2005 White House Conference on Aging

December 11–14, 2005

REPORT TO THE PRESIDENT AND THE CONGRESS

2005 White House Conference on Aging

The Booming Dynamics of Aging: From Awareness to Action

December 11 – 14, 2005

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Letter of Transmittal

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The Honorable Alphonso Jackson
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The Honorable Barbara B. Kennelly
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The Honorable Michael O. Leavitt
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The Honorable Howard "Buck" McKeon
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The Honorable James R. Nicholson
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The President
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Dear Mr. President:

On behalf of the 17-member, bi-partisan Policy Committee, I am pleased to transmit the final report of 2005 White House Conference on Aging.

The 2005 WHCoA, the first of the 21st Century, occurred at a time of unprecedented demographic change in our country. The rapidly approaching aging of 78 million baby boomers has created a sense of urgency that has not existed before. By 2050, one in five Americans will be 65 years of age or older. What is required now to address this dramatic transformation is action at all levels of the public and private sectors in order to implement solutions that will solve challenges related to our growing and diverse aging population. These challenges range from how we will care for our loved ones to where and how we and our family members will live, work, and continue to contribute to our country's success.

There are two overarching issues that are paramount to making this transformation successful.

First, the fiscal realities of Federal, State and local budgets demand that we re-think old ways of doing business, and seek innovation, set priorities, and are diligent in executing change. Just adding new entitlements and funding will only make real problems more difficult to solve. We must think and act in more modern, strategic ways that will cut across existing stove-piped programs and organizations in order to provide those who rely upon these services with more choices and options as they or their family members age.

Second, the responsibility for creating and implementing solutions is not solely a Federal responsibility. The two-year series of events convened around the country leading up to the December Conference involving more than 130,000 citizens, clearly demonstrated that solutions to virtually every challenge before us must involve a collaboration of Federal, State, Tribal, and local governments as well as individuals, communities, business and industry and not-for-for profit partners. This reality reverberated among Governors who shared successes based on solutions that came from within their own respective states. Finally and most important, this reality was confirmed by many of the hundreds of solutions suggested by 1,200 appointed delegates to the Conference who came to the nation's capital ready to make a difference on behalf of older Americans now and in the future.

www.whcoa.gov

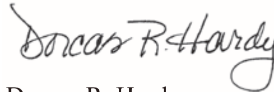
Delegates appointed to the 2005 White House Conference on Aging offered solutions to some of the challenges through implementation strategies proposed in WHCoA breakout sessions they elected to attend related to a particular topic, and the number of delegates attending each session varied widely. As such, the implementation strategies are not intended to convey the sense of all delegates who attended the WHCoA. Nor are the strategies suggested by the delegates and included throughout this report intended to be an endorsement by the full Policy Committee of any particular idea, recommendation or proposed solution. It is important to note, however, that a great many of the ideas and strategies offered by the delegates are thoughtful and innovative, and they deserve to be seriously considered by those who are committed to a quality future for Americans of all ages.

The Committee would like to thank the thousands of citizens across the country who participated in the nearly 400 WHCoA events in the months leading up to the Conference and especially the delegates for their dedication, compassion, and energy. I salute the members of the Policy Committee and the Advisory Committee for their leadership, hard work, and persistence in grappling with how best to frame and present very complex and often contentious issues impacting our current and future aging population.

At the Conference we were reminded that there are Red States and Blue States, but "aging" is Purple. I hope that the readers of this report will strive to integrate and work through the many ideas of the Conference and the Mini-Conferences as well as the tremendous amount of additional input from pre-Conference events and craft their own Purple plans and statements for the future of our nation. We need strategies that are innovative and fiscally responsible, and ones that can be addressed and solved by all of us - governments, individuals, business and industry, and non-profit organizations. Then we will have a real vision for the future.

As we approach the end of the first decade of a new century, we should embrace this opportunity for transformation. Each of us has roles and responsibilities for an aging America. It is more than the pure numbers of Americans who are aging; it is also about the changing face of America as it ages. Ultimately, it is about our families – our parents, our grandparents, and others who have shaped our country and sacrificed for us - and how we will continue their legacy by caring for those who follow in their footsteps.

Sincerely,



Dorcas R. Hardy
Chairman, Policy Committee

CHAPTER 1

EXECUTIVE SUMMARY

Report of the 2005 White House Conference on Aging

THE BOOMING DYNAMICS OF AGING: FROM AWARENESS TO ACTION

EXECUTIVE SUMMARY

The 2005 White House Conference on Aging (WHCoA) and its Final Report are about the future. The future is reflected in the theme of the 2005 WHCoA, "The Booming Dynamics of Aging: From Awareness to Action." The theme shines a spotlight on the changing face of aging in the 21st Century and the need for all Americans to take responsibility to act now to address the challenges of a new century.

As policymakers and others review the data, strategies, and suggestions generated both during the 2005 White House Conference on Aging and at hundreds of pre-WHCoA events, they must consider the reality that the future will be very different than the past.

The potential scope and magnitude of the policy changes implied by the demographic shifts forecast for the future can be summed up in the words of Dr. Paul Hodge, JD, MBA, MPA, Chairperson, Global Generations Policy Institute and Director, Harvard Generations Policy Program, when he addressed the Policy Committee in 2004,

"While many experts, popular pundits and the press have made predictions about how the aging of the baby boomers will affect the United States, in actuality, no one really knows with any certainty what will happen. What is clear is that the policy implications and ramifications are unprecedented in history. America's graying will transform politics, retirement systems, health care systems, welfare systems, labor markets, banking and stock markets. It will force a re-thinking of social mores and prejudices, from issues of age/gender discrimination in the job market to end-of-life care. Whether that transformation is positive or negative will depend on planning and preparation that must begin today."

In the previous four decades, planning for the future meant absorbing 78 million Boomers first into the education system and then into the work force. The size of this demographic phenomenon has influenced political, social and economic systems in every decade. The Boomers will continue to influence public, social and economic policy for at least the next 30 years.

Although Boomers are still from five to 23 years away from traditional retirement age, it is not too early to begin planning for the impact they will have on every aspect of our society and culture. At a minimum, we can reasonably expect the same scope of change that was experienced as they have moved through the first four to six decades.

In areas such as Social Security, health care planning, and the workforce, we are already behind the curve. While experience is always important, it is unlikely that we will find all the answers to future problems in the past because tomorrow's older population can be expected to differ in distinct ways from prior generations:

- They will be healthier and wealthier.
- They will be better educated and desire to make contributions beyond traditional retirement
- They will be more racially and ethnically diverse.
- The average age of the older population will increase as the number of centenarians continues to grow, and there will be longer life expectancy.
- People are likely to stay in the workforce longer than in the last seven decades.

THE BOOMING DYNAMICS

The aging of the population is one of the most important demographic trends in the United States.

The extent of this trend is documented in Figures 1 through 5, which show the distribution of the U.S. population by age and sex for the years 1940, 1980, 2000, 2020, and 2040. In 1940, the majority of the population was under the age of thirty due in part to the large baby boom cohorts born following World War II (Figure 1). There were relatively few persons age 65 and older—approximately 16.2 million—and they represented only 9% of the total population. The aging of the baby boom cohorts (coupled with declines in fertility) gradually changed the shape of the age distribution. As shown in

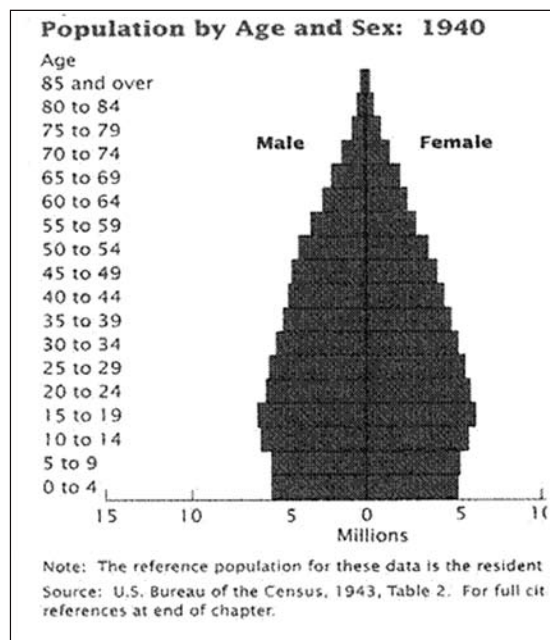


FIGURE 1

Figure 3, about 35 million Americans were age 65 and older in 2000 (12% of the total population). If projections of the population for the next forty years hold, the number of older persons will further increase to 80 million, and one-in-five Americans will be age 65 and older (Figure 5).

The story of the aging of the U.S. population is not simply one of increases in numbers. Over the next forty years there will be a dramatic increase in the average age of the older population. For example, 4.2 million persons were age 85 and older in 2000, and further declines in mortality could lead to a five-fold increase in the number by 2040 (Figure 5). This could have a significant impact on health and long-term care because the use of formal and informal services is strongly correlated with age.

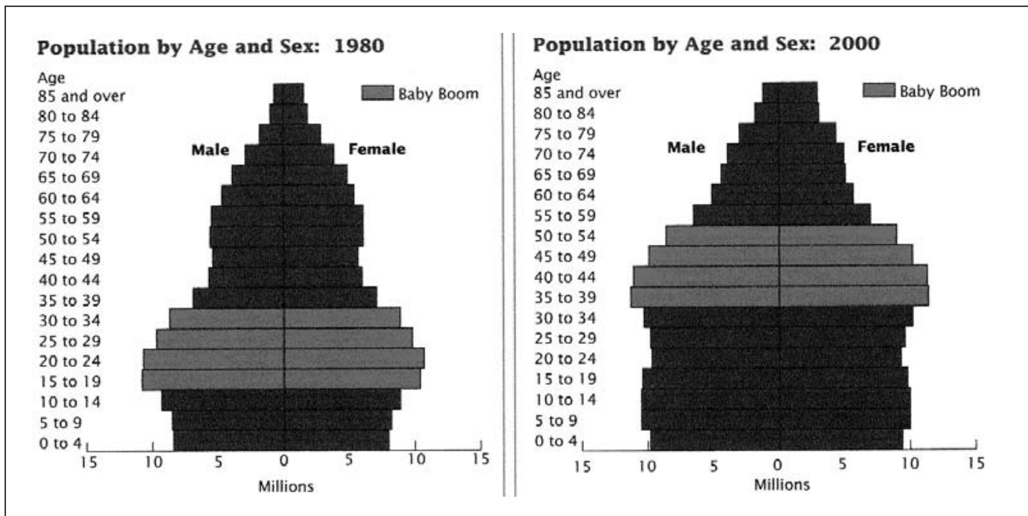


FIGURE 2 FIGURE 3

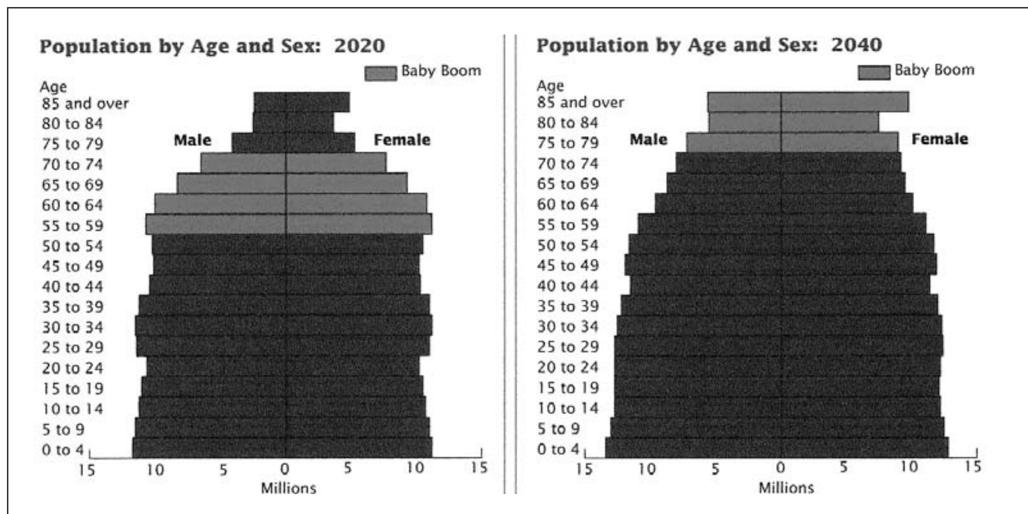


FIGURE 4 FIGURE 5

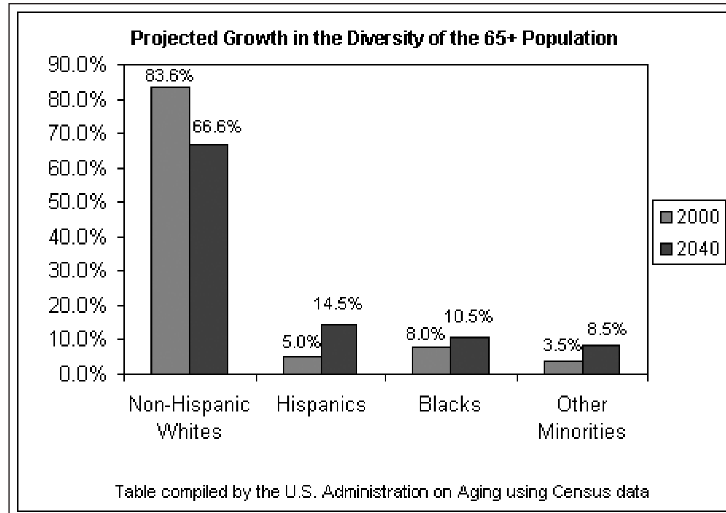


FIGURE 6

As the population grows larger, it will also become more diverse, reflecting the demographic changes in the U.S. population as a whole over the past decades. In 2000, non-Hispanic whites accounted for nearly 83.6 percent of the U.S. older population, followed by Blacks (8 percent), Hispanics who may be any race (5 percent) and other minorities (3.5 percent). Projections suggest that by 2040, the composition will be 66.6 percent non-Hispanic White, 14.5 percent Hispanic, 10.5 percent Black and 8.5 percent other minorities.[1]

A key cohort in this changing demographic story is represented by our nation's veterans. According to the 2000 Census, there were 9.8 million veterans age 65 and older in the U.S. comprised mainly of the World War II, Korea and increasingly Vietnam era cohorts. While there is projected to be a slight drop between 2000 and 2010, the number of veterans over age 65 will again increase as the majority of the Vietnam era cohort ages. Likewise, the number of age 85 plus veterans will continue to increase steadily, reaching nearly 1.4 million by 2012. The Department of Veterans Affairs estimates that as of 2006, approximately 9 million of the nation's 25 million veterans were Boomers. These veteran demographic changes have significant implications not only for the Department of Veterans Affairs in providing benefits, including health care, long term care and other VA services, but for state and local governments and community-based organizations since veterans may be eligible and entitled to services from more than one program.

For a more in-depth look at elements of aging demographics in the U.S., the statistical report, "A Profile of Older Americans 2005" published by the U.S. Administration on Aging is reproduced in the Appendix of this report.

1 Administration on Aging, U.S. Department of Health and Human Services, U.S., Census Bureau data

SUMMARY

Beginning January 1, 2006, on average, a new 60 year old was celebrating a birthday every seven seconds, and these celebrations will continue for another 18 years. The impact of this demographic shift will affect every level of our social, economic and political systems.

In his address to the WHCoA delegates on December 12, 2005, David Walker, Comptroller General of the United States, summed up the challenges our country faces by outlining the consequences that the projected growth of the aging population has for our nation's health care system and its economy, especially if we take no action. Mr. Walker said that "continuing the current national direction of our country is not an option" or the result will be that "our children and grandchildren may face taxes 2.5 times today's levels." He suggested three ingredients needed to address these changing times: "courage, integrity and innovation," and he challenged all delegates to draw upon these ingredients in their deliberations – to have the courage to make tough choices, the integrity to do what is right and fair, and to unleash their minds in pursuit of innovative approaches that will make the coming decade one of positive and productive aging."

Solutions to the challenges ahead will not come from looking back because there is no prologue. As one reviews this report and reflects on the discussions of the delegates and the thousands of other participants who shared their views through pre-WHCoA events, it would be wise to remember that a new lens focused on the future of an aging society, together with an understanding of the past, will be needed. This is perhaps the greatest challenge we will face in the coming decades.

WHCoA BACKGROUND AND PROCESS

Decennial White House Conferences on Aging are now embedded in our national history. Past White House Conferences on Aging, first held in 1961 and again in 1971, 1981 and 1995, have been catalysts for aging policies and significant national programs such as Medicare, Medicaid and the Older Americans Act. Each Conference has been unique and dynamic. Each has carried its own "call to action" reflecting the time in history during which it occurred.

The 2005 Conference was no exception. It was the first WHCoA of the 21st Century, and it was also the first to have a mandated focus through its authorizing statute, the Older Americans Act Amendments of 2000 (P.L.106-501), on the demographic cohort known as the "Boomers." The Conference also continued the WHCoA tradition of using a grass-roots outreach strategy to generate public input that resulted in more than 130,000 citizens participating in forums all across the nation

The 17-member, bi-partisan Policy Committee appointed by the President and the Congress and the 22-member Advisory Committee appointed by the President recognized the uniqueness of the 2005 WHCoA and the opportunity to address key aging issues facing our nation at a unique point in history. Both the Policy Committee and the Advisory Committee have fulfilled their distinctive roles by placing a targeted emphasis on the coming generation of seniors while paying tribute to those individuals who have contributed and continue to contribute to this country's prominence and prosperity.

THE WHCoA PROCESS

The 2005 WHCoA process began in August 2004 and culminated with the December 2005 Conference in Washington, D.C. The WHCoA was nearly the 400th event in a series of forums that were convened across the nation to discuss aging issues and propose solutions to significant challenges.

The WHCoA process was guided by the Policy Committee's development of a framework that provided a structure or organizational umbrella for the variety of issues that would be discussed during all pre-WHCoA events. This framework, referred to as the WHCoA Policy Tracks (which made up the Annotated Agenda), is identified below. The Delegate Workbook provided to the delegates to the December 2005 Conference was organized around these seven categories.

ANNOTATED AGENDA CATEGORIES

- Planning Along the Lifespan
- The Workplace of the Future
- Our Community
- Health and Long Term Living
- Civic Engagement and Social Engagement
- Technology and Innovation in an Emerging Senior/Boomer Marketplace
- Cross-Cutting

A narrative description of the scope and content of each category is included in the Appendix of the report as was provided to the delegates in the Delegate Workbooks.

From the input received by the WHCoA and from the resolutions adopted by the delegates, clear themes have emerged identifying significant challenges that are before the nation with regard to our rapidly aging, diverse population. Those challenges are briefly described in the concluding section of this report.

