



AGING IN PLACE

REALITIES AND POSSIBILITIES

SUMMIT

Supportive Services

March 29 2018

CLARK COLLEGE AT COLUMBIA TECH CENTER

KEYNOTE SPEAKER **VICKI SCHMALL, PhD**

SUMMARY REPORT

APRIL 2018

SUMMARY REPORT

INTRODUCTION

The Aging in Place Summit: Supportive Services, Realities and Possibilities was held on March 29, 2018. Clark County and the Commission on Aging co-hosted the summit with the Area Agency on Aging and Disabilities of SW Washington and Clark College to bring local leaders together to discuss how to increase support for the growing number of older people who want to stay in their own homes and communities safely and independently as long as possible.

This is a summary of the event. The summit can be viewed in its entirety at https://www.cvtv.org/vid_link/25456.

“The older we are, the more likely we will need to face living arrangement decisions. One great need is education and thinking in advance of need, rather than crisis decision-making.” –*Vicki Schmall, Keynote*



“Once diagnosed, patients often retreat to their homes. That’s probably the worst thing they can do. When I meet people, I often tell them I have the disease and the response has been wonderful. That has helped a great deal. I have gotten more hugs since telling people I have Alzheimer’s.” –*Julie Burger, Panelist*



AGING IN PLACE REALITIES AND POSSIBILITIES SUMMIT

Supportive Services

March 29 2018

CLARK COLLEGE AT COLUMBIA TECH CENTER

18700 SE Mill Plain Blvd | Vancouver, Washington 98683

AGENDA

8:30 – 9:00 am	Continental breakfast and check-in	10:15 – 11:15 am	Realities and Possibilities Panel <i>Moderator: David Kelly</i>
9:00 – 9:15 am	Opening remarks Marjorie Ledell Commission on Aging		<i>Panelists</i> <ul style="list-style-type: none">• Susan Engels• Les and Julie Burger• Howard Klink
	Welcome Marc Boldt Clark County Council	11:15 am – 12:15 pm	Group discussion and report back <i>Facilitator: Cory Bolkan</i> Washington State University Vancouver
	David Kelly Area Agency on Aging and Disabilities of SW Washington	12:15 – 12:30 pm	Closing Marjorie Ledell Commission on Aging
	Kevin Witte Clark College		
9:15 – 10:15 am	Keynote <i>Caring For Those Who Cared For Us</i> Vicki Schmall Aging Concerns		

www.clark.wa.gov/commission-aging

VICKI SCHMALL

Are you going to be older one day? Our discussions today not only apply to those who are old now but for those of us in the future.

Aging in Place and Aging in Community

1. Is maintaining people in their homes as long as possible always the best decision for everyone? There may come a time when a home may not be adequate and it is important to recognize that. “Aging in Community” could be a good way to think about these questions.
 - a. What does keeping someone in their home mean for quality of life? It could mean isolation for some.
 - b. Not everyone has an age-friendly home, i.e. with universal design, no steps, etc.
 - c. Rural areas do not always have enough supportive services. Some people retire and build their dream home out in rural area, and a few years later move again because there are not sufficient community services in their rural community.
 - d. Help is often needed to stay at home, such as: use of community services; hiring in-home help; modification of the home; use of assistive devices; house sharing; and, technology.
2. The older we are, the more likely we will need to face living arrangement decisions. One great need is education and thinking in advance of need, rather than crisis decision-making.
3. Mental health and aging: depression goes unrecognized too often in older adults and is not a normal part of aging. Being isolated is common, which can increase the risk of depression, which can increase isolation, becoming a vicious cycle. If there is alcohol abuse involved too, the risk of suicide increases tremendously. Adults over 65, particularly men, have the highest risk of suicide of any age group.

