a commitment to the coordination of emergency preparedness and response activities in King County. Its membership includes all local hospitals in the area, as well as many other partners, such as the Puget Sound Blood Center, the Washington Poison Center, local community health centers, and other agencies.

As part of the Public Health EOC, the King County Healthcare Coalition's Regional Medical Resource Center (RMRC) coordinated medical assets and communications for the health care system and supported hospitals and long-term care facilities in the county. The RMRC staff used the state Department of Social and Health Services' lists of nursing homes and boarding homes to identify facilities that might not have power and to assess which facilities needed resources to "shelter in place," or in other words, remain where they are during the emergency.

Over the course of the week, the RMRC tracked the status of 23 hospitals and more than 200 nursing homes and boarding homes throughout Seattle and King County. In addition, the RMRC located generators, fuel for generators, firewood, refrigerated trucks, and transportation. The RMRC coordinated with the American Red



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Fallen trees knocked out power around the region during the 2006 windstorm.

Cross to deliver cots and blankets to nursing homes and community partners. If the homes were not reachable by phone, first responders visited them to check on their welfare. The RMRC also worked closely with the local electric power companies to ensure that nursing homes, boarding homes, and hospitals were placed high on the priority list for power restoration.

By Saturday, December 16, with a large number of long-term care facilities still without power, the Public Health EOC established a medical needs shelter as an option for any nursing home in King County needing to get its residents out of the cold and dark. Community shelters commonly cannot accommodate people with medical or medical equipment needs. Therefore, the alternative presented by Public Health was designed to meet the needs of medically fragile people. The shelter was open to provide heat, comfort, and basic medical services to medically fragile residents as an alternative to an emergency room visit.

By Monday, December 18, a nursing home evacuation to the shelter was underway. Thirty nursing home residents, along with their medical equipment and staff, were housed and monitored for 36 hours until the nursing home's generator was repaired. Public Health staff worked around the clock for the duration of the storm, ready to provide basic clinical services and support to the nursing home clinical staff. Based on the Public Health-EOC/RMRC assessment and logistical support of all nursing homes in the area, there was no need to expand the capacity of the shelter. In fact, the shelter

had the capacity to serve more individuals. In the future, improved communications about medical shelter availability to the public and providers will likely increase medical shelter demand.

Lessons learned

The windstorm taught Public Health and the King County Healthcare Coalition a number of critical lessons.

- Although the RMRC provides medical resources to support health care system partners during an emergency event, most of the resources requested through the Center were non-medical. Therefore, in the future, better coordination with the EOC and better logistics coordination with emergency management agencies will be essential.
- Improve communication systems with local hospitals and conduct training and exercises focusing on testing an individual hospital's ability to activate its internal emergency operations center during any event that affects other hospitals in the county.
- Include ancillary support services coordination, such as linen and pharmaceutical providers, in the priority list for power restoration.
- Work closely with long-term care providers in developing preparedness plans that are coordinated with local public health and emergency management agencies.
- Continue expanding participation in the King County Healthcare Coalition with wider representation of long-term care providers.
- Develop a coordinated system approach to address the needs of the residents living in nursing, boarding, and adult family homes.
- Further assess long-term facilities' capabilities to independently provide for their residents in the event of a disaster.

Since the windstorm in December, Public Health and the King County Healthcare Coalition have received support from policy makers to fund a staff position to support long-term care and home health planning in the county. Emergency preparedness planners and responders are clarifying roles and responsibilities and expanding relationships with nursing homes, boarding homes, and adult family homes in the area. Response partners look forward to building the relationships and systems necessary to ensure that the residents and staff of these facilities are better connected and better prepared to manage the next disaster. ■

Authors

Cynthia Dold, MPP, MPH, is program manager of the King County Healthcare Coalition, and Carlos Dominguez, MPH, MHA, is manager of Long-Term Care Planning in the Preparedness Section, at Public Health - Seattle & King County.

Anchorage Disaster Registry: A Lifesaver for the Vulnerable

One Anchorage, Alaska, resident is alive today following a five-alarm fire thanks in part to a new disaster registry created by the City of Anchorage. The registry allows vulnerable populations, including seniors, to register with the City Office of Emergency Management. The disaster registry is available to responders during an emergency to assist in rescue and evacuation. To encourage people to register, city emergency planners work with many social service agencies that directly serve vulnerable populations. Barely a year old, the registry contains contact information for nearly 500 people.

This fledgling registry exemplifies how seriously Anchorage takes its obligation to protect the safety and well-being of its more vulnerable citizens. It proved to be a lifesaving tool in identifying seniors and other vulnerable residents who needed help being evacuated during the blaze that raced through a large condominium complex near downtown Anchorage. Monitoring the local fire and EMS dispatch radio, the Anchorage Office of Emergency Management learned of the growing fire, consulted the registry, and quickly told onsite responders the exact unit where one registrant lived. The person was safely evacuated.

In the event of a large incident, such as an earthquake, city resources would be deployed initially to handle events such as structural fires and building collapse. During the course of the disaster, rescue crews would check those listed in the disaster registry to ensure they were safe.

Although registration has its privileges, officials have been careful to tell people it does not guarantee immediate response. Officials recommend that in addition to registering, individuals take personal responsibility and prepare their household for an emergency beforehand. Citizens are encouraged to have enough food, water, and medications for at least five to seven days. The Anchorage Office of Emergency Management encourages people with special medical conditions to fill out an Emergency Medical Information Form and post it on their refrigerator. Responders know to look on the refrigerator for that information.

To date, Anchorage is the only Alaska city or town to operate a disaster registry. At least one Anchorage fire survivor would certainly attest to its importance. ■

Author

Nathan D. Johnson is division manager of Health Planning and Preparedness in the Anchorage Department of Health and Human Services, Anchorage, Alaska. For more information about Anchorage's Vulnerable Populations Registry, contact Kattaryna Stiles, manager of Emergency Plans and Policy, 907-343-1407.

Announcements

Northwest Public Health Wins Grand Award.

The editors are proud to announce that the **Fall 2006 issue** was awarded the **APEX Grand Award for Publication Excellence**. The award recognized *Northwest Public Health* for outstanding work in the category of Magazines and Journals in Nonprofit Small Offices.

Save the Date

August 11-15, 2008.

NWCPHP Seattle Summer Institute.

Information: www.nwcpHP.org/training/summer-institute

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- Health Services
- Pathobiology
- Global Health (jointly with the School of Medicine)

The School also has multiple interdisciplinary programs, centers, and institutions.

The School's emphasis is on strong academic programs in the public health disciplines and extensive multidisciplinary collaboration. The combination of discipline-oriented academic programs, strong interdisciplinary research, and community-based public health activities provides a setting for faculty and students to apply in-depth expertise to important public health problems.

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Leadership Change

at the Northwest Center for Public Health Practice

After nearly eight years as the successful director of the Northwest Center for Public Health Practice, Jack Thompson will be stepping down June 30, 2008. In the next months, Associate Dean for Public Health Practice Mark Oberle will be convening a Search Committee, comprising faculty and practice partners, to choose a successor.

Jack will continue as faculty associated with the Center, concentrating both on partnership development and on linking students in the School of Public Health with the practice community and the Center. For more information, contact Dr. Oberle at moberle@u.washington.edu.

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New People, New Ideas**

**December 11, 2007, 8:30 a.m. - 4:00 p.m.
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Featuring

Larree Renda, Executive Vice President, Safeway, Inc.

Patricia Powers, President and CEO, Center for Health Improvement

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Resource Center for Health Policy

<http://depts.washington.edu/rchpol>



Northwest Center for Public Health Practice

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