THE VOICES OF AMERICA: THE PUBLIC INPUT PROCESS

The public input process that began in August 2004 was designed to create a variety of opportunities for the widest possible participation of citizens in WHCoA activities. To solicit this wide participation, the 2005 WHCoA was based on a vigorous bottoms-up, grass roots strategy involving more than 130,000 people in towns, cities, communities, Tribal reservations and Native American villages and States across the country meeting in various forums to have conversations about aging challenges and solutions. Beginning in August 2004, forums were organized by individuals and communities, academic institutions, business and industry, national and local organizations and

coalitions, non-profits, faith-based organizations, as well as Federal, State, Tribal and local agencies. These public forums took place under the titles of Mini-Conferences, Listening Sessions, Solutions Forums, and Independent Aging Agenda events.

DOCUMENTING PUBLIC INPUT TO THE WHCoA

What set this public participation process apart from previous WHCoA's was the strong emphasis by the Policy Committee for participants to seek visionary, innovative, realistic, and fiscally responsible solutions to aging challenges. From the beginning, the Policy Committee articulated its desire to move beyond simply identifying the issues and to hear ideas about how to solve problems. The public input received by the Policy Committee came from four different types of pre-WHCoA events as described below.

- It was significant that Listening Sessions and Independent Aging Agenda Events conducted around the country confirmed that this is a set of national challenges that states and communities have each been grappling with in their unique ways.
- In WHCoA Solutions Forums, the Policy Committee turned to the imagination of individuals who are experiencing many of these challenges on a very personal level and asked for their recommendations.
- Mini-Conferences developed through public-private partnerships provided the Policy Committee with focused information as well as policy recommendations on single topic areas such as long term care, caregiving, disability and aging, geriatric health care workforce, mature workforce, nutrition, financial security, retirement savings, access and development of health and financial information, and health literacy and health disparities.
- Public comments received by the WHCoA from individuals and organizations provided additional insight and direction.

The issues identified during these public forums were documented and reported to the WHCoA by the leaders of those events. These reports were posted on the WHCoA website (www.whcoa.gov) as soon as the information became available to encourage dissemination of information. The reports from these events were synthesized through a deliberative process involving the WHCoA Policy Committee and Advisory Committee. This synthesis process resulted in the creation of a summary of the key findings and recommendations from the public input process. Those reports are included in the Appendix of this report.

The analysis of the information contained in this synthesis document formed the basis for the identification of a candidate set of resolutions that was ultimately presented to the delegates for their consideration in advance of the December 2005 Conference. Deliberations by the Policy Committee

in consultation with the Advisory Committee resulted in the Policy Committee identifying and developing 73 broad-based and diverse resolutions that were then formally presented to the delegates for their consideration in advance of the December 2005 Conference and their vote on 50. These 73 resolutions were organized under the seven Tracks of the Annotated Agenda. These 73 resolutions appear in the Appendix of the report.

THE DELEGATES

The 1,200 bi-partisan delegates to the 2005 WHCoA were selected by Governors of all 50 States, Puerto Rico, the District of Columbia and the Territories, Members of the 109th Congress, the National Congress of American Indians and the Policy Committee. The delegates represented aging and allied organizations, business and industry, veterans, persons with disabilities, minorities and others with an interest in the future of aging in the United States.

These delegates were the heart and hands of the WHCoA. They were vocal and passionate; experienced and informed. They were seniors and Boomers; some were children of Boomers, and others soon-to-be centenarians. They were grandparents, caregivers, advocates, policymakers, entrepreneurs, financial advisers, volunteers and interested citizens. But most important, delegates to the 2005 WHCoA were not reticent, and most came to the Conference eager and prepared to contribute.

The names of the 2005 WHCoA delegates appear in this Executive Summary and in the Appendix of this report.

THE WORK OF THE DELEGATES AT THE WHCoA

The initial work of the delegates focused on selecting the top 50 resolutions out of the list of 73 candidate resolutions they had received in advance. The selection of the top 50 resolutions was made through a monitored voting process in which each delegate was provided an opportunity to cast a ballot.

Based on the 50 resolutions that were selected by the delegates at the conference, implementation strategy sessions were scheduled for delegates to meet for discussion of individual resolutions. During these sessions conducted through a facilitated process, delegates proposed strategies to implement the resolutions. Facilitators assisted delegates in the sessions to identify strongest, strong, moderate and limited levels of support, and worked with Track Coordinators to provide a summary of the sessions which was reported by the Policy Committee on the last day of the Conference. The power point presentation presented by the Policy Committee on December 14, 2005 is included in the Appendix.

During these sessions, delegates identified implementation strategies that reflected their sense about what needed to be done to make these resolutions a reality. The Policy Committee believed it was critical for delegates to also identify those groups and organizations that have stakeholder accountability and responsibility for each of the implementation strategies as well as those where individual citizens have that same accountability and responsibility. Delegates were also provided

with an opportunity to submit suggested individual implementation strategies that have been included in the proceedings and may be found in the Appendix.

THE PRIORITIES OF THE DELEGATES

The delegates recognized several critical priorities that we as a nation must address in the very near future. Through the voting process and subsequent vote count on resolutions, it was evident that the delegates felt strongly about many of the issues they were considering, but particularly about:

- The reauthorization of the Older Americans Act within six months of the WHCoA;
- The development of a comprehensive and coordinated strategy for affordable and accessible long term care including caregiving support, and
- The importance of mobility and transportation options for older Americans.

In addition and equally important, were other broad, cross-cutting themes that emerged from the work of the delegates and throughout the last two years of public input. Those themes include:

- Planning and Financing Your Longevity
- Independence and Innovation In Livable Communities
- Long Term Supports and Services: The Need for a Strategy
- A Sense of Purpose: The Future of Work and Civic Engagement
- Caregiving: Being There For Our Elders
- Healthy for Life: Challenges and Solutions of Health Promotion and Disease Prevention
- Improving the Health Care System

These themes all present challenges for a new century that must be addressed now if we are to take our responsibilities as policymakers, family members and private citizens seriously. The resolutions adopted and many of the implementation strategies recommended by the delegates provide significant first steps in addressing many of these challenges.

A listing of all 50 resolutions adopted by the delegates according to the votes, along with a brief overview of the issue addressed by each resolution as provided in the Delegate Workbooks and the implementation strategies developed by the delegates which received the strongest and strong support during their respective implementation sessions is included following the Executive Summary. Although the Policy Committee strongly emphasized that participants seek visionary, innovative, realistic, and fiscally responsible solutions to aging challenges, the implementation strategies developed by the delegates did not meet all these criteria to an equal degree.

A complete listing of resolutions and all implementation strategies is included in the Appendix in its entirety.

Although the delegates came from diverse viewpoints and backgrounds, a sense of purpose, bi-partisanship, and consensus permeated most of these working group sessions.

The same energy, passion, and thoughtfulness present during the nationwide pre-WHCoA events carried over to the Conference. The implementation strategies reflect the discussion of the delegates who elected to attend breakout sessions on a particular topic, and the number of delegates attending each session varied widely. As such, the implementation strategies are not intended to convey the sense of all delegates who attended the WHCoA. Further, the strategies suggested by the delegates and included throughout this report are not intended to be an endorsement by the Policy Committee of any particular idea, recommendation or proposed solution.

THE CONFERENCE

As stated previously, the 2005 WHCoA was unique for several reasons, but especially because of three innovative events that were held in conjunction with the Conference. These events are identified and summarized below.

- **Get Involved: A WHCoA Service Project**

  To focus attention on the importance of civic engagement and community service, this Pre-Conference event was organized by the Corporation for National and Community Service and the Washington D.C. Jewish Community Center. Volunteers from Senior Corps joined Conference delegates to help rehabilitate the Educational Organization for United Latin Americans (EOFULA), a Washington D.C. community center for Latino senior citizens. Braving frigid weather, delegates and volunteers painted, repaired and weatherized the senior center.

- **Healthy Living Celebration!**

  The Healthy Living Celebration!, a Pre-Conference event, was organized to highlight the importance of healthy living as well as the commitment of the 2005 WHCoA to health and wellness while demonstrating that physical activity can be fun. These goals were accomplished through the leadership of the President's Council on Physical Fitness and Sports, who co-sponsored the event with assistance from the National Senior Games Association (NSGA).

  A renowned cookbook author shared her knowledge about healthy and nutritional cooking followed by several lively physical activity sessions. Activity leaders from the Washington, D.C. metropolitan area volunteered to lead group fitness classes (T'ai Chi, Line Dancing, Resistance Training, and Aerobic Exercise).

The event concluded with the recognition of delegates who participated in the WHCoA "Profiles in Wellness Program," who received Honorary Athlete medals donated by the NSGA, and the 2005 WHCoA President's Challenge Program sponsored by the President's Council on Physical Fitness and Sports who provided every participant in the President's Challenge with a certificate and a wrist-band that could be worn in support of and in promotion for physical activity, health and wellness at the Conference and beyond.

■ 2005 White House Conference on Aging Exhibit Hall

The first WHCoA Exhibit Hall to highlight technology was held at the 2005 WHCoA. Co-sponsored by ZivaGuide, a customized health care information provider, the Exhibit Hall featured over 140 exhibitors representing a wide variety of public, private and non-profit organizations, firms and government agencies presenting some of the latest initiatives and innovations in providing services to the aging community.

Large portions of the Exhibit Hall were dedicated to highlighting the potential of technology to transform aging in America. Two sponsors of the largest exhibits were CAST, (the Center for Aging Services Technologies) a program of the American Association of Homes and Services for the Aging, and the U.S. Department of Transportation (DOT). The Conference's technology exhibit was the largest ever held by CAST, and included some of America's leading technology companies and universities who assembled dozens of ground-breaking technologies to give policy makers a glimpse of how technology could transform the lives of older adults and those that care for them.

Another portion of the Exhibit Hall, sponsored by the DOT, was dedicated to illuminating promising trends and programs in improving mobility for America's seniors. Secretary Norman Y. Mineta, the first Secretary of DOT to speak at a WHCoA, joined Policy Committee Chairman Dorcas R. Hardy in the opening of the Exhibit Hall. The Secretary emphasized that the DOT-sponsored programs and exhibits in the hall were but a few examples of the research and technology undertaken by the Department and its private sector partners dedicated to achieving a safely mobile older population now and in the future.

The Exhibit Hall received a great amount of positive media reports from all over the country, and its contents helped guide the policy discourse at the Conference as well as in the aging community since that time.

THE GOVERNORS AND NATIONAL CONGRESS OF AMERICAN INDIANS

As required by statute, within 100 days of adjournment of the 2005 WHCoA, the Governors of all 50 States, Puerto Rico, the District of Columbia and the Territories were asked to provide their input for the Final Report. In recognition of the important role of Tribal governments, the National Congress of American Indians (NCAI) was also asked to provide input as to how the resolutions will impact tribal elders across the nation. Each entity was asked to carefully review the resolutions adopted by the delegates and identify those they consider most important to their constituencies. Additionally, they were asked to share what they are currently doing, or hope to do, to implement the resolutions for the people they serve, or will serve, over the next ten years and beyond. Many of the resolutions have state or tribal impacts; therefore, the input provided by the States and the NCAI complements the efforts of the delegates and provides for a more robust Final Report. The input received from the Governors who responded and the NCAI is included in the Appendix of this report and posted on the WHCoA website.

The Appendix provides detailed information on the mechanics of the conference, identifies those who attended, and includes a listing of all resolutions and implementation strategies recorded during the sessions as well as those strategies submitted by individuals.

CONCLUDING REMARKS

Over the last two years, the members of the Policy Committee of the 2005 White House Conference on Aging and the members of the Advisory Committee have listened to professionals and volunteers in the field of aging as well as interested citizens to identify the most pressing issues facing our nation's seniors and those who care for them.

In addition to the passionate Conference delegates, more than 130,000 individuals, representing business, associations, organizations, governments and advocates participated in several venues to contribute to the 2005 White House Conference on Aging deliberations. After reflecting on the substantial amount of input, responses and reports received, the Policy Committee has asked:

How can the 2005 White House Conference on Aging provide a foundation for positive change during the next 10 years that will result in a better world for current and future seniors? What is needed to make that happen?

FROM AWARENESS TO ACTION – A SENSE OF URGENCY

The 2005 WHCoA Policy Committee and the Advisory Committee believe that action must be taken now to address the many challenges that have been identified in this report by the delegates and pre-WHCoA event participants. Throughout these past two years, it became apparent that there are critical factors that demand attention from individuals as well as private and public players at all levels, including Tribal organizations, local and community groups, and not-for-profit organizations.

All must step forward now to meet these challenges. The reasons why we must act now are summarized as follows:

- The U.S. is in the midst of a demographic shift that will transform our nation. The policy implications and consequences of this change are unprecedented.

- The impact of longer life expectancy on all phases of life must not be underestimated. Longer participation in the workforce, individual responsibility for financing one's longevity, and the need for long term supports and services as we age with disabilities or age into disability are all critical components of longevity.

- Tomorrow's older population will differ in distinct ways from prior generations. The characteristics of this diverse Boomer population must be viewed as opportunities rather than as problems to be solved. Yet, at the same time, one must recognize that many hardships, challenges and uncertainties that come with aging may not change for millions of Americans.

- The fiscal realities of Federal, State and local government budgets transcend simple solutions. Policymakers must balance competing priorities which requires that they exercise decisive leadership, and innovation and demonstrate courage in making individual and collective choices. Public financing will continue to be essential, but cannot be the only answer.

- Finally, there are limitations in our delivery of health care and social services to our older population. Whether these limitations are in the size of our caregiver or geriatric health care workforce, the investment and management of technology, the ability to address the cultural differences and needs of our growing diverse population, the availability and accessibility of transportation options for many who are disabled and aging; these and other limitations will only become greater impediments to success the longer action is delayed.

GUIDING PRINCIPLES FOR ACTION

The basic principles outlined in the Older Americans Act have remained relevant since the Act was first enacted in 1965, but it is imperative that they be modernized for the 21st Century. The message arising from this 2005 WHCoA is that we must now modernize our aging polices for the 21st Century to deal with the challenges we are facing and those we see on the horizon. Modernization of our nation's aging policies and programs must be guided by some overarching philosophies.

- The role of personal responsibility and accountability for planning for one's longevity is of paramount importance. No set of new policies or changes in existing programs can be successful

unless individual citizens assume greater responsibility for planning to meet their current and future needs - to the best of their ability- from preparing for future potential long term care needs to choices about financing. Individuals must become informed about and involved in these choices and options.

- In making decisions about the development and execution of modernized aging polices and programs, leaders and managers must take the following courageous steps:

    - Proactively realign and modernize current aging programs and networks to be more efficient and effective in their performance, so as to free-up resources for unmet needs. These programs, by necessity, must continue in order to serve those seniors who have depended on them. Such support has greatly served to enhance the quality of their lives. That support should be continued using more modern and integrated approaches.

    - Transform the “world of aging” - policies, programs, and organizations – from a series of “stove-pipes” into a 21st Century system of coordinated services and networks that will meet the future needs of the Boomers, while also improving services to current seniors. It is not useful to try to push 21st Century needs though outdated “silos” to try and achieve solutions. A true 21st Century system of aging services must be based on new concepts and designs of policies, programs, and organizations where evidence-based outcomes result.

    - Proactively work to fully integrate the efforts of Federal, State, Tribal, local and community, private, and not-for-profit stakeholders. It is critical that each entity know its role and responsibility, but it is more important now than ever before for these stakeholders to collaborate.

As stated in the introduction, the 2005 White House Conference on Aging and this final report are about the future. The decade ahead will put us in the midst of one of the most dramatic demographic transformations in our history. We should embrace this future with a new commitment to planning and action at all levels of society to meet the needs of our aging population. Individuals, families, communities; the public, private and volunteer sectors have roles and responsibilities in meeting these needs.

The issue at hand is about more than the pure numbers of Americans who are aging. It is also about the changing face of America as it ages and the special responsibility we have to recognize and have our policies, practices and attitudes provide an environment of equal opportunity to age well. The role of government may change over time, but it has and will continue to have a fundamental

responsibility to help those in need irrespective of age. The value of a lifetime is the essence of aging. We should not approach the challenge of aging with fear and apprehension, but rather with creative foresight, optimism, and a sense of determination.

The challenges described in this report provide each of us with extraordinary opportunities. However, we need courageous leadership from all sectors of our country; we must have the will to make changes in our social services and health care delivery systems, and we must be innovative as we tackle the tough choices ahead. Only through this courage, will, and innovation will we be able to make the magnitude of changes that are necessary to serve the evolving needs of our aging population. This report provides a roadmap of actions for positive change.

During challenging times in our history, previous generations have been called upon to lead. Now is our time, and our mandate is clear. Let us lead by ensuring that the legacy of the 2005 White House Conference on Aging is one of relevance, vision and action. May we look back knowing that we made a difference for future generations, and may we look forward knowing we are helping our nation transition to a better and healthier future for all Americans.

CHAPTER 2

RESOLUTIONS AND IMPLEMENTATION STRATEGIES

- Resolutions Adopted by Conference Delegates *(Top 50)*
- Implementation Strategies *(Strongest and Strong)*

Resolutions Adopted by Conference Delegates

(Top 50)

RESOLUTION # 1 — TITLE: OLDER AMERICANS ACT
Reauthorize the Older Americans Act Within the First Six Months Following the 2005 White House Conference on Aging.

RESOLUTION # 2 — TITLE: COORDINATED LONG TERM CARE STRATEGY
Develop a Coordinated, Comprehensive Long-Term Care Strategy by Supporting Public and Private Sector Initiatives that Address Financing, Choice, Quality, Service Delivery, and the Paid and Unpaid Workforce.

RESOLUTION # 3 — TITLE: TRANSPORTATION OPTIONS
Ensure That Older Americans Have Transportation Options to Retain Their Mobility and Independence.

RESOLUTION # 4 — TITLE: MEDICAID PROGRAM FOR SENIORS
Strengthen and Improve the Medicaid Program for Seniors.

RESOLUTION # 5 — TITLE: MEDICARE REFORM FOR THE FUTURE
Strengthen and Improve the Medicare Program.

RESOLUTION # 6 — TITLE: PREPARED HEALTHCARE WORKFORCE
Support Geriatric Education and Training for All Healthcare Professionals, Paraprofessionals, Health Profession Students, and Direct Care Workers.

RESOLUTION # 7 — TITLE: NON-INSTITUTIONAL LONG TERM CARE
Promote Innovative Models of Non-Institutional Long-Term Care

RESOLUTION # 8 — TITLE: RESPONSIVE TO MENTAL ILLNESS
Improve Recognition, Assessment, and Treatment of Mental Illness and Depression Among Older Americans.

RESOLUTION # 9 — TITLE: CAPACITY OF THE GERIATRIC WORKFORCE

Attain Adequate Numbers of Healthcare Personnel in All Professions Who are Skilled, Culturally Competent, and Specialized in Geriatrics.

RESOLUTION # 10 — TITLE: COORDINATION OF AGING-IN-PLACE

Improve State and Local Based Integrated Delivery Systems to Meet 21st Century Needs of Seniors.