Caregivers

1. Family caregivers are the backbone of long-term care, but too often may become the hidden patient. Caregiving can impact a caregiver’s life in many ways, including the following:
 - a. Emotional impacts that include an increase in depression and anxiety associated with role overload, poor health, lower life satisfaction before caregiving, and being an adult child caregiver. Caregiving can also increase the chance of using psychotropic drugs.
 - b. Physical health impacts can include poorer self-rated health status; aggravation of existing physical health problems; decrease in immune system function; decrease in engaging in preventative health behaviors; and a high level of psychological stress associated with negative health outcomes.
 - c. Social impacts can include decreased time for other family members; marital and family conflict; decreased involvement in leisure, social and personal activities; and increased isolation.
 - d. Financial and work impacts can include coming to work late; leaving work early; rearranging work schedules; turning down promotions; quitting work or retiring early’ and taking time off without pay.
2. Factors related to higher caregiver stress include behavior and emotional problems in the care receiver; caregiver’s appraisal of situation as disruptive; competing role responsibilities; poor relationship prior to caregiving; caregiving is not voluntary; disagreements among family members; and living with the care receiver.
3. Because family caregivers are a core part of health care and long-term care, it is important to recognize, respect, assess, and address their needs.
4. Caregiving is stressful but it is not universally stressful as the stress can vary depending on the type of caregiver, i.e., spousal caregivers, adult children and older LGBT caregivers.

5. What makes a positive difference in the caregiving journey?
 - a. Having a sense of mastery and control: good information, skill building, and a sense of confidence.
 - b. Having social-emotional support: perceived vs. actual support and value of support group.
 - c. Using a direct style of coping, including: using help-seeking strategies, using problem solving, reframing problems.
 - d. Finding meaning/rewards in caregiving.
 - e. Taking breaks: prevent - not treat - exhaustion, discretionary – not obligatory – activities
 - i. Both short and long term breaks are important, i.e. short break through use of adult day centers could help for a few hours, to go grocery shopping, etc. Longer breaks such as a week-long vacation are also important.
 - ii. Start breaks early and don't wait until at the end of rope with stress.
6. Dementia caregiving impact
 - a. In 2018, every 65 seconds someone in the US develops Alzheimer's dementia. In 2050, this number is expected to be every 33 seconds.
 - b. In 2018, 5.5 million people 65+ have dementia, 200,000 under the age 65. In 2025, there will be 7.1 million people with dementia. In 2050, that number will be 13.8 million.
 - c. 1 in 10 individuals are 65+ and dementia percentages within this bracket are as follows:
 - i. 65-74: 3%
 - ii. 75-84: 17%
 - iii. 85+: 32%
 - iv. The oldest old group is growing the fastest and at greatest risk of Alzheimer's or other types of dementia.
 - d. Dementia caregiving is highly stressful, though some experience that dementia takes the rough edges off of a person.
7. Is there anything positive about facility placement? Focus can be on companionship and meeting emotional needs; family relationships may be strengthened; a greater variety of activities may be available; and, increased interactions with others.
8. Challenges and tough decisions, the "Big 5":
 - a. Driving concerns
 - b. If a family member has dementia, the question is not IF a person should give up driving, but WHEN
 - c. Financial: when problems arise with managing finances
 - d. Taking action when the person lacks capacity to make decisions
 - e. End-of-life care
9. Message to caregivers: taking care of yourself is the best gift you can give to the person who needs your care.