RESOLUTION # 11 — TITLE: PRINCIPLES OF SOCIAL SECURITY

Establish Principles to Strengthen Social Security.

RESOLUTION # 12 — TITLE: INCENTIVES FOR OLDER WORKERS

Promote Incentives for Older Workers to Continue Working and Improve Employment Training and Retraining Programs to Better Serve Older Workers.

RESOLUTION # 13 — TITLE: STRATEGY FOR INFORMAL CAREGIVERS

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

RESOLUTION # 14 — TITLE: RETENTION OF OLDER WORKERS

Remove Barriers to the Retention and Hiring of Older Workers, Including Age Discrimination.

RESOLUTION # 15 — TITLE: PROTECTION FROM ABUSE AND NEGLECT

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

RESOLUTION # 16 — TITLE: AFFORDABLE HOUSING

Enhance the Affordability of Housing for Older Americans.

RESOLUTION # 17 — TITLE: ACCOUNTABILITY FOR IMPLEMENTATION OF 2005 WHCOA RECOMMENDATIONS

Implement a Strategy and Plan for Accountability to Sustain the Momentum, Public Visibility, and Oversight of the Implementation of 2005 WHCOA Resolutions.

RESOLUTION # 18 — TITLE: LONG-TERM CARE FINANCING

Foster Innovations in Financing Long Term Care To Increase Options Available To Consumers.

RESOLUTION # 19 — TITLE: COORDINATED HEALTH AND AGING NETWORKS

Promote the Integration of Health and Aging Services to Improve Access and Quality of Care for Older Americans.

RESOLUTION # 20 — TITLE: DESIGNS FOR LIVABLE COMMUNITIES

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

RESOLUTION # 21 — TITLE: DISEASE MANAGEMENT PROGRAMS

Improve the Health and Quality of Life of Older Americans Through Disease Management and Chronic Care Coordination.

RESOLUTION # 22 — TITLE: HEALTHY NUTRITION

Promote the Importance of Nutrition in Health Promotion and Disease Prevention and Management.

RESOLUTION # 23 — TITLE: CARE IN RURAL AREAS

Improve Access to Care for Older Adults Living in Rural Areas.

RESOLUTION # 24 — TITLE: INCREASED RETIREMENT SAVINGS

Provide Financial and Other Economic Incentives and Policy Changes to Encourage and Facilitate Increased Retirement Savings.

RESOLUTION # 25 — TITLE: NATIONAL STRATEGY FOR VOLUNTEERING

Develop a National Strategy for Promoting New and Meaningful Volunteer Activities and Civic Engagements for Current and Future Seniors.

RESOLUTION # 26 — TITLE: EMERGENCY RESPONSE OR DISASTER PLAN

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

RESOLUTION # 27 — TITLE: AVAILABLE HOUSING

Enhance the Availability of Housing for Older Americans.

RESOLUTION # 28 — TITLE: NATIONAL AND COMMUNITY SERVICE ACT

Reauthorize the National and Community Service Act to Expand Opportunities for Volunteer and Civic Engagement Activities.

RESOLUTION # 29 — TITLE: INNOVATIONS IN AGING RESEARCH

Promote Innovative Evidence- Based and Practice- Based Medical and Aging Research.

RESOLUTION # 30 — TITLE: SUPPLEMENTAL SECURITY INCOME

Modernize the Supplemental Security Income (SSI) Program.

RESOLUTION # 31 — TITLE: OLDER ADULT CAREGIVERS OF CHILDREN

Support Older Adult Caregivers Raising Their Relatives' Children.

RESOLUTION # 32 — TITLE: VETERANS HEALTHCARE

Ensure Appropriate Recognition and Care for Veterans Across All Healthcare Settings.

RESOLUTION # 33 — TITLE: DESIGNS OF SENIOR CENTERS

Encourage Redesign of Senior Centers for Broad Appeal and Community Participation.

RESOLUTION # 34 — TITLE: AWARENESS OF DISPARITIES

Reduce Healthcare Disparities Among Minorities by Developing Strategies to Prevent Disease, Promote Health, and Deliver Appropriate Care and Wellness.

RESOLUTION # 35 — TITLE: ISSUES SURROUNDING THE END OF LIFE

Educate Americans on End of Life Issues.

RESOLUTION # 36 — TITLE: HEALTH INFORMATION TECHNOLOGY

Develop Incentives to Encourage the Expansion of Appropriate Use of Health Information Technology.

RESOLUTION # 37 — TITLE: PROVIDER EDUCATION ON CONSUMER HEALTHCARE

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

RESOLUTION # 38 — TITLE: RURAL ECONOMIC DEVELOPMENT

Promote Economic Development Policies that Respond to the Unique Needs of Rural Seniors.

RESOLUTION # 39 — TITLE: EVIDENCE-BASED LONG-TERM CARE

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

RESOLUTION # 40 — TITLE: CONSUMER DRIVEN HEALTH EDUCATION AND HEALTH LITERACY

Improve Health Decision Making through Promotion of Health Education, Health Literacy, and Cultural Competency.

RESOLUTION # 41 — TITLE: SOCIAL SECURITY DISABILITY INSURANCE

Strengthen the Social Security Disability Insurance Program.

RESOLUTION # 42 — TITLE: GERIATRIC HEALTHCARE CONTINUUM

Evaluate Payment and Coordination Policies in the Geriatric Healthcare Continuum to Ensure Continuity of Care.

RESOLUTION # 43 — TITLE: SHARED HEALTH INFORMATION

Encourage Appropriate Sharing of Healthcare Information Across Multiple Systems.

RESOLUTION # 44 — TITLE: CARE FOR SENIORS WITH DISABILITIES

Ensure Appropriate Care for Seniors with Disabilities

RESOLUTION # 45 — TITLE: PROSECUTION OF FINANCIAL CRIMES

Strengthen Law Enforcement Efforts at the Federal, State, and Local Level to Investigate and Prosecute Cases of Elder Financial Crime.

RESOLUTION # 46 — TITLE: PROGRAM ALIGNMENT AND PERFORMANCE

Review Alignment of Government Programs That Deliver Services to Older Americans

RESOLUTION # 47 — TITLE: CAPACITY FOR SAFE DRIVING

Support Older Drivers to Retain Mobility and Independence Through Strategies to Continue Safe Driving.

RESOLUTION # 48 — TITLE: INNOVATIVE HOUSING DESIGNS

Expand Opportunities for Developing Innovative Housing Designs for Seniors' Needs.

RESOLUTION # 49 — TITLE: PATIENT ADVOCACY

Improve Patient Advocacy to Assist Patients in and Across All Care Settings.

RESOLUTION # 50 — TITLE: PRESCRIPTION DRUG IMPROVEMENTS

Promote Enrollment of Seniors Into the Medicare Prescription Drug Program With Particular Emphasis on the Limited- Income Subsidy.

Implementation Strategies
(Strongest and Strong)

2005 White House Conference on Aging
Resolutions, Overviews and Implementation Strategies(IS) with Strongest and Strong Support

#	Titles/Resolutions	Implementation Strategies	Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions										
			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
1	**Older Americans Act: Reauthorize The Older Americans Act Within The First Six Months Following The 2005 White House Conference On Aging.**	**Overview:** **The Older Americans Act was signed into law on July 14, 1965 and was due for reauthorization in 2005. At the federal level, the Administration on Aging (AoA) administers OAA programs designed to allow persons age 60 and older to remain in their homes by offering them an array of supportive services. The OAA currently funds supportive services for over 7 million older Americans and their caregivers.** **OAA services are provided through a National Aging Services Network comprised of State Units on Aging, Area Agencies on Aging (AAA), and other local service providers. Each State Unit on Aging is allocated funds by the AoA based on the number of older persons in each state. Most states are divided into Planning and Service Areas (PSAs) so the local needs of particular areas are considered. The State Units on Aging in turn provide grant funding to AAAs responsible for delivering senior services at the local level. The AAAs may also contract with public and private groups to deliver services locally. In total, the National Aging Services Network includes 56 State Units on Aging, 655 AAAs, 243 tribal organizations, over 29,000 local community service organizations, 500,000 volunteers and a variety of national organizations.** **OAA programs provided 143 million home-delivered meals, 105 million congregate meals, 19 million hours of personal care and homemaker services and 38 million rides in 2004. These programs target low-income minority seniors, those in greatest social and economic need, and those in rural areas. Other programs include caregiver support, demonstration and training programs related to older Americans, employment and training opportunities for low-income adults, services addressing the needs of older Native Americans, elder rights programs, and elder abuse prevention efforts.**											
		Implementation Strategies: Permanently authorize ADRC's with funding by creating a new part in the OAA.	X										

The implementation strategies reflect the discussion of the delegates who elected to attend breakout sessions related to a particular topic, and the number of delegates attending each session varied widely. As such, the implementation strategies are not intended to convey the sense of all delegates who attended the WHCoA. Further, the strategies suggested by the delegates and included throughout this report are not intended to be an endorsement by the Policy Committee of any particular idea, recommendation or proposed solution.

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#	Titles/Resolutions	Implementation Strategies	Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions										
			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Establish set authorization levels for all OAA programs throughout the authorization period. Increase authorization levels for all of the Titles in the OAA by a minimum of 25%, allowing flexibility and capability for local autonomy, ensuring necessary resources to adequately serve the projected growth in the number of older Americans, taking into consideration the growing ethnic and cultural diversity, and particularly the growing ranks of the "old-old," those age 85 and over, who are the most frail, vulnerable, and in the greatest need for aging support services.	X										
		Elevate the director of the office of American Indian, Alaska Natives, and Native Hawaiian programs to the deputy secretary level in Administration on Aging.											
		Strengthen the policy and program management linkages between the Older Americans Act and Medicaid funded home and community based services programs.											
		Modernization: Strengthen the OAA by adequate funding, access, and community planning through authorization of levels reflecting current and future growth of the older population with an immediate 25% increase in funding for all Titles and future funding equal to the percentage of growth of the aging population; ensure accessibility and coordination by creating a new Older Americans Act Title to establish ADRCs nationwide and a new title establishing a requirement to the aging network to assist communities to prepare for the aging of the baby boomers, including services to foster livable communities for all ages	X										

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		OAA funding – a. Restore all funding that has been cut from OAA over the past 20 years and increase by 50% over the next two years and give parity to Title VI programs for Native elders. 25% increase in OAA appropriations b. Establish set authorization levels for all OAA programs throughout this authorization period. Increase authorization levels for all titles in the OAA by a minimum of 25% ensuring necessary resources to adequately serve the projected growth in the number of older Americans from the baby boomers to the old-old those 85+ years of age. No unfunded mandates will be acceptable for OAA programs at the implementation level. Increase OAA funding. Advocate for an increase in OAA funding. (A dollar under initial authorizations is now worth 57 cents.)Funding increases and flexibility a. Increase funding to reflect increased populations and at least 10% funding increase b. More flexibility for transfers between titles c. More flexibility at local level d. Encourage partnerships with other Federal programs, including chronic disease management initiatives e. Explore direct federal funding of model senior centers especially as wellness centers E.Funding Increase authorization levels for all titles of the OAA to ensure the necessary resources to adequately serve the projected growth in the number of older Americans. This will take at least a 10% per year increase over the next decade. Funding must be flexible at the local level and ensure an adequate funding base for rural and special needs areas through all titles of the OAA.											
		Allow for the maximum amount of flexibility in the allocation of resources and provision of services under Title III so that Area Agencies on Aging and Title VI Native American aging programs can most efficiently and effectively meet the growing and changing needs in their community.											

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Create a new title within the Older Americans Act to authorize State Units on Aging, Area Agencies on Aging and Title VI Native American aging programs to proactively help communities prepare for the aging of the baby boomers, using their expertise to help state agencies local city and county elected officials, local government agencies, tribal councils, and private and non-profit organizations to develop policies and services to foster livable communities for all ages and cultural and ethnic diverse populations. Increase OAA funding of at least 10% per year over the next decade. A new section and greater emphasis on civic engagement, retain the Title V SCSCP programs vital, historic focus o n community service, which gives older Americans an opportunity to work, contribute to their communities, renew a sense of self worth, improve communities where they live, and fill unmet needs of local community board organizations and the aging network. Maintain the Title V program's partnership between state and national grantees, retain the program's vital, historic focus on community services to support local community organizations and the aging network, and streamline program eligibility to promote increased participation to meet demographic changes and the growing ethnic and culturally diverse population. Support dignified, economically sustainable, community-based volunteer transportation programs that help older Americans age in place.	X										
		Engage the Senate Special Committee on Aging to develop a resolution, seeking co-sponsors, that calls for the immediate reauthorization of the OAA no later than June 15, 2006, with authorization levels increased by a minimum of 25%. Delegates representing congressional members will make individual contact to reinforce this action, seeking bi-partisan champions/sponsors in the House and Senate. All delegate, individuals, and groups are called upon to engage key media contacts to educate legislators and the general public about the impact of OAA services and programs	X										

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Title V SCSEP: Maintain the dual structure of state, minority and rational grantees; retain the vital, historic focus on community services to support local community organizations and the aging network; streamline program eligibility to promote increased participation to meet demographic changes and the growing ethnic and culturally diverse population to include tribal organizations. Note: Last year, SCSEP participants contributed 46 million community service hours through organizations such as libraries, schools, museums, government offices, care providers, and more. On average, every hour an older American spends in community services is worth $17.55 to the organization	X										
		Strengthen ombudsman program: Strengthen the long-term care ombudsman program through continued funding of the National Ombudsman Resource Center; funding to meet the staffing levels recommended in the Institute of Medicine Study (1:2000); funding to ensure that residents of nursing homes, assisted living and other facilities have access to ombudsman services, including board and care homes; and that ombudsman are able to advocate on behalf of residents with any entity without interference											
		ADRCs: Permanently authorize ADRCs within every planning and service area in the nation, giving AAAs the right of first refusal to be designated as the ADRC within their service area. These centers should serve as a one-stop source to assist seniors and disabled citizens with their long term care and supportive service needs.											
		Promotion of authorization: Promotion of authorization of the OAA with congressionally authorized committees comprised of members and staff familiar with the Act, increasing funding by at least 15% with more flexibility in allocations and the ability to transfer between funds as needed decided locally											

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
2	**Coordinated Long Term Care Strategy: Develop a Coordinated, Comprehensive Long-Term Care Strategy by Supporting Public and Private Sector Initiatives that Address Financing, Choice, Quality, Service Delivery, and the Paid and Unpaid Workforce.**	**Overview:** **Long-term care encompasses a broad range of help with daily activities that chronically frail and disabled individuals need for a prolonged period of time. The demand for long-term care services is projected to rise almost two-fold by 2020. The result of this increased demand will be a significant rise in long-term care expenditures for older adults, from a projected $123 billion in 2000 to $207 billion by 2020, and this expenditure will continue to increase with the aging of the Baby Boom generation. Private financing such as long-term care insurance and personal savings may become more important funding sources over the next decade and beyond for older Americans who require long-term care services.** **The service delivery system is very fragmented, with the acute and chronic health care and supportive services, in public and privately funded silos. Older people do not necessarily have the choice of living in the least restrictive setting. The majority of people providing long-term care are family and friends, but there will be fewer family members in the future to act as caregivers. In addition, the paid workforce is shrinking. Both these groups lack training and support to do their job of providing long-term care.**											
		Implementation Strategies:End the institutional bias in Medicaid long term care by opening eligibility to any and all long term care options. Dollars follow the person to the care setting of choice.	X										
		Give states and local communities maximum flexibility with use of Medicaid and program design to coordinate and implement, in cooperation with the private sector, appropriate initiatives in long term care and health services in the community.	X	X	X				X				

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Establish a national long term care policy that includes: a comprehensive educational program; incentives to plan ahead; a partnership with the private sector & all stakeholders; comprehensive assessment to determine need; information on services that respect consumer choice; and an extensive network of support services for caregivers. Change Medicaid long term care by making home and community services assisted living and a mandatory provision under Medicaid with home and community-based options presented as a first choice, eliminating the need for special "waivers" and advancing the requirements of the Olmstead decision. Permit integration of Medicaid state plan HCBS waiver and state funding and Medicare funding to provide flexible individualized long term care benefits within a case management system using functional eligibility to assure consumer choice of cost effective options covering all settings in all types of care. Expand choices and supports for seniors through: consumer-directed services; caregiver supports; cultural competent, adequately paid and trained workers and expansion of national ombudsman program and center for Nursing Home and Assisted Living.	X					X	X	X	X		
		Develop a single point of entry to the system of long term care services with coordination of all stakeholders at the local level. Ultimately this would lead to a national database of these services and stakeholders. Establish a single point of entry through the ADRCs to provide counseling on long term care options through every AAA in the nation. Establish "one stop" ADRCs as a local source of objective long term care information and single point of entry into public long term care system. Require joint support by AoA and CMS to encourage long term care options counseling, planning and prevention. Establish and fund a single point of entry in every community for elders and people with disabilities to provide information and counseling on long term care options.	X	X									
		Provide a basic long term care health benefit to all Americans, financed by expanded payroll taxes, tax incentives and insurance products, that includes a comprehensive array of housing, community based, home and institutional services that build on the existing area agencies on aging and that does not force impoverishment to obtain access.	X										

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		Coordinated long term care should include; a model that integrates the delivery of primary and long term care services that are a part of a continuum of care. HCBS are provided an entitlement option; the system should promote consumer direction and choice; the system should be culturally competent to meet and understand the need of all consumers; increase technology to promote the effectiveness of the system.	X	X									
		Institute regulatory flexibility for all funding sources to allow for the most cost effective services in the least restrictive environment in a manner that honors individual choice.		X		X	X						
		Reopen the dialogue initiated under the Pepper Commission in the late 1980's and early 1990's to develop a rational long term care strategy to include: education on personal responsibility to plan for long term care; support for family caregiving; better coordination of Medicaid with private long term care insurance as in the partnership programs.	X						X	X	X		
		Develop quality indicators and quality outcomes improvement processes under all sources of funds for all long term care as opposed to a regulatory process approach.	X						X	X	X		

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3	**Transportation Options: Ensure That Older Americans Have Transportation Options to Retain Their Mobility and Independence.**	**Overview:As Americans grow older, they need transportation options that allow them to remain independent. While more and better public transportation programs will help to address this need, within a few years the number of transit-dependent individuals will increase rapidly, and public transportation and public resources alone will not be sufficient to meet the need. The average American household spends almost 20 percent of family income on transportation, second only to expenditures for housing. If baby boomers are to plan for the transportation future, and if we are to care for the mobility needs of today's seniors, private as well as public resources will be needed. Better coordination among publicly funded transit programs and among public and private programs through the use of information technology will help, as will attention to land use planning that prevents sprawl and promotes better pedestrian access. No single transportation solution will be able to address all of the needs of the aging population. Rather, a family of transportation alternatives will be necessary—rail, fixed route bus, paratransit, taxi, and volunteers. Most older people who stop driving outlive their decision by more than a decade. It will take many transit options, both public and private, to adequately meet the mobility needs of the aging population.**											
		Implementation Strategies: Increase public and community transportation investment and include statutory language in the Older Americans Act that increase funding support to the Aging Network to promote senior mobility, expand cost-effective transportation options and facilitate coordination of human service transportation…with a focus on rural and suburban areas and SAFETY-LU programs (ex. 53-11, 53-10). Require public transportation organizations and local governments to participate in disaster preparedness planning for evaluation of seniors without transportation—funding by the Department of Homeland Security (DHS). Better coordination among public and private transportation providers.	X	X	X	X	X	X	X	X	X	X	X

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		Local and state governments need to work with insurance companies to develop (and fund) policies that cover volunteer drivers for door to door and door through door transportation services. Mandate insurance liability for volunteer drivers (no fault) to encourage volunteer driver programs. Promote community-based volunteer transportation options and protect volunteer drivers from unreasonable insurance premiums. Fund development of volunteer-based transportation for older adults including liability protection for volunteers such as Resolution 22.	X	X	X	X	X	X	X	X	X	X	X
		Fund locally operated transit systems for development of coordinated human service transportation systems to continue to meet needs with emphasis on rural areas. Increase the use of technology to facilitate the payment and coordination of transportation services for the aged and disabled. Increase funding for existing programs designed to provide mobility for older people particularly for underserved rural elders. Examples include specialized transportation programs for the elderly and persons with disabilities under section 5310 and 5311. Require coordination of federal, state and local transportation. Fund ADA paratransit program properly so that "curb to curb" funds don't get pillaged. Increase the use of technology to facilitate the payment and coordination of transportation services for the aged and disabled.	X	X	X	X	X	X	X	X	X	X	X
		Make federal transit job corps monies flexible to permit funding for "On Demand" systems using idle faith-based and nonprofit vehicles (i.e. vans) for reimbursing to the organizations for insurance, fuel, and maintenance plus out of pocket expenses and for a stipend for volunteer drivers. Expand to job corps tie to resolution 52 and 59. Facilitate expansion of volunteer transportation services; tax incentives for individuals who volunteer/donate vehicle (also insurance considerations). Fund public/private and community based organizations that provide senior transportation. Promote community based volunteer transportation options and the protection of volunteer drivers from unreasonable increases in automobile insurance when they use their own vehicles to drive seniors.	X	X	X	X	X	X	X	X	X	X	X

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		Promote the use of best practices in local planning of transportation options for seniors including coordinating use of private and public systems, promote community-based volunteers supplementary transportation through tax incentives, family pre-tax transportation accounts, and removal of legal barriers for volunteers (including protection from unreasonable increases in automobile insurance rates when volunteers use their own vehicles to drive seniors. Promote coordination in local planning of transportation options for seniors including the use of private and public systems, promote community based volunteer supplementary transportation through tax incentives, family pre-tax transportation accounts and removal of insurance barriers for volunteers—(Good Sam-like laws) using concepts advocated in the program United We Ride.	X	X	X	X	X	X	X	X	X	X	X
		Create new funding through the Older Americans Act and Medicare for mobility options for seniors including capital funds for projects such as walkable communities and allowing for flexible jurisdictional boundaries mobility training for seniors. Provide one-to-one counseling services through the Aging Network for seniors who must cease or limit their driving and learn other modes of transportation.	X	X	X	X	X	X	X	X	X	X	X

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4	Medicaid Program for Seniors: Strengthen and Improve the Medicaid Program for Seniors.	Overview: Medicaid, which is jointly financed by the federal government and the states is the largest payor of health and long-term care in the U.S. Operating within broad federal guidelines, states largely administer it. Therefore, the program varies across states depending on how states choose to structure their programs in terms of eligibility and coverage. Eligibility is complex and varies based on a range of factors, including income, assets, categorical group (i.e., children and families, the elderly, people with disabilities) and functional status. The scope of what Medicaid covers is broad and diverse ranging from long-term care for people in nursing homes and in the community, to premium assistance for Medicare beneficiaries, to payments to hospitals providing a disproportionate amount of uncompensated care. Over five million of the oldest, lowest income, most vulnerable seniors in our nation receive some form of assistance from the Medicaid program. This assistance provides an essential safety net that meets critical health and long-term care needs not covered under Medicare. In 2001, Medicaid spent an estimated $64 billion on the elderly. Approximately 9% of Medicaid enrollees are elderly, while about 26% of Medicaid dollars are spent on seniors. Medicaid is the largest public source of funding for long-term care. Medicaid in its current form suffers from a serious institutional bias. According to the Urban Institute, only 16% of Medicaid's long-term care expenditures for the elderly are spent on home and community services. We need to build a framework for a Medicaid long-term care program that provides better choices and control, improves quality, and better supports families. Medicaid costs are high and growing, but there are no easy answers to reducing the cost of providing care to the Americans who now depend on Medicaid for health and long-term care assistance. It is critical to maintain optimal coverage for our most vulnerable citizens, while reviewing and balancing the responsibilities for coverage and financing between the federal and state governments.											

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		Implementation Strategies: Home and Community-Based services with adequate federal funding: 1) provide permanent Medicaid funding for Home and Community-Based Services; 2) Improve and expand HCBC care. Help states' ability to provide Home and Community Based Services to ensure quality and protection; 3) Simplify and emphasize community based services- Change Medicaid's LTC focus by making available Home and Community Based Services. Create a mandatory provision under Medicaid with available home and community based options presented as the first choice, elimination of waivers, advancement of requirements of the Olmstead decision, and an incorporation of appropriate technologies in monitoring customer health status; 4) Expand state plans to include HCBS to expand services for seniors.	X	X		X	X						X
		Seamless System HCBS emphasis w/ AAA emphasis - Implement a seamless Medicaid system that will ensure coordination of all long term care services in the most effective high quality cost effective setting. Make HCBS mandatory provisions under Medicaid focused on the least restrictive setting and consumer choice allowing money to follow the person and building on the aging network of AAA to assure seamless non medical system. Long term care – to meet the increase in need of boomers in long term care and assisted living expand Medicaid benefits to include home care and care in facilities other than SNFs.	X	X									
		Public Private Partnerships (PPP) to strengthen Medicaid -Strengthening Medicaid must be viewed in the context of the goal of universal coverage which can only be achieved through PPP. Expand the Long Term Care Partnership program and create flexible coverage provisions. Responsible long term care planning -- government should link asset protection with the acceptance of personal responsibility for long term care planning perhaps through the partnership program where assets are protected up to the value of a long term care policy. Long term care incentives – encourage younger workers to purchase long term care insurance to avoid ever having to use Medicaid funded services.	X	X									

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		No Waiver- Policy initiatives must adequately fund the continuum of care to assure choice in care settings, allowing the funds to follow the consumer. Medicaid waiver provisions should be replaced (no waiver required) simplification of eligibility process should be mandated. Reform Medicaid to provide access to a range of services in the least restrictive, clinically appropriate environment without waivers.	X	X									
		No Block Grants- Oppose any efforts to block grant, cap spending, weaken entitlements or impose higher cost sharing.	X	X									
		Adequate Funding - Government must offer and adequately fund a complete continuum of care through Medicaid to ensure choice of care settings and providers for seniors. Long term care continuum of care -- reform Medicaid to provide consumer choice and access especially in rural settings, to a stable fully-funded continuum of long term care including Home and Community Based Services eliminating the need for waivers.	X	X									
		Ensure the viability of the Nursing Home Reform Act of 1987 by adequately reimbursing nursing homes and compensating care personnel, and properly funding education of staff and surveyors. Ensure that the regulation and standards of care are retained and enforced and apply to all LTC services financed by Medicaid. Strengthening existing nursing home reports. Better enforcement of the 1987 Nursing Home Reform Law, including PASARR with standards for pre-admission screening and annual resident review, and that all providers of services financed by Medicaid comply with federal standards	X	X									

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		Maintain Medicaid as a federal program with strong federal eligibility standards allowing state waivers only to increase coverage, do not cut, cap or block grant federal funding. No caps or block grants for Section 1115. Ensure that federal Medicaid funding for states is not subject to a cap grant; No caps and blocks grant in Medicaid; Section 1115 waivers should be used for innovation, and demonstrations not to reduce eligibility and access, and not to diminish quality. Total federalization of the Medicaid program for dual eligibles; the Medicaid program for the dual eligible population should be a completely federally funded program. Such a program would provide uniform minimum standards of care	X	X									
		Parity in Mental Health Care- Expand services on mental health waivers.	X	X									
		Standardization of services- Create federal regulations for use of Medicaid funds that would increase the uniformity and expansion of services e.g. transportation, dental, nutrition, appropriate preventive care services. Implement and enforce the existing Nursing Home Reform Act so that all residents receive quality of care and quality of life. Oral health, eyeglasses, and hearing aids should be mandated by the federal government to be paid for by the state programs.	X	X									
		Asset Transfers- Medicaid should strengthen the rules over asset transfers to protect beneficiaries and providers to hold individuals accountable through third party guarantees or other means who receive transferred funds needed for care. Extend the look-back for Medicaid eligibility to five years and place more emphasis on investigation of fraud while simplifying Medicaid eligibility. Limit Medicaid to the truly needy. Those who have assets should be expected to use those assets for their long term care needs. Individuals should receive incentives to purchase long term care insurance.	X	X									
		Removing Institutional Bias - Amend Medicaid statue to eliminate institutional bias and give people real choices in where to receive long term care services and support. Redefine the Medicaid entitlement to remove the institutional bias to make HCBS and incentivize this shift by increasing the HCBS match.	X	X									

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5	**Medicare Reform for the Future: Strengthen and Improve the Medicare Program.**	**Overview:** **When Medicare was enacted in 1965, only about half of all older persons had any form of health insurance. Today, Medicare provides health care to more than 40 million older and disabled Americans. Medicare faces multiple fiscal and coverage challenges as it prepares for the retirement of the soon-to-be eligible baby boomers while strengthening the program to address chronic care needs. Chronic illness is America's highest cost and fastest growing health care problem.**											
		Implementation Strategies: Expand Medicare to include a new part E for comprehensive life time long term care benefit for all. Traditional Medicare delivery of drug benefit (under Part B) with the government bargaining the better price; One prescription drug plan; a Medicare Plan with Dental.	X										
		Reform of regulatory compliance system to make it more cost efficient for providers and recipients: (a) Strengthen Medicare ability to provide appropriate care in most appropriate and cost effective setting (b) The mandatory three-day acute care stay should be eliminated thereby saving significant dollars for the Medicare program.	X										
		Modernize Medicare by including mental health parity, payments, provider lists and family involvement. Pass the Medicare Mental Health Modernization Act. Define the current differential in co-payments as discriminatory. Expand provider list (e.g. MFTs) to increase access to underserved and rural areas for older adults. Guarantee parity in coverage and reimbursement for mental health and substance abuse services as compared to physical health services.	X										
		Strengthen and improve the traditional national Medicare program by offering the following services in traditional Medicare: Oral health services, including diagnosis, prevention and treatment; Vision services, including diagnosis, treatment & eyeglasses; hearing services including diagnosis treatment & hearing aids; other emerging preventive services.	X										
		Repeal the provision of Medicare that prohibits the Secretary of HHS from negotiating drug prices for Medicare beneficiaries.	X										
		Restore the 4.5% planned reduction in physician fees.	X										

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		Promote prevention and disease management.	X	X	X	X	X	X	X	X	X		
		Expand Medicare benefits to include medically necessary dental care and palliative care.	X										
6	**Prepared Healthcare Workforce: Support Geriatric Education And Training For All Healthcare Professionals, Paraprofessionals, Health Profession Students, And Direct Care Workers.**	**Overview:** **Many health care professionals and direct care workers are not specifically trained to provide health care for the aging population as specialists in geriatrics. The current shortage of geriatricians is expected to worsen. There is also a shortage of advanced practice graduate level nurses certified in geriatrics. Social workers have no national certification for geriatric social work. Registered dieticians and dietetic technicians have no formal program in geriatric nutrition. As the baby boomers age, it will be important that care by qualified geriatric workers be available across the health care continuum in ambulatory, acute, home and community-based services, assisted living, and long-term care settings.**											
		Implementation Strategies: Support academics by requiring educational institutions to provide geriatric education to qualify for federal and state funding, including: core curriculum throughout system, providers to support academics, standardized front line education (user friendly), create grant within Bureau of Health Professions, federal funding based on geriatric education. Support ongoing education: CEU's (on-site, electronic, tech.); $$ with advanced training; Early introduction of field of aging in each program; Recognition of field (CAN through system)	X	X			X						
		Eliminate Title VII cuts and expand geriatric education centers promoting private and state support for geriatric training among all relevant professionals. Assess outcomes of training.	X	X									
		Congress should authorize a new geriatric assessment and care coordination benefit for frail elderly persons with multiple medical conditions or one medical condition and cognitive impairment that reimburse qualified providers that conduct one assessment and a patient designated primary care provider who is responsible for coordinating with other providers, one patient and caregivers	X										

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		Congress should commission a study to examine the current reimbursement structure for evaluation and management services, particularly as it applies to primary care providers and interdisciplinary teams and how it serves patients with multiple chronic and complex conditions.											
		Accrediting bodies, educational institutions, licensing boards, professional associations and consortia must establish competencies in aging geriatrics and interdisciplinary models of care and include geriatric-related content in the curricula and in licensing and certifying examinations and promote life-long learning and cultural competence.									X		
		Restore the federal funding process that supports colleges and universities to develop gerontological and geriatric training programs. OAA Title IV	X										
		Mandatory requirement that health care professionals (i.e., physicians, nurses, pharmacists, dieticians, etc.) take at least 5 hours CMS/ continuing education units (CEUs) based upon a geriatric national care curriculum in order to renew their license in each of the licensure renewal cycles		X							X		
		Geriatric education to be “required” before licensing or certification by all physicians and health care professionals.		X							X		
		Implement a marketing and positive brand image campaign to dissolve the negative perception of geriatrics and aging in order to increase the attractiveness of the field.	X	X		X	X		X		X		
		Congress should mandate that the Centers for Medicare and Medicaid Services conduct demonstration projects: (1) that do not put providers at risk to evaluate reimbursement structures for interdisciplinary team care for beneficiaries that have multiple chronic conditions and (2) to evaluate reimbursement structures for interdisciplinary geriatric care, without putting provider participants at risk.											
		Promote increased use of electronic health records technology to ensure optimal communication and coordination of health care services to seniors across sites of care with all health care providers.											

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		Congress should mandate that reimbursement systems should reward both medical and non-medical services to frail older adults where they are integrated.	X										
		Ensure stable funding sources, Congress should explore fiscally responsible approaches to combining social insurance, private insurance, individual saving and social welfare in new and innovative ways.	X										
		Reallocate all graduate medical education dollars from the medicine fund, and focus it solely on training all health care professionals in geriatrics.	X										
		Create a certification in geriatrics for all professions and direct care workers, and encourage certification with incentives such as enhanced compensation, career ladder opportunities.		X				X	X		X		
		Require formal training for paraprofessionals who provide care in the home. These are the home caregivers hired by families for caring of loved ones in the home. This is not home health. Standardize curriculum. Create certification process, not registration process, through national organization that needs to be created.		X							X		
		The care coordination and quality assurance processes in long term care facilities, including assisted living and residential care, is greatly facilitated by trained geriatric medical directors. It should be mandated that all geriatric medical directors attend a learning program in medical direction and mandate assisted living/residential care facilities have a requirement for a medical director.		X		X	X		X		X		

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7	**Non-Institutional Long Term Care: Promote Innovative Models of Non-Institutional Long-Term Care**	**Overview:** **Older Americans want to age in place. Care of chronic disease presents an increasing challenge to a health care system that emphasizes care for acute illness. Eighty-three percent of Medicare beneficiaries have at least one chronic condition. Nearly one-quarter have five or more chronic conditions. Among Americans over age 65, more than one-third will spend some time in a nursing home and half of these will spend over a year in a nursing home. At any given time, five percent of persons over age 65 are in nursing homes, and ten percent living in the community need some form of long-term care. Innovative models of care have demonstrated that an appropriate and timely array of non-institutional long-term care services can be a favorable and less costly alternative to nursing home care for selected individuals with chronic disease and disability. For example, the "Cash and Counseling" model sponsored by Robert Wood Johnson Foundation, the U.S. Department of Health and Human Services and the Administration on Aging combines elements of financial support with direct services such as information and counseling, to help consumers make informed choices about their care.**											
		Implementation Strategies: Increase the use of technology to facilitate non-institutionalized care and enhance communication among care providers. Eliminate institutional bias in Medicaid-eliminate waivers and make care coordination, care management, medication management and presumption eligibility standard (Tribal/Urban/rural/culture). Eliminate fed/state/local regulatory barriers (including Medicare/Medicaid) that prevent access to LTC services at home and in the community	X	X									X
		Evaluate and decrease regulations to create new and expanded authority and funding at CMS and AoA to expand and examine a new model of productivity for LTC services, tribal continuing care community/NORC, greenhouse, Co-located services and other independent living settings	X		X								
		Create incentives for HCB provider development including: Federal demonstration grants, Federal and state tax incentives, Low interest loans, Reimburse rates(living wage) Tribal/Rural/Urban/Culture.	X	X									

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		Incentivize community based providers, hospital, HHA and nursing homes and Indian health services to develop naturally occurring retirement communities (NORC) like models of care tailored to their communities.		X	X	X	X						
		Provide the least restrictive environment to meet the needs of the aging population allowing for maximum choice and funding streams that follow the person along the continuum of care. Integrate funding sources to negate silo effect. Expand the use of best practices for current successful models. Integrate and leverage federal , state, local and private funding streams to care for people at home and in their communities, including tribal communities and to create effective consumer directed LTC: expand, simplify and speed-up.	X	X	X	X	X				X		
		Foster and expand community based models that allow elderly to stay at home, such as group homes: financial support for caregivers, training for home care givers, coordinate one-stop service centers, money follows the continuum of care, use of alternative financing (e.g. reverse mortgages). Provide more support to family caregivers through adult daycare and the other respite services, senior centers, tax credits, legal services, transportation the National Family Caregiver Support Program through the recruitment, education, training and retention of paid family and non family caregivers by providing federal grants to states to improve efficiency and client satisfaction, to help address growing workforce shortage and to provide access to interdisciplinary geriatric care management services to all families responsible for caregiving in home settings. Ensure that each senior has access to an interdisciplinary geriatric trained team to provide medical and psycho-social services to the client and non-professional caregivers. Provide a comprehensive continuum of care (e.g. transportation, day care, appropriately trained nursing home aides, and health care disciplines in the non-institutional setting).		X	X	X	X	X	X	X	X		

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Resolutions, Overviews and Implementation Strategies(IS) with Strongest and Strong Support