Questions	
1	<p>Q: Is there anything in state or local policy that could help aging concerns?</p> <p>A: We need a lot. We need to recognize the needs of older adults. 80% of caregivers are family members. Long-term programs that are more affordable are needed. Fortunately, my mom and dad were savers and had money to cover mom's costs, but who knows what would have happened if she had lived even longer. It is important to have services that meet those needs and that we feel good about, especially for folks who are low income. We also need to maintain existing services such as social security.</p>
2	<p>Q: What are the keys for successful transition from home to memory care? We saw a loved one deteriorate rapidly when they lost a familiar environment.</p> <p>A: It is different for each individual, as it depends where the person is at in the disease process. My mother thrived. Other residents seemed to thrive too before the downhill slide. Make the transition as easy and familiar as possible. Is it easier with someone else or in their own space? Observed with mom: took double room as a single-room at first and she did quite well. She thought she was in an apartment. She did even better in a smaller single-room. The more space, the more there was to organize, that is why the smaller space was better. You need to look at the individual. Also, if a caregiver's health is at risk that could also mean it is time to look for a change. One common question you hear is: "When can I go home?" One of the most important things is to seek calmness and comfort. Check out facilities and find one that fits your family member. Even the decorations could make a difference in comfort level.</p>
3	<p>Q: Do you have suggestions for our community on how we might be able to support the aging population better?</p> <p>A: What you are doing in terms of the Commission on Aging and looking at what's needed is important. This year's focus on transportation is important, as that is a supportive service. Don't just look at transportation for medical appointments. I am on the board of Ride Connection – transportation can help avoid social isolation, which is just as important as a medical appointment.</p>
4	<p>Q: What do you think the greatest challenge is for adult children who need to delegate care because they don't live close?</p> <p>A: The greatest challenge is not being there and not being able to see what's happening closely. When you are close-by, you will be less aware of the deterioration because it happens gradually. You might hear from someone who is not close-by: "why didn't you tell me how much mom deteriorated?" Communication among family members is key.</p>
5	<p>Q: What do you think are the most important first steps when you think a family member might need care?</p> <p>A: Have an open conversation at a time hopefully when the person can still actively participate. Encourage having a family meeting including the older adult and letting them say whatever they want to say and not get angry at it.</p>

REALITIES AND POSSIBILITIES PANEL

This was a moderated discussion with four panelists who provided responses to the following questions:

1. How do you see Clark County residents' ability to successfully age in place?
2. Do you think the services that are available today are meeting the needs for those that would like to age-in-place as long as possible?
3. If, not what needs to change?

HOWARD KLINK

1. Social determinants of health: "Circumstances, in which people are born, grow up, live, work and age, and the systems put in place to deal with social well-being, health and illness. These circumstances are in turn shaped by a wider set of forces: distribution of money, power and resources at global, national and local levels." –World Health Organization
2. Health equity: "Health equity is achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups and communities, especially for those who have experienced socioeconomic disadvantage or historical injustices related to poverty, race, ethnicity, tribal affiliation, age, gender, education, disability or sexual minority status." –From Healthy People 2020 (mostly)
3. Housing with Services (HWS) Project Overview: Cedar Sinai Park Project
 - a. Eleven Section 8 properties and rent subsidy properties housing 1408 seniors and people with disabilities.
 - b. Population profile: mostly 65+, dual eligible, chronic/co-morbid health conditions, mental health needs, food insecurity, and experience barriers to health care access.
 - c. Nine LLC partners with equity investments: including three housing agencies, the state's largest Medicaid Insurer, and five social services nonprofits to provide site-based preventative services.
 - d. LLC staff provides administrative support and services coordination management. The LLC is made up of 1.5 staff members.
 - e. Services are provided by staff assigned to HWS and funded by partner agencies.
4. Think about: partnerships, equity to get to underserved populations.
5. HWS funding sources: \$1,815,000
 - a. Providence Health Systems: \$75,000
 - b. Enterprise Community Partners: \$125,000
 - c. FamilyCare (CCO): \$125,000
 - d. HWS LLC Equity Investment: \$335,000
 - e. Neighbor Works: \$75,000
 - f. Weinberg Foundation: \$430,000
 - g. CMS: State Innovation Model Grant: \$440,000
 - h. HEDCO Foundation: \$60,000
 - i. Meyer Memorial Trust: \$150,000
6. HWS goals
 - a. Improved access to primary care and behavioral health services
 - b. Improved health outcomes
 - c. Reduced health care costs
 - d. Delayed entry or re-entry into institutional care
 - e. Increased resident engagement