#	Titles/Resolutions	Implementation Strategies	Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions										
			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
8	**Responsive to Mental Illness: Improve Recognition, Assessment, and Treatment of Mental Illness and Depression Among Older Americans.**	**Overview:Though older Americans report lower rates of mental health problems than younger Americans, they too are likely to experience mental illnesses, such as major depression. Some older persons believe that mental health disorders and treatment are shameful, represent personal failure, or will lead to a loss of autonomy. As a result, they may deny having problems or refuse to seek treatment. Because mental disorders are often mistaken for other conditions in older adults, they may go undiagnosed and untreated or be treated inappropriately. According to the American Association of Geriatric Psychiatry, 15 percent of adults over 65 will experience depression, but if referrals for treatment are not timely, the condition can exacerbate other illness conditions through poor self-care, or lead to high-risk behaviors, such as substance abuse. In general, the psychology of older Americans is under examined, yet it is well understood that the mind-body relationship has significant effects on disease risk, physical fitness, and capacity for self-care.**											
		Implementation Strategies: Parity coverage for mental health and substance abuse as compared to physical health in Medicare and all other health programs. Implement strategies, regulations and statutes at the Federal and State levels that provide for (1) a minimum basic mental health and substance abuse health insurance benefit for all older Americans and (2) parity of coverage for mental illness and substance abuse in the public and private health insurance markets. Parity within Medicare and Medicaid is especially important.	X	X			X		X		X		

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		Assure access to affordable, comprehensive, quality mental health and substance abuse services in a variety of settings including senior centers, housing, nursing facilities, assisted living centers, adult day care and independent living, by qualified providers. This should include, but not be limited to, prescription availability, diagnosis, counseling, and preventative health initiatives. All services should be provided by trained professionals and health providers in a bi-lingual and bi-cultural appropriate setting. Mental health assessments and treatments must take place where older adults are: at work and at home. NIMH funding should be directed to the development implementation, and evaluation of: (1) work-based mental health consultation and treatment services; (2) integration of mental health service into community based, consumer-directed long-term care services (e.g., Cash and Counseling Demonstration and Evaluation). Broadly define "substance abuse" to assure responsive medication management for older adults who need help in managing prescription drugs and over-the-counter medications.	X	X			X		X	X	X		
		Pass the Positive Aging Act.	X										
		Mental Health Parity- Eliminate mental health payment discrimination: (a) Mental Health Parity under Part B (b) eliminate 190 day lifetime cap for inpatient psychiatric services. (c) Insist on unified coverage by Part B intermediaries, eliminate variability. Pass Medicare Mental Health co-payment equity Act. Abolish the co-pay inequity for mental health and physical health under Medicare. Pass mental health legislation for age groups. Encourage public and private health care insurance plans to guarantee parity in private and public coverage and reimbursement for substance abuse and mental health treatment services. Recognizing that relapse is an expected component of the recovery process from mental health and substance abuse disorder, urge public and private funding and insurance companies to eliminate the pre-existing clauses in their policies. All medical insurance coverage including Medicare co-payment for mental health services must be equal to the co-payment for the Medical coverage.	X	X	X	X	X		X	X			

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Promote Training and Education for Early Intervention – Education - professionals, families, communities, elders about mental illness and treatment. Service Delivery – geriatric counselors who go to seniors' homes; supervision of these workers by qualified geriatric psychiatrists, physicians, social workers. Funding – encouragement to include geriatric education in medical, social work schools with more focus on mental illness as it related to physical problems. Nursing Home Treatment – providing care to residents of nursing homes.		X	X	X	X	X	X	X	X		
		Integrate culturally competent older adult mental health and substance abuse services into primary care and other wrap around service systems as supported by the recommendations of the President's New Freedom Commission on Mental Health. Support an integrated and age appropriate mental health and substance abuse services system that is: culturally competent, consumer-driven, and working in close collaboration with primary health care, long-term care and community based services using baseline assessment and treatment practice guidelines that are evidence based. Recommend that mental health services to older adults include management of behavioral disturbances in dementing disorders. Behavioral disturbances in dementia disorders are the primary reason older adults with these disorders can not remain in their homes. Mental health services are needed to treat these behavioral disturbances such as depression, and anxiety disorders.	X	X	X	X	X	X	X	X	X		

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		Promote older adult mental health research and coordinate and finance evidence based and emerging best practices and collaboration between research institutions and community-based service delivery including, but not limited to, recognition of senior centers as focal point for delivery of mental health services to consumers in the community and/or to homebound. Promote older adult mental health and substance abuse services research and coordinate and finance the movement of evidence based and emerging best practices between research and delivery of services by: directing NIMH funding to increase programs of clinical research related to geriatric mental disorders; directing training funds to assure mental health service providers who have experience and expertise in aging; increase program effectiveness research to assess the impact of suicide prevention and intervention efforts; increase public awareness via a media campaign of the range of mental illness in later life and the context of later life (workplace, home and community based care).	X	X	X	X	X	X	X	X	X		X
		Implement Recommendation 1.1 of the President's New Freedom Commission on Mental Health " to advance and implement a National campaign that includes tribal and culturally specific languages to reduce the stigma of seeking care and a national strategy for suicide prevention "incorporating" an emphasis on older adults." (within 6 months of the Report year).	X		X	X							
		Group/Headline: Educate and Train Primary and Hospital Based Physicians to Provide Screening and Assessment Including ER Settings/Integrate Mental Health Services Across Multiple Settings (primary care, hospice, etc). Training and Education Program for increased awareness: (1) Crisis Intervention Team; (2) Caregivers – professional or non-professional. Facilitate early recognition and treatment intervention. Emphasize geriatric mental health training in medical schools and primary care medicine residencies through geriatric psychiatry faculty and other mental health professionals. Provide detailed training to CMS survey staff and LTC about the significant contributions of providers, "LTC Culture Change," for enhancing mental health of older adults in nursing homes. Promoting Public Awareness and Education and Training. Need to empower people with mental illness and respect their rights, dignity and independence.	X	X	X	X	X		X	X	X	X	X

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		Group/Headline: CMS to Incentivize LTC Providers to Adopt LTC Culture Change to Improve the Mental Health of LTC Residents	X										
9	**Capacity of the Geriatric Workforce: Attain Adequate Numbers of Health Care Personnel in All Professions Who are Skilled, Culturally Competent, and Specialized in Geriatrics.**	**Overview:** **The demand is increasing for health care professionals formally trained in the care of geriatric populations. People age 65 and older use 23 percent of U.S. ambulatory care visits, 48 percent of hospital days, and 69 percent of home health services. It is estimated that the U.S. will fall 25,000 short of the 36,000 geriatricians that health care experts say the nation will need by 2030. In addition, recruitment and retention of paraprofessionals in nursing homes and home-based care is a growing challenge because of unfavorable job features, including low wages and benefits, lack of career advancement, high potential for injury, exposure to emotional stress, and inadequate training. In addition to the increasing demand, the population needing services is increasingly more diverse. Studies have found direct links between cultural competency and health care improvement, thus appropriately trained providers are critical for the geriatric workforce. Cultural competency is the ability to provide care to persons with diverse values, beliefs, behaviors, and needs including tailoring delivery to meet patients' social, cultural and linguistic needs. Today, few professionals are offered training for such work.**											
		Implementation Strategies: Design and implement a multi-faceted public awareness and recruitment campaign that includes public service announcements highlighting career opportunities in geriatrics, engages K-12, post-secondary and post baccalaureate programs, and provides financial incentives for choosing a career in geriatrics.	X	X									

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		Reinstate Title VII Bureau of Health Professions Geriatric Education Center Funding ($31.5 million) that to date has trained 425,000 professionals in 27 disciplines and expand this program to create geriatric academic career awards for other health professions (e.g., nursing, social work, pharmacy, psychology) and support geriatric educators throughout their careers. Congress must provide funding mechanisms including loan forgiveness, stipends, training grants, and fellowships to recruit and retain faculty in geratrics through career development programs in clinical teaching or research for academic geriatricians and other health professionals including oral health and mental health. Congress must continue to fund the geriatric education centers, academic career awards and fellowship funding (Title VII). Immediate resolution to retain Title VII GEC funding to be delivered to Senator Frist/Senator Gregg and other federal legislators.	X	X									
		States must provide financial incentives in the form of continuing education and career ladders to attract and retain direct care workers. State and federal liability waiver programs for all professionals willing to work in geriatrics	X	X									
		Provide incentives to bring new persons into the field and keep existing geriatric professionals by: a. Loan forgiveness for student loans (students who commit to X years in geriatrics) b. Work with professional boards to recognize importance of geriatrics and institute best practice curricula related to aging; and c. State/federal liability waiver programs for all professionals willing to work in geriatrics.	X	X							X		
		Encourage public and private efforts to forgive and reimburse educational loans for those working in critical areas of geriatric service provision.	X	X				X	X		X		
		Attract and retain new health care providers with advanced training in geriatric medicine, mental health, social work, nursing, dentistry, allied health professions and direct care workers by establishing geriatrics as an underserved profession and by supporting expanded training opportunities, and financial incentives including loan forgiveness, benefits and appropriate reimbursement.	X										

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Require that professional education programs of various disciplines (health, mental health, etc.) that receive federal funding introduce geriatric coursework or rotation for all students that includes promotion of evidence based and emerging best practices and skills (in treating people with co-occurring mental and addictive disorders) and in complex chronic disorders and cultural competency and diversity.Cultural competence means understanding of influences of gender, race, ethnicity, religion, disability, sexual orientation, geographic origin, immigration status, and social class. Social work education should be mandated for gerontology education. Establish geriatric core competencies and curriculum that will allow direct care workers to be trained to support clients and their families across the LTC continuum. This should include all issues including prevention of elder abuse and neglect.	X	X									
10	**Coordination of Aging–in-Place: Improve State and Local Based Integrated Delivery Systems to Meet 21st Century Needs of Seniors.**	**Overview:** **Failure to coordinate senior services is the most significant obstacle to aging in place in one's own home. While assisted living residences and continuing care retirement communities integrate housing and care services, they won't necessarily meet the needs of current and future seniors. Implementation of a culture of consumer-focused services has demonstrated dramatic improvements in quality care services for older adults aging-in-place. Barriers to achieving quality of care and quality of life include the use of non-standardized assessment protocols, duplicated paperwork and processes, multiple medical records, ineffective triage, and professionals who lack the training in geriatric-related conditions. Coordination for aging-in-place is also affected by a general shortage in affordable homes for low-income seniors, and transportation infrastructure that is not designed to be elder-friendly. For example, older adult populations need transportation coverage by public transit systems and senior-friendly designs of road signs, signals, and lighting. A broad systems approach to coordination of multiple services begins with application of successful strategies from managed healthcare to transportation and housing models. The degree to which the nation's governmental, non-profit, and for -profit agencies are coordinated, aligned, well consolidated, and accountable will greatly determine the ability of older Americans to access quality services in the 21st century.**											

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		Implementation Strategies: Create new Title 12 OAA – Called Community Preparedness for an Aging Population: Create and fund a new title to the OAA to promote “community preparedness” for today and tomorrow’s aging population. The new title would support AAAs to be the liaison to help cities, countries, tribal councils as well as the private / non-profit sectors to address the needs of older adults in the areas of housing and transportation, health, human services, public safety, recreation, workforce development. This is needed since every aspect of a community will be directly and dramatically impacted by an aging population. Goal: to ensure that America’s communities are good places to grow up and grow old. Justification for the New Title – add new objective to OAA focused on “Aging Well in Livable Communities”. Encourage evaluation of results in 10 years by GAO. a. Provide a new title out of Older Americans Act to support funding area agencies to be liaison to develop local plan for creating livable communities, now and for the future. b. Create a new title within the OAA to authorize SUAs, AAAs, and Title VI Native American Programs to proactively develop partnerships amount private, public, medical, transportation, housing and other entities to develop and integrate policies, funding, programs and service to foster coordination of aging-in-place. C. Authorize and fund a new title within the OAA for SAAs, AAAs and Title VI to develop and implement an integrated again in place initiative. Evaluate outcomes and allow for the new title to sunset after 10 years if community preparedness goals have been achieved. D. Step 1: Planning for 21st Century Aging Populations including: involvement of stakeholders – consumes, policy makers, private sector and social service agencies: Utilize the national aging network as the vehicle for implementation. E. Step 2: Establish a national focal point for best practices in developing plans for addressing the needs of the aging population of the 21st century. F. “Aging Well” within livable communities to enable older Americans to plan for the last 3rd of their life, to include responsibility for financial stability, health, physical fitness, volunteerism, work personal relationships, and mental health. The beginning of the continuum on aging from wellness, prevention to frail elderly and end of life issues.	X										
		Encourage the design of an Aging society that is the standard rather than exception including: housing design, accessibility to services, building codes, signage, transportation consideration at local level, senior centers, court rooms, education, civic engagement, access to health, libraries, medical, and technology.											
		Redefine basic service along the whole continuum and redefine entitlements (including respites, elder abuse shelters, etc.)	X	X									

Column group heading for Federal through Technology: Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions

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		Eliminate the institutional bias of Medicaid and expand Medicare. Federal standards established for older group homes assisted living facilities, continuing care communities and nursing homes. "Culture change" needs to be the rule and not the exception.											
		Create national, state, local dialogue with for profits and nonprofits to address removing barriers to co-locating home and community based services within and in close proximity to senior communities. Develop criteria and standards for livable communities and implement strategies. Support OAA's initiative on livable communities.	X										
		Develop a template that helps each new planning position turn each community into a livable community. The template would include housing, transportation, accessibility, education, civic engagement, access to health libraries medical, technology, etc. This would facilitate cooperation and coordination of above services.	X	X			X						
		Develop outreach and education strategy that gets buy-in from all communities.	X	X									
		Expand the scope of community preparedness to address health and long term care in housing, transportation, livable communities, civic engagement, education, recreation, economic development, quality of life, individual retirement security and cultural competencies.	X	X									
		Federal government should provide approximately $250 million to the aging network at national, state and AAAs to conduct community readiness planning in collaboration with the caucus of government, regional planning organizations and economic development councils.	X										
		Fund a new title under the Older Americans Act for a new planning position that could be run through AAAs this position would select a group of community planners through an RFP process.	X										
		Include Aging and Disability Resource Centers in the OAA. Expand Aging and Disability Resource Centers in every state and give AAAs the right of 1st refusal to manage & coordinate ADRCs. ADRCs will ensure coordinated points of entry for home and community-based independent living options and assist older adults, caregivers, and person with disability to make informed choices about these options.	X	X									

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		City, State, and County organizations should cross file information on locations where specified assistance is provided for seniors that is computerized and listed in a catalog and a file of trained, geriatric service providers in the area (available to all of the Federal, State, and community agencies in the area).	X	X	X	X	X						
		Congressional mandate for all federal departments and agencies to collaborate through memoranda of agreement with AoA to ensure National readiness for aging of America. Require similar collaboration at the State Level.	X										
		Require ARDC as a service; develop National Standards, w/ State flexibility, w/a single point of entry including intake assessments, and standard operating procedures. Point of entry should be based in the local communities utilizing existing qualified agencies. Remove funding barriers for increased funding flexibility.	X	X	X								
		Assure basic infrastructure of case management, technology and transportation is in place.	X	X	X	X							
		Encourage non-profit and for profit entrepreneurial care provider, especially with home and community-based services and streamlining new providers into the continuum of care marketplace.	X	X			X		X	X	X	X	
		Redefine financing so that dollars follow the client.	X	X			X						
		Olmstead Decision: A consumer driven system that provides home and community based care as an entitlement (in accordance with the Olmstead decision) consumer choice, independence, & dignity; local decision making; flexibility across funding streams with money following the client to the services delivery point of their choice											
		Create new title within the OAA to authorize SUAs, AAAs, & Title VI, Native American Aging programs which establish technology-based web system, to help communities prepare for the aging boomers, establish ADRCs at the local level to integrate & coordinate access to LTC support.	X	X	X	X	X					X	
		Create new title in OAA that would fund ADRC's technology based web systems.											

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		Establish a consumer-driven system that provides home and community-based care as an entitlement (in accordance with the Olmstead decision). The principles of this system would include consumer choice, independence & dignity; local decision making; and flexibility across funding streams with money following the client to the services delivery point of their choice.											
11	**Principles of Social Security: Establish Principles to Strengthen Social Security.**	**Overview:** **The Social Security program provides economic security for workers and their families upon the retirement, death or disability of the worker. From its beginning, Social Security has been a pay-as-you-go program in which current benefits are supported by current payroll taxes. It is not an investment program. Payroll taxes are 12.4 percent of wages or self-employment income up to a taxable maximum of $90,000 in 2005. When there is a surplus of income over outgo, those excess funds are credited to the Social Security trust funds in the form of U.S. government securities. The proceeds to the federal government from the purchase of these securities by the trust fund are used to finance other government programs.** **Americans are living longer and having fewer children than previous generations. These demographic changes present a long-run financing challenge for Social Security because the number of beneficiaries is growing faster than the number of workers paying payroll taxes that fund each year's benefits.** **All agree that the Social Security program faces a long-term funding shortfall. The annual cash flow of the program is projected to peak in 2008 and then decline as the baby boom generation begins to retire. Social Security benefits will first exceed tax receipts in 2017, when repayment of the debt which the government owes itself will begin to become due. Repayment options include increasing the rate of return on assets, raising taxes, reducing other government spending, or additional government borrowing. By 2041, the trust fund will be exhausted and Social Security tax revenues will be able to pay about 70 percent of benefits, declining to approximately two-thirds of benefits by 2079. Social Security faces a long-term solvency challenge that needs to be addressed through development of a full range of principles in order to assure that it will be a reliable source of retirement, survivor, and disability income for generations to come.**											

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		Implementation Strategies: Maintain the entire Social Security (SS) system without privatization, including survivor benefits, disability program, and current COLA formula.	X				X						
		Affirm that Social Security remains a "safety net" insurance plan including dependent's and disability rights. Find some other means to encourage individual savings.	X				X					X	
		Retain the progressive defined benefit structure by not directing SS contributions to create private accounts.	X					X	X	X		X	
		Reject privatization. It is the wrong direction for America in my generation (from a 25 year old student representative).	X				X					X	
		Invest 2% of SS into a personal private investment account. In addition allow up to 13% of your own taxed income invested in same account. This would allow up to 15% in private participation.	X					X	X	X			
		Invest a portion of SS Trust Fund in equity and bond markets and dedicate the inheritance tax for estates to the SS Trust Fund.	X					X	X	X			
		Retain the progressive defined benefit structure by removing caps on earnings for SS contributions. Raise the current $90,000 cap to $150,000 on taxable earnings.	X				X					X	
		Cover newly hired state, county and local government employees beginning in 2008. Could also consider a 5-yr phase-in.	X	X		X	X	X	X	X		X	
		Create a national strategy to educate Americans of all ages and backgrounds about their Social Security statement. Many Americans lack basic knowledge about when and how much they will receive in SS benefits. This effort will show that SS alone is not sufficient to live a comfortable retirement. Americans will need to save more and plan for retirement. This will be a good starting block.											
		Educate young people about any changes in SS and are able to engage in choices of solutions for lifetime investments.	X	X	X	X			X	X			
		Maintain the integrity of the present system of Social Security as a social insurance program of defined benefit with a base benefit for all workers. If private accounts are considered, no SS funds are to be diverted.	X	X	X	X			X	X			
		Re-establish SS tax cap at a level that encompasses 90% of all earnings, and index the cap to maintain that ratio.	X					X	X	X		X	

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Resolutions, Overviews and Implementation Strategies(IS) with Strongest and Strong Support

#	Titles/Resolutions	Implementation Strategies	Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions										
			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Eliminate taxation of Social Security benefits to encourage people to keep working.	X	X		X			X	X		X	
12	**Incentives for Older Workers: Promote Incentives for Older Workers to Continue Working and Improve Employment Training and Retraining Programs to Better Serve Older Workers.**	**Overview:** **Available evidence suggests older workers receive less employment training than younger workers. While there have been successful programs targeted at older workers, more can be done to help workers remain in the workforce, particularly low-wage workers. Studies show that older workers with more updated computer skills may be less likely to retire and more likely to stay in the workforce. In addition, there are a number of economic, legal and institutional barriers to providing incentives to older workers to stay in the workforce. Some of these barriers could be overcome by including more flexible employment arrangements like phased retirement. To expand the reach of programs like phased retirement, traditional thinking about older workers needs to change and laws that regulate retirement and employee benefits should be reexamined.** **Older workers are valuable additions to the workforce. In the role of mentor to younger workers, and as invaluable sources of knowledge, older workers contribute significantly to a successful workplace. Employers need to be made aware of the value of older workers through education campaigns. They should also be educated about the impact of a declining pool of labor that can lead to prospective skill shortages.**											
		Implementation Strategies: Amend the OAA to recognize the special needs of older job seekers and the particular barriers they face by establishing a set-aside specifically to assist older job seekers											
		Provide greater access to educate and training for older worker via education grant, tuition waivers, new financing mechanism like a training education 401K											
		Provide additional standard tax deduction for each worked past the normal retirement age of 65.											
		Require local Workforce Investment boards to set aside minimum of 15% of adult WIA training funds to support the training of older workers (use the navigation concept)											
		Expand and adequately fund training, retraining and life long learning programs at no cost to the Older Americans Act through local and state institutions.											