- f. Increased access to culturally specific services
- 7. Services delivery model
 - a. Resident services coordinators
 - b. Health navigators
 - c. Behavioral health specialist
 - d. Health and housing case manager
 - e. Culturally specific outreach and navigation
 - f. Federally qualified health center
 - g. Prescription medication management
 - h. Food insecurity prevention and intervention
- 8. Key evaluation results
 - a. Two evaluations completed so far
 - b. Health care costs declined by 16%
 - c. Primary care use increased and frequency of ER visits decreased
 - d. Care coordination positively affected health outcomes
 - e. Preventative health services use increased
 - f. HWS intervention reduced food insecurity and food insecurity was significantly higher for those with a mental health diagnosis
 - g. HWS successfully reached residents to prevent eviction and premature nursing home placement
- 9. What's in it for Community Partners?
 - a. Improve client and program outcomes
 - b. Improve capacity to achieve health equity outcomes through partnerships with culturally specific providers
 - c. Promote service efficiency to increase provider capacity
 - d. Strengthen resource development capacity
 - e. Build natural coalitions to increase the impact of advocacy efforts
- 10. What's in it for the Health Care System?
 - a. Investment in best practice and innovative program development
 - b. Access to research and evaluation data
 - c. Improved individual and population health outcomes
 - d. Reduced health care costs
 - e. Alignment with ACA mandates
 - f. Reduction in Medicare re-admission penalties
- 11. Different reasons for each partner to be involved
 - a. Group of aligned folks can help make the case at the state or national level
 - b. If you are going to get the health system to pay for project or part of it, that's harder
 - c. Need to make the business case to get them to get involved. Need the data.
- 12. Model has been running for 6 years. There have been some changes related to changes in the Portland insurance market.

JULIE AND LES BURGER

Julie

1. It took me a year or more after recognizing memory and cognitive issues to tell my husband. But once I did so, I was evaluated and diagnosed. With progression of the disease, in 2016 I was diagnosed with early stage Alzheimer's. I went through an enhanced PED scan and confirmed the diagnosis.
2. I was embarrassed at how little I knew about the disease. Becoming involved in the Alzheimer's Organization prompted my learning. There is great reading material available. Educating both health care providers and patients is important. Just as education about heart attacks and strokes occurred, we need a similar campaign for Alzheimer's and dementia. Families need time to plan for the future. That's important.
3. Once diagnosed, patients often retreat to their homes. That's probably the worst thing they can do. When I meet people, I often tell them I have the disease and the response has been wonderful. That has helped a great deal. I have gotten more hugs since telling people I have Alzheimer's.
4. My husband and I attend a support group. More such programs would be of benefit, i.e. some restaurants in the county have trained staff to deal with cognitively impaired people and set up time for patients and care partners.
5. One final point: I'm sometimes asked if I am afraid. Yes I am. It's just that the hope of conquering the disease is greater than the fear of failing.

Les

1. The Alzheimer's Association just published the 2018 numbers. It is remarkable to look at the impact on our community and across the nation. It's the most expensive disease in the US. No doubt it's like we were with HIV/AIDs 20-30 years ago. There is no cure, it is a deadly disease and incredibly costly. We are really at that beginning stage and have a long way to go. Alzheimer's is the 6th leading cause of death in the US. Of the top 10 killers in the country, it is the only one with no treatment, cure, or prevention. We can't even slow the disease down.
2. We are blessed in Clark County. We live in a community that reaches out to each other. As we grow, we need to figure out how to maintain what we have. Julie and I can't go to a bank, restaurant or grocery store without having people reaching out, understanding and helping. We need to maintain that. Education is key for the government, providers, etc.
3. I practiced medicine for many years. With an older patient, we took blood pressure, pulse, checked respiration, etc. It seems that with prevalence of cognitive impairment, physicians should ask questions for cognitive function for any patient over 65. The mental status exam is one example.
4. In Washington State, there are 115,000 people with dementia. The number of caregivers is more than double that. This is a large and growing problem.
5. The issue of staying socially engaged is absolutely critical. The county can help with programs and welcoming people, such as restaurant staff training, art and music programs, community walks for people that will keep people engaged, etc.
6. Weekly support groups would be great.
7. In the scope of this disease, getting more folks trained, both family members and paid caregivers, in how to provide services for people is getting to be a challenge.
8. Geriatrics – there are fewer than 3,000 geriatric physicians in the country which makes no sense. We are very concerned about primary care, but we need to train people in the geriatric specialty.

SUSAN ENGELS

1. Older American's Act: available to anyone 60 or older or family members advocating for them. There are available resources that could be used instead of more expensive options.
2. The good news is WA State has been ranked by AARP as the number 1 state in the nation for long term services and support system. When AARP ranks, they do so over 5 domains: affordability and access, choice of setting and provider, quality of life and quality of care, support for family caregivers, and effective transitions, like between hospital and home or other settings. It is interesting to note that WA was not number one in any of those, but high enough on all of them. This means there is lots of work to do to meet the age wave.
3. In 2007, the legislature required us to make sure we were targeting resources to make sure they would have impact. The legislature wants clinically/statistically proven approaches.
4. Expansion funding was provided in 2012 and 2013 and studies showed a return on the investment. What we needed was more funding. Even with expansion, we could only touch ~1% of caregivers in the state.
5. Centers for Medicare and Medicaid services approved an 1115 waiver demonstration project, so we will be receiving \$160 million over five years. This expanded funding will help reach a new population with folks at risk of Medicaid. Knowing that moving into an institutional setting is about 2.5 times the average household median income; so many families don't have this savings. The CMS program will create help for people who have a nest egg of about 6-months' worth of services. These services could divert you from the full package of services. We have hopes of getting the right services to the right people before caregivers burnout.
6. Dementia Action Collaborative
 - a. This group is working on the state Alzheimer's plan accepted by the legislature. They are looking for additional funding from the legislature and figuring out how to approach the legislature in the next biennium. There is a strong coalition who think it is time to ask for the next step.
 - b. The Caregiver Roadmap is an outcome of this group's previous work.
 - c. The group is working for a robust public awareness campaign and ways to disseminate early diagnosis tools. When surveyed, many medical professionals don't know what to do and won't broach the conversation because they don't know what to offer their patients. Knowing early is vital to early, advanced care planning.
 - d. The group is getting folks to help with linkages to services and funding for those services.
 - e. More support groups needed, there are not enough.
 - f. Classes like powerful tools for caregiving are needed too.
7. Coalition on long term care trust:
 - a. This is the first such coalition in the nation and will go in front of legislature soon.
 - b. It is like another social security payroll trust that, once a person vested, would be eligible for \$100/day towards long term support services for a year.
 - c. Many people don't need it that long.
8. Please visit the community living communications website to connect with the resource directory, how to contact your local office, etc.

Questions for panel

1	<p>Q: When you talk about family caregiver, are you talking about paid, unpaid, or both categories?</p> <p>A: Unpaid family caregiving, which could include a paid break.</p>
2	<p>Q: Do you do customer surveys of residents about satisfaction of feeling connected? If so, who conducts these surveys, the LLC or partner agencies?</p> <p>A: Prior to launching the project, we set up a residential advisory board from each building. This group helped design the evaluation model/surveys. We received lower rankings at first when coordination was not as solidified and there was some resource confusion. Ratings have increased since then. The LLC is responsible for collecting the data. The resident advisory council meets regularly. They are not shy about providing feedback. Early on, we came up with a monthly services package model, though we are not currently using it. The Vancouver Housing Authority is doing extra work with their client. Adult family homes and resident locations are terrific partners in working with us in Clark County.</p>
3	<p>Q: For the aging population who need placement in an assisted living or adult foster home, with limited income but not qualifying for Medicaid, what are the financial resources to help with placement?</p> <p>A: People with any resources would use those to go to a place of choice and begin to live there. They could apply for home and community services and/or Medicaid coverage. There is a need to understand the policy of a particular setting to make sure you can age in place there. Accountable community health is a huge problem for those caught in between limited funding and not qualifying for Medicaid. In WA, we are working to address this. WA is experimenting with a payroll tax, but that's 5-10 years out. People are spending down their resources to qualify for Medicaid. That's not a good system. We need to work on this and do so rapidly. The Vancouver Housing Authority and Clark County are trying to get more housing options which could help. It's both a public policy and funding issue – no one has solved this systemically yet. Mostly bandaid solutions have been provided so far.</p>
4	<p>Q: How do you approach a single senior citizen, non-family member, showing signs of mental concerns?</p> <p>A: You need to try to have a conversation with that individual and hopefully make some progress by reaching out. The demonstration project, TSOA, saw need for the vulnerable individual without family support. The Alzheimer's association has good resources such as a communication training module. The main thing is not going to them with the idea that they do have dementia. Approach the person as though they are a normal person. There are preconceptions about what dementia looks like/behaviors are. Observe, become educated first.</p>
5	<p>Q: How can the rural areas within Clark County, and in the surrounding, associated counties, face their rural challenges?</p> <p>A: Support groups would be the best bet if people can get to them. Julie and Les have a support group member who lives in a rural area. A strength of rural areas is the same dozen people do</p>