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		Remove barriers to the retention and hiring of older workers, including age discrimination.											
		Provide incentives for employment training and education to reduce age discrimination a. conduct research on the value and cost of the older workers (Senate Rep 108-345 Labor HHS 2005 Appropriation Bill) b. Annual Department of Labor reports on characteristic of the workforce. c. Identify availability and impact of training for older workers-including internships.											
		Change IRS regulations to allow that 591/2 to draw pensions while confirming to work.											
13	**Strategy for Informal Caregivers: Develop a National Strategy for Supporting Informal Caregivers of Seniors to Enable Adequate Quality and Supply of Services.**	**Overview:** **Family members, neighbors, friends, and other unpaid informal caregivers are the primary source of labor in the U.S. long-term care system. Approximately 80 percent of all care to older Americans is by an unpaid family member or friend. It is estimated that there are 44.4 million informal caregivers in the U.S. Family caregivers face challenges in providing care to seniors, including access to home and community based services, availability and access to resource information, and promoting consumer choice in delivery of home care. In the case of caregivers who work, many face challenges balancing work, caregiving, and family responsibilities. Despite significant efforts to assist family caregivers, challenges still remain in assessing caregiver needs, receiving education and training, coordinating local services, accessing coordinated information, planning long-term options, and creating incentives for families to continue informal non-institutional care. Emerging technologies may help the older adult and the caregiver; they range from low tech gadgets such as mechanical lifting devices to more complicated electronic monitoring.**											
		Implementation Strategies:Refine definition of kinship care to include designated non-related caregivers in the OAA, FMLA and other federal and state laws that pertain to family caregiving (benefit cost=$0); In NFCSP redefine the word "family" to include friends and neighbors.	X	X			X		X	X	X	X	

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Provide for economic security in retirement for caregivers through a combination of tax credits or incentives including Social Security credit for caregiving years, small business tax credit for allowing use of FMLA equivalent time for caregivers. Include Medicare health insurance, public disability insurance, tax credits, credit for time caregivig for Social Security, Inflation protection on calculation of their peak earning years (S.S.), and 6 weeks of respite. Offer a range of financial and other incentives to caregivers including tax credits, deductions and cash vouchers to all family caregivers, and affordable health insurance, long term care insurance, and retirement security for individuals who leave the workforce to provide care to a family member. Provide access to uninterrupted affordable health care for informal caregivers.	X	X	X		X		X	X	X	X	
		Double the $162 million authorized appropriation for the National Family Caregivers Support Program (Title IIIE-OAA) to include aging caregivers of adults age 19 and over of lifelong disabilities to reach thousands more caregivers and families, as well as business and the long term care industry. This should specifically include expanded efforts for training and education of informal and formal caregivers – reduced match requirement to be consistent to other Title III programs (15%) and increase culturally and linguistically appropriate educational materials to ensure awareness of and access to services	X	X	X		X		X	X	X	X	
		Amend Medicaid regulations at the federal level to allow family caregiving as a paid service and develop system that allows consumer choice in who provides services such as “money follows the person” no matter where the service is provided or source of funding under Medicaid	X	X									
		Permanently authorize Aging and Disability Resource Centers through the OAA to be supportive/resources for caregivers at all localities and at many varied locations, ie, public libraries, hospitals, doctors' offices, and malls through use of technological and traditional options while providing increased availability of culturally and linguistically appropriate educational materials to ensure awareness of and access to services	X	X	X	X	X						

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		Support working caregivers by encouraging and incenting employers to provide information and referral, geriatric care management, caregiver leave, flextime and other worklife programs, and to help working caregivers prepare for their own retirement by providing retirement education, advice and availability of long-term care insurance and other benefits. Employers should consider ways to work through area agencies on aging and other community agencies to achieve these objectives. Educate EAPs through NFCSP about Eldercare Locator and other information resources, including comprehensive geriatric assessment and care management. Provide small business tax credit for allowing use of FMLA equivalent time for caregivers.	X	X			X		X	X		X	
		Expansion of federally funded programs: expansion of Title IIIE to serve older adults caring for adult children with lifelong disabilities; flexibility in use of funding – no mandated uses of dollars; broaden definition of kinships to include non-blood relationships; amend OAA to include Americans with lifelong disabilities who experience aging prematurely.	X	X									
		Enact the Lifespan Respite Care Act regardless of age or type of disability as overarching strategy to meet the respite needs family caregivers.	X										
		Congress should authorize and fund the Agency on Aging to develop a nationally coordinated caregiver education and skill training program and to contract with non-profit organizations and academic centers with a track record on public education concerning aging and illness to develop and implement a plan for public education about the scope of family caregiving, the skills needed, stress management, and the programs that work in supporting family caregiving. Look at the Ryan White Act as an education and case management model.	X	X									
		Financial Incentives: Offer a range of financial and tax/other incentives for caregivers and employers, for example, protecting the health insurance and retirement security of caregivers who must leave the workforce to care for family member.	X	X									
		Conduct extensive outreach to (boomers and younger) caregivers to ensure they know what supports, education and training are available and when and how to access these.	X				X		X	X		X	X

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		New or reallocated federal funding for caregiver supports rather than institutionalization	X	X			X					X	
		Evidence based and emerging best practices- target funding for the best outcomes; caregiver assessment for both physical and mental health, encourage collaborative community approaches	X	X	X		X						
		Use "Military Leave Act" USTERRA concept for family caregiver leave; tax incentives for caregivers who need to leave work to provide caregiving – also providen for preserving health and pension benefits; workplace flexibility for caregivers, including flextime, part-time and benefit preservation; provide information to businesses highlighting advantages of supporting employed caregivers; include evidence based practice in the workplace	X	X									
14	**Retention of Older Workers: Remove Barriers to the Retention and Hiring of Older Workers, Including Age Discrimination.**	**Overview:** **An aging population in combination with a falling fertility rate diminishes the size of the national workforce. The impending retirement of the Baby Boom generation can have compounding effects which destabilize the overall strength of the economy. Employers will lose many experienced workers, and likely face skill gaps in their workforce. Meanwhile, pressures on the Social Security and Medicare programs will increase while tax funds for the programs will decrease. Currently, federal laws are barriers to keeping older workers in the workforce because they discourage employers from using flexible employment arrangements that encourage older workers to stay employed.** **Furthermore, workplace discrimination involving Americans of older age and persons with physical, sensory, and neurological impairments related to chronic illness and disability is increasing according to published scientific research studies. Strategies to prevent age discrimination from affecting opportunities for older workers are needed. While the Americans with Disabilities Act outlaws discrimination in employment on the basis of disability, the labor force participation rate continues around 32% for people with disabilities and 81% for those without disabilities.**											

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		Implementation Strategies: Retain and increase funding for Title V program to allow people to enroll sooner and serve olders workers who are economically disadvantaged. Employers or placement should not unduly overshadow its vital and proven community service purpose. Create a frontier section within Title V as a part of the Older Americans Act re-authorization to provide more flexibility to provide transportation assistance training and frontline staff. Promote increased participation to meet demographic changes of a growing ethnic and culturally diverse population.	X	X		X	X		X	X	X		X
		Implement phased retirement options to encourage flexible work options for older workers' businesses.	X	X					X	X			
		Create older worker opportunity to create a taskforce	X										
		Encourage development of technologies so that after people retire they can return to work from home or near their communities in less manual jobs more meaningful work.											
		Amend and reauthorize the Workforce Investment Act (WIA) to make older workers a priority group for set aside funding to meet growing need to train and retain older workers to meet needs of the workforce.	X	X		X							
		Eliminate means test basis for Title V and encourage greater collaboration with WIA programs that promote training, education, health and support for older worker	X				X		X	X	X		X
		The WHCoA should endorse the Older Worker Opportunities Act of 2005 introduced in the Senate in October											
		Provide greater access to education and training for older worker via, education grant, tuition waivers	X	X			X		X	X			
		Create a new financing mechanism like a training education 401K	X										

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15	**Protection from Abuse and Neglect: Create a National Strategy for Promoting Elder Justice Through the Prevention and Prosecution of Elder Abuse.**	**Overview:** **A recent study by the National Research Council estimated there to be between one and two million cases of elder abuse in the U.S. The Senate Special Committee on Aging estimates there may be as many as 4 times as many cases of elder abuse that go unreported. Data collection is impeded by non-uniform definitions and monitoring. Family members are the most common perpetrators of elder abuse. Due to the challenges presented in the identification, prevention, and prosecution of elder abuse, effective strategies are needed at all levels of government and across public and private sectors. Many states have an inadequate supply of Adult Protective Services (APS) case managers to receive and investigate reports on elder abuse. As a result, caseloads far exceed the number recommended by the National APS Administrators Association. This leads to APS clients receiving very few direct service hours. Some states do not consider Adult Protective Services to be a priority issue. Generally, there is a lack of coordination, support, standards, and training for programs to protect seniors from abuse and neglect.**											
		Implementation Strategies: Pass Elder Justice Act: a. Clearinghouse of information b. Expand APS funding to ensure adequate case managers to investigate and support the coordination of cases and prosecution must include better training for workers, c Increase penalties for those who are prosecuted fro crimes against the elderly, d. National model for APS and definitions for abuse & monitoring.	X	X									
		Develop a national adult protective office within DOJ to oversee development of accessible and interdisciplinary training for judges / prosecutors / law enforcement in detecting and prosecuting crimes against the elderly and vulnerable adults on the state, local, tribal level for a coordinated approach.	X	X									

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		An Elder abuse awareness, semi-postage stamp act (similar to breast cancer stamp). Enact legislation and funding to create rapid response financial abuse specialist teams nationwide to increase prosecution of financial crimes, prevents financial distribution and save lives. There are proven models.	X			X			X	X	X		
		Enact and fully fund comprehensive elder justice legislation to address elder abuse, building capacity of APS programs nationwide with specific funds & focus on elder financial abuse exploitation.											
		Create public private partnership for the training of police officers. Do a Public Awareness campaign using PSA's, the Press, and other media outlets to educate the public; training, education, national hotline, scams prevention	X	X		X	X		X		X		
		Fund research in all aspects of elder mistreatment including financial exploitation, self neglect, physical & sexual abuse, and caregiver neglect. Include research in competency issues, cultural sensitivity issues, and evaluation of programs. This includes widespread dissemination of research results.		X		X					X		
		Establish Regional rapid response task forces to include prosecutors, law enforcement (federal, state, land), social workers to assist victims and follow-up.											
		Strengthen the justice system to include better competency evaluations, guardianship reform, and coordination and alignment with the national caregiver system. Expand victim advocate programs for specially trained staff to work with elder victims.				X	X						
		Consequences for perpetrators: Force restriction when convicted; background checks for those working on the elderly abuse cases; prioritize when we have DNA materials.				X	X						
		Pass and adequately fund federal legislation including the EJA, reauthorize the OAA with emphasis on Title VII, Violence Against Women Act, victim of crime act and social services block grants.	X		X								

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		Strengthen federal laws and programs addressing elder abuse, including the Social Services Block Grant, the OAA (especially Title VII, including first time funding of the Native Americans Program), the Victims of Crime Act and the Violence Against Women Act by increased appropriations and improvements through reauthorization.											
16	**Affordable Housing: Enhance the Affordability of Housing for Older Americans**	**Overview:** **For the older adult, housing is a major determining factor supporting their ability to continue to age in place in the community as opposed to being institutionalized in a long-term facility. Home ownership provides a significant cost saving alternative to a nursing home. Eighty percent of seniors own their own homes. Almost 2 million older adults, mostly low-income single women live in federally-assisted multi-unit rental housing, more than the number that live in nursing homes. Government-subsidized programs (e.g., Section 202 and Section 8) support low-income elderly; however, in 1999, there were nine applicants for each available Section 202 unit. However, many seniors are still faced with high housing costs and structurally deficient homes or apartments. In 1999, 7.8 million older families lived in unaffordable (paying more than 30 percent of their income on housing) or poor quality dwellings.**											
		Implementation Strategies: Create new mechanisms at the Federal, state and local level (such as trust funds, tax cuts and bonds) to increase the supply of accessible housing and retro-fit and modify existing homes. For example, the federal government must increase the supply of 202 units to 25,000/year, including ongoing overhead as well as operational and service coordination expenses. These strategies apply to both the current reality as well as the upcoming wave of aging boomers. Establish a Federal Housing Trust Fund in the amount of $500 billion to meet planning and development (including sustainability) for housing of low-income and disabled older Americans.	X	X		X							
		Enhance/encourage the preservation of existing housing for seniors (low income and otherwise). Encourage innovative models to provide a continuum of care from active to those with early dementia/Alzheimer's (all incomes – especially the low income).				X	X		X		X		

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		Increase funding for housing assistance such as home repairs, home modifications refurbishing older buildings to promote independent living, including increasing Section 8 housing assistance would also increase availability of housing options. This strategy promotes aging in place with dignity. Re-institute the Section 8 modernization funds to refurbish housing units for aging in place and to expand the Section 8 rental housing assistance program.	X										
		Create housing opportunities that allow for public/private financing methods, such as more tax credit financing, HUD 202 program, and experimentation with housing voucher programs for low income elderly – allow grandparent housing. Provide and apartment for an older American who can work at the complex for payment of rent (i.e., rental manager, fix it, babysit, tutor). Subsidize senior housing (from private and public resources), which must include tax refunds and credits when the private sector contributes. Provide tax relief and subsidize the construction of senior friendly homes and communities that can delay nursing home placement.	X	X									
		Section 8 funding more available. Over 26% of persons using homeless-related services in the US today are elders. (Elder homelessness is the fastest growing cohort of homeless in MA with over 11,000 MA elders homeless in the course of a year.) The largest user group of the Section 8 program in the country is elderly. Even with these statistics the federal government has drastically cut funding in Section 8 and 202 programs to the lowest levels in 25 years. Funding needs to be restored or the federal government will experience off-setting costs. Also funding needs to take into consideration regional differences in construction costs. Higher cost areas (such as Boston) have higher rates of housing-related impoverishment in the 202 program cripple housing development in those high cost areas.	X	X		X							
		If you are in a high enough income for condo, town house, your own home…When seniors are low-income, subsidized housing needs to be available; workers in service industries are too low to afford housing, rent; 50% of Baby Boomers have saved nothing.											

Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions

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		Encourage local and state governments to offer homestead exemptions and tax deferral for low income elderly. Reduce property taxes based on means tested evaluations for seniors.				X	X	X			X		
		Public/private individual collaboration to promote and facilitate co-housing for seniors who can share home services, as needed.						X	X				
		Increase coordination among community based housing programs, such as, but not limited to, housing authorities, weatherization programs, cities and counties, that use COBG funds, Section 202, and farmer home programs.				X	X						
17	**Accountability for Implementation of 2005 WHCoA Recommendations: Implement a Strategy and Plan for Accountability to Sustain the Momentum, Public Visibility, and Oversight of the Implementation of 2005 WHCoA Resolutions.**	**Overview:Historically, the statutory authority calling for the WHCoA has not included a mechanism to provide on-going visibility and accountability for implementation of WHCoA recommendations after the Conference and submission of the WHCoA Implementation report to the Congress and the Executive Branch. As a result, there has been limited focus on long-term implementation of WHCoA recommendations. There is a clear need to establish public or private mechanisms to facilitate follow up.**											
		Implementation Strategies: Require the Department of HHS to appoint a post-WHCoA Oversight Commission, representative of the primary stakeholders, to provide oversight to the Administration on Aging, regarding the organization and administration of resulting conference strategies to continue momentum and to ensure implementation of priority strategies. The Committee would include government, community based organizations, private sector, baby boomer technology expert and tribal stakeholders. The committee/work group will be empowered by the 2005 WHCoA Policy Committee within 6 months!	X										

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		The WHCoA delegates urge the President to establish a web page to provide quarterly progress by resolution on the implementation of resolution strategies as adopted.Elevate the Director of the Office of American Indian, Alaska Native, & Native Hawaiian programs and permanently establish the position of Deputy Secretary in the Administration on Aging to provide leadership and guidance in implementation and coordination of the WHCoA resolutions across government programs serving older Indians. Re-establish the process of engagement of the Indian White House Conference on Aging as previously provided in the OAA to honor the commitment to the principles of government to government consultation between the federal government and Indian Nations in the provision of services for Indian elders prior to the next WHCoA.	X										
		Responsibility at state level, each state delegation to take responsibility for some portion of implementation program	X										
		Congressional legislation to fund and authorize an equally bipartisan board to implement monitor and report to congress and the public on implementation of the 2005 WHCoA Resolutions and strategies.	X										
		Require a progress report from head of state aging agency every year regarding work to implement. As appropriate, tie the authorization of the OAA every 5 years to maintain momentum and ensure accountability.	X	X	X	X	X						
		Use the outcomes from this WHCoA to plan the next White House Conference on Aging.											
		The President, by Executive Order, should maintain the office of the White House Conference on Aging or alternatively should assign the implementation and oversight to an existing agency. The responsible party should present an annual report to the President and Congress and maintain the WHCoA website as on on-going communication tool. The report should include a status report on implementation at the Federal, State, local and tribal levels. Substantial public input should be solicited in order to provide a complete listing of steps taken by each party responsible for the implementation strategy.											