Questions for panel

everything, which is true to some extent in Clark County, but resources are scarce and geography is challenging. Resources and person power are the issue – multi-county coordinated care groups who have set up systems to help across a broader geography can help. It seems rational for the health care sector to think about community benefit funds, healthcare funds, etc.

Questions not answered as time ran out

1	Has anyone addressed the lack of reimbursement for Occupational Therapy to identify driving skills, needs and cessation? Currently not reimbursed by Medicare. Only skilled profession to make this determination.
2	For Howard: who or what were the 5 or 6 social service non-profits?
3	Does Medicare/Medicaid pay for the enhanced PET Scan?
4	What can be done to address the rapidly escalating shortage in the professional caregiver workers?
5	What is the medical community doing to promote specialization in gerontology in medical schools?
6	Is there reliable genetic testing for Alzheimer's (predicting) disease? Environmental factors?

GROUP DISCUSSION AND REPORT BACK

Attendees participated in table discussions and reported back to the group on the following two questions:

1. From your perspective and what you heard today, what do you think is the biggest challenge people face to successfully age in place in Clark County?
2. Do you think the services and opportunities currently available in Clark County are meeting the needs of residents that wish to age in place? What works well and what needs to change or added?

Report out: most compelling idea

1	Biggest challenge we saw is the middle-class, people are not able to afford services on their own and don't qualify for Medicaid or other low income programs.
2	Lack of access to geriatricians. This is not a field to make a lot of money and folks have shied away.
3	How to coordinate care between social services and health care?
4	How do we leverage existing resources?
5	What are our resources and how do we look to leverage community health works in that capacity?
6	Medicare now mandates depression and cognitive testing as part of wellness testing. Lack of integrated care at the primary care level.
7	Community charity groups work well, but it can be challenging recruiting volunteers and getting more outreach. Need to start earlier in high school.
8	Lack of unified policy approach. Need to determine government responsibilities. There is a partisan divide on the proper role of government and what services should be funded.
9	How do we incentivize current contractors and construction companies to build houses meeting universal design standards?
10	Lack of incentives to build universal design homes and lack of awareness of resources.
11	Lots of social services, challenges with medical coordinated services.
12	Affordable housing and housing with supportive services. Impressed with the HWS model and would like to bring that here.
13	The presentations focused on family caregiver support and the importance of caregiver support. There are lots of low income single women with no family caregivers or family at all. How to approach what their needs are as their cognitive decline begins?
14	AADSWA provides great services and caregiver support program.
15	Transportation and social isolation barriers, especially in rural areas. If can't access the services, what's the point even if the services are great?
16	Transportation is the glue and we often don't think about it until it's gone.
17	Just because you're older doesn't mean you don't want to go out to a restaurant or movie.
18	We need a transportation solution that's affordable, convenient and accessible for all.
19	There is freedom with mobility.
20	There is no one answer, we need: good transportation, education about transportation resources, and we need to think about the future.
21	We need to start saving for retirement and have more classes focused on this. We don't spend enough time thinking about this.
22	Getting the word out, education: marketing. We need better marketing about what's available and what the need is here.

Report out: most compelling idea

23	There is not a lot of social worker/human development programs focused on the geriatric community.
24	Idea of silos. Silo for mental disabilities, kids, geriatrics, etc. Caregiving is all about the family and we need more focus on intergenerationality.
25	Pre-planning. No one wants to think about getting old or aging in place. With support from companies, community, etc. we can be better prepared as a community.

WRITTEN RESPONSES FROM GROUP DISCUSSION

WORKS WELL

- Villages model/social network
- Area agency on aging
- Caregiving resources
- Charities/faith based programs, i.e. caring closet/giving closet
- County engagement in improving aging in place
- Family/friends to help with care
- Community involvement is high here
- Good Commission on Aging Advocacy

BIGGEST CHALLENGE/NEEDS TO CHANGE

- Improved transportation
- Attach cognitive assessment to reimbursement to ensure that it is done
- Knowledge of information/resources
- Dissemination of information/resources
- Improvement of intergenerational programs
- Improving number of volunteers
- Clark County volunteer fair
- Resources: need more money and people
- Health and wealth
- Lack of early planning
- Lack of standardized care
- Lack of integrated care/other disciplines actively involved
- Insurance/reimbursement issues/barriers
- Funding
- Housing
- Advocacy
- Affordable housing and care
- Social isolation
- Need for coordination of services (“HUB”)
 - Where to start/awareness for the community more readily available

- Increased placement of “HUB” brochures
 - More workplace seminars
 - Increase awareness of “211” and “311”
 - More general need for education on social services that are in place
 - Increased available care caregivers and transportation
- Put resources into recruitment in gerontology related fields (schools/colleges) and encourage a living wage for providers who do go into those professions
 - Supply education on need, statistics, diversity of professions in “gerontology”
- Solve issues related to “silo effect” of various agencies and populations, providing resources – across generations, family, culture
 - Increase inclusion, links, education
 - Marketing
- Transportation issues (related to social isolation)
 - No services in north county
 - Difficulty in navigating the system
 - Need for advocacy
 - Resolve negative effects of riding public transportation (remove barriers)
 - Stigma
 - Safety
 - Expensive to use alternatives (uber, etc.)
 - Distance to bus stops
 - Difficult to use for seniors to shop due to carry bags/parcels
- Lack of knowledge of what we have – dissemination of information needed
 - Social stigma
- Elder friends – reinstitute, it was great
- Behavioral health – suicide risk (65+ males), needs to be addressed
 - Isolated population
 - Alcohol
- More services needed for caregiver support. We have some, need more!
- Help people understand they “are” a caregiver
- Since its cheaper to keep people in their homes. To do that we need caregivers – paid and unpaid (home being house or facility)
 - Develop strategies to gain (train, recruit, etc)
 - Caregiver and caregiver support services
- Help people emotionally deal with planning for death
- Middle class
 - Difficult to qualify – financial resources
 - Paying for services or basic needs
- Cognitive assessment
 - Advocating for help (patient)
 - Physician training and comfort addressing cognitive issues
 - Limited gerontology specialization
- Early planning and education
 - Checklists and other resources
- Education on aging – what it is and isn’t
 - Current thinking, research, data
 - Changing aging.org: Dr. Bill Thomas, Village movement

- Balance
 - Libraries: Aging in Place – free
- Creating a supportive community
 - Confidence for aging folks to stay healthy/living in home
 - Living/aging in your community
 - No isolation
- Food insecurity/nutrition: huge
 - Ombudsman website – availability, access
 - Programs – Meals on Wheels, food banks, money limitation and where to turn
 - Faith communities – rural assist?
- Telehealth: technology dependent
- Barriers to access services
- Lack of family support
- Lack of unified policy approach
- Partisan divide on proper role of government, what services ought to be funded
- Denial of reality of aging process
- Awareness of programs/services available in Clark County
- Built environment-incentivize
- Universal Design
- Lack of requirement to build to universal design standards
- Social services are meeting the needs to age in place, but not medical services
- Change: increase education and awareness; physician training in gerontology