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		The subsequent WHCOA should have ongoing visibility, responsibility, and accountability addressed in the statutory authority including ongoing funding. All subsequent conferences should include a report on the implementation of the resolutions of the previous WHCoA.											
		State implementation to include : Annual reports to the authorized board, Governors to receive reports, Funded by Congressional authorization		X									
		Establish a regular process of reporting on progress including major public relations program											
18	**Long Term Care Financing: Foster Innovations in Financing Long-Term Care Services to Increase Options Available to Consumers.**	**Overview:** **The American population is aging and, as a result, demand for health care and long-term care services is increasing. Public funds and institutions are not sufficient to meet these needs. Although options are expanding, few Americans (only 6%) purchase insurance to protect themselves from the high cost of potential long-term care needs. Although states are encouraged to find more innovative methods for funding healthcare, especially in the Medicaid program, they have not been encouraged to develop changes in how they provide long-term care or prolonged care due to disabilities. Currently, the structure for long-term care lacks options and incentives for individuals and families to pursue long-term care financing, contracts, or other arrangements; either for themselves or in cooperation with state systems. In addition, few Americans are pursuing disability insurance to protect them from unexpected risks of injury or illness. Both government programs and consumers can benefit from opportunities to pursue innovative products and contracts.**											
		Implementation Strategies: Implement a national and state tax credit to encourage the purchase of long term care and health savings plans that allow individuals choice of services. i.e. continuum of care.	X	X			X	X	X	X		X	

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		Provide incentive to employers to provide long term care insurance to individuals to purchase long term care insurance. Incentives should be in the form of tax credits, tax deductions, cash vouchers or other programs with the goal to reduce government costs and to promote personal responsibility and self-sufficiency. Expand the participation of all states in PPP (Public Private Partnerships).	X	X		X	X	X	X	X		X	
		Change the focus of Medicaid to allow home and community based options rather than only covering institutional care. Eliminate waivers, allowing money to follow consumer choice, without compromising quality.	X	X				X				X	
		Long term care financing options should include: tax credit for early purchase of long term care insurance; employers should allow employees to use health saving accounts to purchase long term care insurance and cover expenses; removal of federal barriers that prevent paying for long term care with pretax dollars; create a fiscally responsible method of establishing a social insurance program to be supplemented by private long term care insurance and individual savings with Medicaid for the poor.	X	X				X	X	X		X	
		Expand the CMS/DHHS Long Term Care Awareness Campaign including counseling on long term care insurance.	X				X	X	X	X	X	X	
		Eliminate the Medicaid program's institutional bias, allow for funding of multiple long term care options across the continuum, permit funding to follow the person; permit flexibility to use long term care funds to expand and coordinate services; tie funding for services to level of acuity; ensure quality through full implementation and enforcement of the Nursing Home Reform Act of 1987; ensure adequate staff and training and support for direct care staff across the long term care continuum. Reform Medicaid financing of long term care services; expand flexibility in provision of needed service (eliminate waiver system); increase current level of personal assets (greater than the 2000 defined 1965) to allow seniors to qualify to live in HCB setting; maintain Medicaid eligibility/transfer of asset rules for long term care.	X	X			X	X	X	X	X	X	

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		Reform Medicaid at the fundamental level to develop a system of care that provides for consumer access services in a home or community environment first eliminating the need for special "waivers." Incentivize the removal of institutional biases, in particular, to rebalance the Medicaid entitlement to cover HCBS.	X	X			X						
		Congress should create a Part E (MEDICARE) for long term care services and raise the funds through payroll tax to pay for these services. Allow states to supplement income-eligibility for participants. Create a "buy-in" feature for people to participate in program. The system should provide comprehensive services including HCB and Institutional services, and single access point.	X	X		X	X	X	X	X	X	X	
		Develop action group to identify corporate donors to fund the formation of a "foundation" dedicate to the financing of the long term care services.	X										
		Create meaningful tax incentives: use a lifetime scoring method for cost accounting of above-the-line deduction of Long term care Insurance; eliminate barriers to expansion of Long Term Care Partnership Programs with reciprocity between states; allow for above-the-line deduction of long term care Insurance; tax credit for caregivers. Encourage the purchase of long term care insurance by: amending the tax code to provide above the line deductions for long term care insurance premiums; private cafeteria plan treatment for long term care insurance; allow tax-free withdrawals from 401k, IRA, annuities and other tax-favored savings vehicles for amounts applied to long term care services or insurance premiums; expand long term care partnership programs by permitting all states to amend their Medicaid plans to allow asset protection for benefits received from qualifying Long term care insurance. Legislators should require uniformity and reciprocity across the states and grandfather existing long term care policies; provide standards for long term care insurance similar to MediGap standards. Long term care IRA - - establish a savings vehicle (much like an IRA) to cover the purchase of long term care insurance or .ong term care services. Ability to purchase long term care insurance through cafeteria plans (section 125) and flexible spending accounts (FSAs). Provide federal state tax incentives to encourage long term care savings; including personal Savings accounts and/or long term care insurance.	X				X	X	X	X		X	

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		Expand the standardized availability across all 50 states of the partnership model of state/federal partnership program of Long Term Care Insurance, allowing purchase of Long Term Care through IRAs. 401(K)s, 403(B)s and expanded Health Savings Accounts using best practices in the states and private sector.	X	X		X		X	X	X	X	X	
		Standardize long term care insurance policies to comply with IRS regulations for full deductibility of premiums and state regulations for the protection of the home from Medicaid liens.	X	X				X					
		Authorize and fund a National Universal Long Term Care program with the following features: basic, first $ coverage of a package of home, community based and residential long term care services; supplemental coverage begins the basic public benefit package then state-approved fully deductible private long term care insurance products; and, Medicaid as a safety net for those who cannot afford supplemental coverage and state eligibility criteria.	X	X				X					
		Moving Medicaid resources in long term care from institutions starting in 2007. Repealing the Waxman amendments develop tax policy and subsidy strategies for the poor to support universal financing for long term care which would be controlled by the consumer's choice to the setting of care.						X					

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19	**Coordinated Health and Aging Networks: Promote the Integration of Health and Aging Services to Improve Access and Quality of Care for Older Americans.**	**Overview:** **Health care demanded by older Americans is complicated because it can require a mix of services, including supportive elements. In order to meet these needs, consumers need access to coordinated communication systems that provide comprehensive information and help integrate the array of services that are appropriate for changing needs. Aging networks have helped improve how seniors and their families get information, make decisions, and manage contacts as their needs and interests change. However, these information and communication systems have not been integrated well with acute medical care, long-term health services, and health funding sources. The lack of effective communication has made management of care confusing, tiring, and even wasteful for seniors. Effective integration of health communication into aging networks would improve health and information referral, assist caregivers, and enhance individual decision-making. Furthermore, coordinated information can also assist local governments with planning public investments to fill gaps between seniors' needs and available services.**											
		Implementation Strategies: To integrate health promotion, food nutrition, and disease prevention as cost effective service in Medicare and Medicaid funded and other home and community based services, provide new federal and state funds and preserve state flexibility and implement community and culturally appropriate services.											
		Update Medicare to place greater emphasis on establishing cost-effective linkages to home and community based options through the Aging Network to promote chronic disease management, and increase health promotion and disease prevention measures.											
		Develop national assessment elements.											
		Create a standard set of definitions and codes for a healthcare and wellness record to allow easier interfaces between multiple information systems and establish reimbursement incentives for systems that incorporate these standardized definitions and codes.											

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		Facilitate improved standardized information and exchange/communication providers—health records, billing, and other forms/paperwork.											
		Identify, assess, and address federal and individual state regulations that are barriers to sharing information between systems.											
		Amend HIPAA and other restrictive regulations to allow meaningful communication between health providers and the aging network regarding client care.											
		Pass legislation that simplifies HIPAA, clarifies and encourages the sharing of scarce patient/client information, especially as it relates to Medicaid, to standardize security guidelines across systems and establishes policies and protocols for states and communities.											
		Establish and maintain performance standards for cultural competence diversity, and multi-lingual service delivery activities.											
		Re-adjust funds to develop a single point of entry system that can be a one-stop shop (ADRC, Senior Center) but also has a virtual electronic component data base that is shared between providers (i.e., medical, health, social services) – especially home and community-based services.											
		Reauthorization of the OAA should include creation of a single point of entry into LTC services. That single point would be a collaboration between aging, health and other related services with a community health information network would be based on a shared electronic data base of client and provider info used by all. Of course it would be HIPAA compliant. This system would be connected to other sites where consumers can access health information thru technology such as libraries.											
		Insure access to health/aging services to all senior populations through the establishment of a new Title under the OAA to create ADRC's (single point of entry) in each region across the nation. Each ADRC is charged to coordinate health and aging programs and ensuring access to diverse populations.											
		Expand the Aging and Disability Resource Center pilot model by making it permanent and expanding it to all states—creating a consistent, accessible focal point for access to aging services delivery agencies.											

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		Make available federal and state funding for a range of healthy aging programs on issues including, but not limited to, the benefits of physical activity, senior wellness and mental health screening and treatment services, utilizing web based information an planning tools for individuals and caregivers.											
		Require grantees of public funds to integrate health and aging services in their acceptance of funding.											
		Establish a national commission that reports to Secretary of HHS the results of a study on how to integrate acute and chronic care services and implement the findings within 3 years.											
		Create evidence based structure with funding for one full time aging health planner in each state to plan, develop and assist with statewide programs											
		Improve utilization of technologies to improve coordination of care and communication between patients and providers through the development of federal, or private initiative or partnership that would require broadband access in all states											
		Congress, through CMS, should recognize and reimburse interdisciplinary care coordination models that address needs of seniors with complex conditions and disabilities linking services, providers and person centered care across settings.											

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20	**Designs for Livable Communities: Encourage Community Designs to Promote Livable Communities that Enable Aging in Place.**	**Overview:** **The current and future housing demands of older Americans may require a review of the sustainability of current home and community building practices, as well as support for innovation in the home building industry, especially for new models of housing that integrate and provide for the needs of older Americans. Most new housing in the United States is not designed for populations who have or will have functional limitations. One place best practices in senior friendly design have been identified is through the National Endowment for the Arts' universal design initiatives. Residential design elements that can enable older people to remain in their homes include easy access to entries, bathrooms and doorways that can accommodate walkers or wheelchairs, and pathways that are safe for limited mobility. Modifications to homes after they are built can be too expensive for seniors to stay in their homes. Incorporating universal design into new home construction is estimated to be 2-4 percent of the total cost, as compared to 20-27 percent of the total cost of retrofitting an existing home. In many case, aging Americans may not be aware of the possibility for home modification during construction. Likewise, developers may be unaware of the rising need for such modifications in new homes.**											
		Implementation Strategies: Change codes, funding mechanisms and regulations to develop new models of community that includes a variety of accessible/universally designed housing types and a variety of transportation choices. These communities must include rich opportunities for older adults and families such as community spaces that support learning, religious practices, cultural participations, and physical activity.											
		Using economic incentives, retrofit existing communities including NORCs, by modifying homes, building senior housing convenient to transportation services and adding services. The most up to date technology should be utilized and seniors should be involved in key leadership roles.	X	X	X	X							
		Encourage development and change regulations to incorporate home and community based services (such as adult day care, home care, etc.) and more comprehensive services near and within residential senior communities.											

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		Promote national dialog on livable communities and the role local communities (consumer merchants, land owners, governments) play in applying good principles of development											
		Create and fund a new title within the Older Americans Act to authorize state units on aging, area agencies on aging and Title VI Native American Aging Programs to help communities prepare for policies, programs and services that foster communities for all ages.											
		Identify and address priorities affecting ideal “aging in place” communities, including transportation, local regulations/building codes, intergenerational concepts	X	X	X	X	X	X	X	X	X	X	X
		Create a housing trust fund similar to the transportation trust fund to help finance livable communities, and assist local jurisdictions in increasing available and affordable housing	X										
		The new models described in the other recommendations here need to be inclusive of diversity of color, economic diversity, and age. These models of communities need to be in a variety of neighborhoods and more rural as well urban communities spread throughout, not just concentrated in one area, city or county of the state.											
		Provide incentives and resources from the Older Americans Act to communities, businesses, and developers to build and modify public spaces to comply with universal design principles to support aging in place.											
		Incorporate principles of “livable communities” and universal design and use of technology into university curricula for planners, architects, community organizers, and other disciplines.											
		Identify and develop methods of working with city planning commissions to assure that land use, plans, and zoning and infrastructure in communities is supportive of older persons											

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21	**Disease Management Programs: Improve The Health And Quality Of Life Of Older Americans Through Disease Management And Chronic Care Coordination.**	**Overview:Life expectancy is increasing and a growing number of Americans are living with multiple chronic conditions. Seniors require a 21st Century health system that includes programs focused on managing chronic diseases. Chronic care and disease management coordination programs share similar objectives. The best programs include primary, secondary and tertiary prevention and use evidence-based practice guidelines to help patients take responsibility for their own care, under the supervision of medical professionals. Current Medicare disease management demonstration and pilot projects focus on promising areas for clinical and cost effectiveness. Successful implementation of these projects may provide a road map for improving clinically effective and cost effective programs for Medicare beneficiaries with chronic illness.**											
		Implementation Strategies: Congress should commission a study to evaluate the current system for health care of frail, medically or psychologically complicated older adults. The system should support the patient's designated primary care provider and should not be based on episodic care or recognize solely face to face care.	X										
		Congress should require a new payment system for frail elderly – reimburse multiple disciplines: Increase emphasis on health and prevention through incentives, better reimbursement and improved funding. Incentives should apply to older adults, organizations and clinicians to promote lifestyles that support wellness and prevention.	X										
		Congress and the Administration should create resources and financial incentives to promote geriatric care and chronic disease management, such as a reallocations of graduate medical education from hospitals to geriatric programs to provide interdisciplinary education on chronic disease and frailty. Disease management, care management and pharmacy management should be funded as part of Medicare and Part D.	X										

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		Congress and/or Centers for Medicare and Medicaid Services should develop a geriatric assessment including telephone management and other technologies for monitoring health status outside the office.	X										
		Congress should mandate a Marshall Plan coordinated national effort to standardize health information technology, (uniform metrics, coordination of information on multiple chronic conditions and medications), to support efficient, effective integrated, team-based chronic care, and to reduce redundancy, waste, inappropriate prescribing in the health care system.	X										X
		Holistic care and comprehensive assessment: Care for older adults must be holistic, including components of cultural, social, emotional, cognitive and physical domains. Comprehensive assessment should be the foundation of chronic care or disease management model.	X	X	X	X	X	X	X	X	X		
		Support the passage of the Geriatric and Chronic Care Management Act of 2005 which supports geriatric assessment by qualified professionals and coverage of chronic care management services in Medicare	X										
		Conduct demonstration projects to develop evidence-based practices that provide culturally-competent (ethnic, diversity in language, sexual orientation) chronic care coordination through an interdisciplinary team to enhance the individual's quality of life and informed decisions.	X	X	X	X	X	X	X	X	X		
		Develop disease management and care advocacy programs for chronic diseases and frailty in partnership with the private sector specifically targeted for seniors. Include Centers for Excellence in geriatrics and chronic conditions in medical centers and other institutions, including rural, as well as create a partnership with Administration on Aging – HRSA to develop initiatives on community involvement with lay persons, family members, patients and caregivers in disease management.	X						X	X	X		
		Provide coordination of services through technology.											X

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		Integrate Advance Care Planning along with financial, legal, LTC, community service and practical issues for all individuals identified with chronic illness and for every individual as they become Medicare eligible. Perhaps this should be a requirement at Medicare enrollment and include Medicare FAQs on monthly beneficiary mailings. Make advance directives and surrogacy designations available across care settings, by internet-based registries or electronic personal health records. Integrate advance care planning into all health information technology (HIT) projects. All states should adopt a Physician Orders for Life-Sustaining Treatment (POLST) like program that converts the patient treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including LTC, EMS and hospital. Integrate POLST like program into all HIT projects. See www.POLST.net	X	X									X
22	**Healthy Nutrition: Promote the Importance of Nutrition in Health Promotion and Disease Prevention and Management.**	**Overview: Good nutrition can sometimes be difficult for seniors, especially if they have not already developed healthy habits. One important message for seniors is that it is never too late to benefit from healthy nutrition practices. Another important message is that physical changes that take place during aging can result in different nutritional needs. These changes can contribute to decreased food intake, unintentional weight loss, malnutrition, and/ or obesity. The federal government has taken a lead role in promoting health and nutrition initiatives for older Americans. The 2005 Dietary Guidelines for Americans provide evidence-based information to promote health and reduce risks for major chronic diseases through diet and physical activity. Major causes of morbidity and mortality are related to poor diet and a sedentary lifestyle. Cardiovascular disease, type 2 diabetes, hypertension and other diseases have been linked to poor diet and physical inactivity. Poor diet and physical inactivity contribute to the increase in overweight and obesity in this country.As the largest generation in American history the aging of the baby boomers will have significant repercussions on health and healthy living. If trends continue unabated, the next few years may see significant increases in the numbers of new cases of diabetes, heart disease, and other chronic diseases that could be addressed by a healthy diet and exercise.**											

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		Implementation Strategies: Form a public/private nutrition and fitness alliance that would become the authoritative source for seniors and caregivers, and promote through a national media campaign.	X						X	X			
		Respond to the special nutritional needs of individual seniors to enhance independent living by reauthorization of the OAA to include the flexibility to utilize non-traditional food sources and strengthening the congregate and home delivered meal programs to increasing services up to 7 days and expanding Seniors Farmers Market Nutrition Program nationwide.	X										
		Access to Reliable Nutrition Education- Through the reauthorization of the OAA (Title III) expand funding to ensure adequate nutrition (eliminate undernutrition) and provide reliable nutrition education/information delivered by registered dieticians and/or technology which can then empower individuals.	X										X
		Evaluate outcomes and effectiveness via an Institute of Medicine study of OAA nutrition and other programs for older adults to correct deficiencies in the system via promotion of best practices.	X								X		
		Exercise and nutrition- Utilize existing nutrition sciences to concurrently deliver physical activity and exercise information and programs to older adults.			X	X	X	X	X	X	X		
		Include specific OAA re-authorization language, regarding one or more national resource centers on nutrition and physical activity.	X										

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23	**Care in Rural Areas: Improve Access To Care For Older Adults Living In Rural Areas.**	**Overview:** **Approximately 25% of the nation's older persons live in rural America. Preventive medical care is often inaccessible to consumers in rural areas, as they do not have readily available transportation, often resulting in a crisis medical situation and much higher medical costs. Older adults in rural areas often struggle with poverty, a limited number of health care professionals in their area and minimal services. With the projected increase in the aging population over the next decade, it is expected that rural areas will face an increased demand for services. For example, the 2000 Census shows that five of the eight counties in one rural Appalachia district do not have a hospital or emergency care facility. Four of eight counties in the same area have 5 or fewer physicians and there are no critical access hospitals. Cost-effective service delivery options are needed to study and develop in order to address the health and long-term living issues in rural areas.**											
		Implementation Strategies: Community of Care: Expand volunteer services and eliminate liabilities (Good Samaritan Law) Sr. Corp programs, RSVP and Senior Companion, PACE model for rural areas. Provide regulatory and reimbursement flexibility and incentives for existing LTC providers to retool, diversity, to provide fuller array of aging services (including tribal elders).		X		X	X						
		Community of Care: Provide menu of vouchers for seniors helping seniors. Home-delivered geriatric mental health services and education by senior mental specialists. Expand nutrition sites to include other functions such as respite care.		X		X	X						
		Transportation-Increase funding for Sec. 5311, block grants, rural transportation assistance, meals on wheels and separate titles in OAA ; Expand Good Samaritan Laws, volunteer drivers, NSSC, RSVP volunteer programs; Expand and strengthen United We Ride program with the flexibility to use funded vehicles school buses and Head Start buses, day care sites.	X										

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		Transportation: Flexibility in programming: permit local agencies to use funds more flexibility				X	X	X	X	X			
		Transportation: Limit liability for volunteers who provide transportation services.		X					X	X			X
		Transportation: Foster mobile medical clinics					X	X	X	X	X		X
		Transportation: Use school buses and other vehicles for senior program transportation when buses are idle during school hours.											
		Transportation: Promote demonstration projects: "Frontier Nurses" who provide care in far rural communities.	X	X	X	X	X	X	X	X	X		X
		Transportation: Use CTAA/Chamber of Commerce partnerships for transportation support.					X		X	X	X		
		Rural Economic Development: Tax abatement, business exemption, i.e. Social Security tax exemption.	X	X			X						
		Rural Economic Development: Equitable reimbursement for rural providers. Flexibility at local level for implementation of how dollars are spent and how matched dollars are mandated. Create aging as an industry to attract for profit vendors to provide services.	X	X			X						
		Rural Economic Development: Training incentives for health care practitioners in rural and tribal areas	X	X			X						
		Rural Economic Development: Reauthorization and increased funding for Indian Health Care Improvement Act.	X	X	X		X						
		Economic Development: Funding formula revised to increase weight for rural development	X	X									
		Economic development and revitalization in rural areas; recognize the economic importance of health care facilities to economic development.	X	X									
		Economic Development: Develop infrastructure for technology/communication/broadband.	X										X
		Economic Development: Improve access and availability to health care frontier services.	X										X
		Technology: Apply 1930-style rural electrification model to provide broadband access to all rural areas, promote telemedicine, promote long distance caregiving term. Promote tribal infrastructure for communication and medical technology. Promote long-distance mental health care.	X	X	X		X						

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		Technology: Telehealth enhanced access to health increase technology training		X									
		Telemedicine uses the Farmer's bureau model to expand training in health care, and marketable skills.		X									
		Technology: Computer labs training in senior centers partnering with seniors and youth; also partnership with libraries and also include partnering with the Bill and Melinda Gates Foundation for computer labs in libraries											X
		Technology: 211 non-emergency access to human services, info		X									X
		Health: Partnership with libraries to deliver rural medical services.		X									X
		Health: Expand mobile clinics.											X
		Health: Develop critical care hospitals in rural areas.	X										X
		Health: Partner with existing VA hospitals.	X										
		Health: Better access to healthcare through coordinated transportation to health care				X	X						
		Health: Critical access hospitals in rural settings with the advantages of cost reimbursement primary care and long term care		X		X	X						
		Health: Federal qualified medical centers are under used in rural areas…the program is difficult to develop. Make it easier to place FQMCs in rural areas.				X	X						
		Health: Address differences in the payment for Medicare and non-Medicare (inadequate payment for geriatric practice cost reimbursement.	X	X									
		Health: Partnership with libraries to deliver rural medical services.											
		Workforce: Financial incentives for rural health care professionals: Debt forgiveness for doctors, nurses, etc.		X			X		X	X	X		
		Workforce: State coverage of malpractice insurance for voluntary providers (decrease liability issues for volunteers)		X			X		X	X	X		
		Workforce: Improve technical skills for seniors who can work in the community		X			X		X	X	X		
		Workforce: Improve cultural competency development for workers		X			X		X	X	X		
		Workforce: Provide telework opportunities for health care workers		X			X		X	X	X		
		Workforce: Increase recruitment for retired military and federal providers		X			X		X	X	X		

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		Workforce: WICHE program (Western Institute/Council of Higher Education program to support training of health care professionals (WY model).		X			X		X	X	X		
24	**Increased Retirement Savings: Provide Financial and Other Economic Incentives and Policy Changes to Encourage and Facilitate Increased Retirement Savings.**	**Overview:** **Retirement savings is an effective strategy for ensuring that many baby boomers and seniors are ready to meet their needs over their lifespan. Savings can provide seniors greater ability to exercise their preferences in how their needs are satisfied. What can be achieved through savings varies depending on individual's earning power and their proximity to retirement. Current laws both encourage and discourage such savings. Stronger incentives for saving early in one's life have potential for satisfying future needs. Coordinated reforms in savings-related policies can have far reaching benefits, including advantages for seniors, future workers, and government programs. Simultaneously, taking account of the needs of those unable to accumulate adequate savings, such as unprepared Baby Boomers nearing retirement, is essential.**											
		Implementation Strategies: Financial education and literacy should be a core curriculum requirement and mandatory for a high school diploma. Financial education across the lifespan must become an individual goal.	X	X	X	X							
		Use the federal tax code to give further incentive to encourage retirement savings and the purchase of long term care insurance	X				X		X	X		X	
		Make permanent the capital gains tax rate of 15% on all distributions.	X									X	
		Encourage new savings by enacting or expanding existing savings incentives such as IRAs, 401Ks, 403(b)'s, in order to strengthen the retirement picture for all Americans to include: A $1,000 one-time federally-funded birth account unavailable to the beneficiary until reaching Social Security eligibility, making the Saver Credit refundable repealing or raising the mandatory withdrawal age of 70 _, annuitization incentives, and dependent care credit expansion.	X				X		X	X		X	

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		Strengthen pension laws and improve incentives to include plans participant default provisions for automatic enrollment and investment (with opt-out provisions); safe harbor protection with diversified funding requirements and investments; and retroactive protection of hybrid plans.	X	X					X	X		X	
		Establish financial education as a high school and college graduation requirement, beginning in middle school. Provide public sector and private foundation funding to develop educational tools that can be used by employers, government and other stakeholders in educating workers about savings, investment and income management principles across all of life's stages and at all income levels. Emphasize importance of financial education (especially, time value of money) saving and planning for retirement with special focus on K-12 learning, women and small employers.											
		Encourage K-12 financial literacy education and collaboration between public and private sector entities offering such education. Remove barriers to providing financial advice to defined contribution participants.											
		Enhance default mechanisms (e.g. automatic enrollment, life style funds, retirement target funds) to be sure that individuals who decline to make a choice are more likely to be enrolled in a plan (and become savers) and to invest their assets appropriately for their age and for the best risk-adjusted return.											
		Saving early is the best way to achieve targets. We should develop a plan to give $1000 at birth retirement accounts, a 3 % mandatory national savings plan, automatic/ default provisions on retirement plan, a reformed credit savers credit and $10,000 tax free annual annuity income.											
		Permit the use of pre-tax 401K and IRA dollars to fund long term care expenses/LTC insurance; and charge the federal tax structure to better incentivize the use of annuities, life insurance and other investment vehicles to fund LTC expenses/LTC Insurance.											
		Standardize employer-sponsored defined contribution plan structure with the following features: complete transferability, simplified contribution rules, and auto-pilot features.											

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		Make permanent the 15% capital gain dividend tax rate and treat distributions from employee benefit plans (403b, 457, 401) and IRAs as capital gain distributions.											
		Repeal the minimum required distribution rules											
		Balance Accumulation: increase limits to 401K, IRAs, and other defined contribution plans; allow tax incentive to fund Retiree Health Care Costs; catch up contributions for self employed and pre-retirees; support Automatic plan features including enrollment and contribution escalation; encourage employers to start and continue defined benefit and defined contribution plans. Allow employers to match and deduct up to 5% of total salary.											
		Pass safe harbor legislation to allow default investment into an appropriated investment account.											
		Provide incentives for annuities or appropriate installment savings programs to support lifetime income. Including incentive to purchase future income during accumulation for a plan											
		Require mandatory enrollment in employer sponsored plans. Require opt-out rather than opt-in											
		Long term care is an essential saving need and premiums should be able to be paid on a non-taxable basis retirement plan assets spent on LTC would not be taxable											
		Offer tax incentives to: expand eligibility for the savers credit, encourage the purchase of LTCI, expand the dependent care credit, encourage small employers to offer retirement saving plans.											

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25	**National Strategy for Volunteering: Develop a National Strategy for Promoting New and Meaningful Volunteer Activities and Civic Engagements for Current and Future Seniors.**	**Overview:** **Faith-based, civic and family volunteerism is a cornerstone of American society. As tomorrow's baby boomers join today's large force of senior volunteers, the nation needs a strategy for fully utilizing this significant number of talented and available people. The 2002 Health and Retirement Study indicated high rates of volunteerism after retirement, including formal volunteering, informal volunteering and caregiving for family and friends. Today, almost 23 percent of Americans ages 65 and older volunteer. Forty-five percent of volunteers donate time to religious organizations and almost 18 percent support social or civic organizations. Many volunteers are still in the workforce while they find opportunities to volunteer and support their communities. This makes coordination between corporate, community, and individual volunteerism goals an important requirement for future America. The advantages of late-life stability, experience and talent, and more disposable time make the senior population a valuable resource in faith-based and civic activities. Not only does volunteerism provide a valuable resource to communities, it also helps support the social engagement and active lifestyle that enhances older adults.**											
		Implementation Strategies: Establish a broadly representative National Commission to develop a blue print for capturing baby boomers in significant sustained volunteer service to their communities. Consider CNCS as lead agency. Seek a national spokesperson (baby boomer) to lead the effort.	X					X	X	X	X	X	X
		Establish a fund for innovation to foster the growth of promising practices and program models that foster volunteering by older adults to address critical human and community needs.					X	X	X	X	X	X	X
		Begin new RSVP programs in unserved areas and expand existing RSVP programs so that every county in the country is served by RSVP including tribal/tribal organizations. Use RSVP and its experienced volunteer recruitment and management infrastructure to enable faith-based and other community organizations nationwide to actively use volunteers over the age of 55 in accomplishing their missions.	X	X	X		X	X	X	X	X	X	X

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		Authorize and fund the Americorps Program to establish the Silver Scholarship initiatives, a one-thousand dollar tax-free transferable education award for older adults who serve a minimum of 600 hours per year. Establish incentives for organizations to engage greater numbers of older adult volunteers.	X				X	X	X	X	X	X	X
		Include civic engagement into the Older Americans Act (OAA) through senior centers and aging network initiatives. Provide funding to support pilot civic engagement initiatives in terms of recruitment, linkage to community services and value of volunteerism.	X	X	X	X	X	X	X	X	X	X	X
		Develop a national communication strategy and marketing campaign with a website promotion to stimulate demand for volunteers. Creatre a clearing house to educate seniors about and enlist their participation in volunteer activities. Coordinate through local government and utility companies a campaign to register volunteer skills. Ask Google to make volunteer opportunities available and easily researched on the internet.	X				X		X	X		X	X
		As appropriate, incentives should be provided, such as stipends, tax incentives, silver scholarships, and other innovative incentives to attract more volunteers including baby boomers. Federal, state and local groups such as the Corporation for National and Community Service (CNCS), AAAs, non-profits, AoA should partner, develop and offer a tax-credit, similar to WIN and other programs for employers who initiate and support employees-volunteer programs that attain certain levels of community services, or encourage tax deductions or grants.	X	X	X		X	X	X	X	X	X	X
		Support the expansion to 1 million volunteers in Senior Service Corp and support this program being a part of Corp. for National and Community Service with increased funding. Senior Corps Funding – Support the Foster Grandparent Program (FGP), RSVP, and Senior Companion Program (SCP) as part of the national volunteerism strategy by: (1) reauthorizing the Domestic Volunteer Service Act and lowering age of eligibility for all 3 programs to 55 and increasing income eligibility for FGP and SCP to 200% of the national poverty level; (2) housing federally funded volunteer efforts for Americans 55 and over with the Corporation of National Service; (3) doubling the number of RSVP, SCP and FGP volunteers to 1 million by 2010.	X										

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		Reauthorize the Domestic Volunteer Service Act.	X										
		Encourage the business community and institutions of higher education to reward volunteer activities among its employees and use tax breaks for the business community. Engage employers to sponsor volunteer fairs to be held at least bi-annually in cooperation with their communities to acquaint their employees about volunteer activities available to be involved in pre- and post-retirement. Provide incentives such as; tax credits for employers to allow time off.					X	X	X	X	X	X	X
		Provide federal support for volunteer clearinghouses to identify volunteers statewide that are available to serve and volunteer opportunities available to match with those volunteers. Make volunteerism convenient – (a) Public campaign/media/PR: list of volunteer activities at federal, state and local levels; (b) Rework clearinghouse idea; (c) Create personal data card for volunteer that can use this as screening process and to track volunteer hours.	X										
		Eliminate the liability for volunteer drivers and escorts and other volunteers in order to encourage the development of enhanced transportation programs to transport volunteers to sites of service needs.		X					X	X	X		
		Reauthorize the CNCS Act with flexible hours for Americorps volunteers and more funding for RSVP to recruit, train and place boomers for episodic volunteer opportunities, raises in FGP & SCP income limits, amendments to the CNCS Act to significantly expand, revamp and recruit more adults. Amend the National Community Services Trust Act (NCSTA) to be more inclusive by lowering age, omitting means testing, and providing stipends. Charge the CNCS with increasing the numbers of volunteers enrolled in the program to one million by 2010.	X										
		Congress should increase funding to CNCS/RSVP, FGP, SCP in order to develop recruitment and marketing strategies, new meaningful roles for baby boomers allowing for more civic and social engagement in order to increase the number of volunteers to one million by 2010. This additional funding can be used for intergenerational programming and other expansion and innovative ideas.	X										

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		Allow federally funded provider maximum flexibility in spending and match requirements to promote local initiatives and program ownership.	X										
		Streamline the grant application process for non-profit senior groups.							X		X		
26	**Emergency Response or Disaster Plan: Encourage the Development of a Coordinated Federal, State, and Local Emergency Response Plan For Seniors in the Event of Public Health Emergencies or Disasters.**	**Overview:** **Our nation must develop and implement reliable communication, coordination, and control of services across government agencies, the aging network, and care provider systems at the private, non-profit and public levels as the base of our emergency plans. The Department of Health and Human Services, the Administration on Aging, and the Office of the Assistant Secretary for Health and Emergency Preparedness should assist state and local governments and assure that emergency preparedness and disaster planning is coordinated at federal, state, and local levels and is sensitive to the unique needs and resources of seniors. Some seniors will have increased physical, mental and emotional needs during emergencies, requiring assistance to initiate protective actions. Those in institutions and with limited mobility may require extensive transportation efforts and assistance. Still other, actively involved seniors can serve as useful resources supporting the emergency response as they bring years of expertise to bear on the situations.**											
		Implementation Strategies: Utilize federal and state funds to coordinate planning and training efforts between government, law enforcement, emergency planning, public health, human services (including aging, disability services, mental health), EMT/fire, care facilities and social service agencies at the state, regional, county and local level.	X	X		X	X						
		Convene a national commission to explore disaster management for seniors and disabled. This commission must include persons from multiple parts of the county as well as specialists in gerontology including geriatricians, social workers and nurses and other member aging networks. Must involve all stakeholders with equal voices. Will need command structure, trigger for accessing local, state or federal response.	X										

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		Develop federal, state and local coordination for senior/medical needs emergency preparation. Considerations include: shelters, staffing, transportation, coordination, and individual planning.	X	X		X							
		Require local/state participation for responsible entities (AAAs, SUAs) on the state/local emergency management agencies for planning, coordination, and integration with senior systems, through single-point-of-entry service and information system that includes emergency action plans and technology-driven, geo-coded databases with protected/links to emergency preparedness systems. Required and funded by federal resources via AoA.		X		X	X				X		
		Need: coordination, communication, advocacy planning strategies. Have local, state, federal plan to address issues of aging that is peer-reviewed by aging experts. Have one person/one entity accountable at federal, state, local level. Have resources set aside, available/accessible at time of emergencies. Have SOP for mass shelters – special needs. Benchmark/best practices for private corporations disaster plans. Mandate curriculum in medical and nursing schools to include disaster management.	X	X		X							
		Develop safe center concept as new senior centers are constructed and provide funding for same or upgrade existing centers or other appropriate public buildings to provide shelter and resources for seniors.				X	X		X				
		Develop a geographic information system (GIS) for tracking vulnerable individuals, combined with robust wireless communications networks, and global positioning system (GPS) tracking system (opt-in for individuals) for first responders and vulnerable individuals. This can leverage telemedicine technology, states are responsible for implementation, feds and state for funding and development.	X	X									
		Clarify role and responsibility areas of federal, state and local governmental entities relative to evacuation procedures, funding to support evacuation, return, restoration, and service provision. Further clarify the relationship of Red Cross with local entities. Develop and incorporate gatekeeper measures for seniors residing in shelters to minimize elder abuse, neglect and exploitation. These measures should be a part of operating guidelines for all shelters.	X	X		X	X						

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		Food supplies should be "friendly" to the population in need. Ground-level resources availability first and move up a hierarchy of importing items. Restaurants, grocery stores, etc., all have food available that will be wasted or thrown out, and they can serve local populations immediately.				X	X						
27	**Available Housing: Enhance the Availability of Housing for Older Americans.**	**Overview:For the older adult, housing is a major determinant of their ability to continue to age in place in the community as opposed to being institutionalized in a long-term facility. Low-income, frail seniors, people living alone, and those living in rural areas are the most likely to have unmet housing needs. Although seniors would like to remain in their homes, homes require modifications and assistive technologies if the individual with chronic illnesses and disabling conditions is to remain living independently in the community. Changes in housing design and community planning need to reflect the limitations in mobility of current and future seniors.**											
		Implementation Strategies: Change the zoning laws to allow physical modernization of existing homes which allows the resident to use supportive services. Encourage/mandate zoning law changes to allow building group homes and assisted living facilities. Set aside 10% of all future housing for sustainable senior housing and provide for higher density based on square foot per unit. Change codes, funding and regulations to develop new models of housing (e.g., intergenerational, mixed use, shared housing, assisted living, housing linked with services, accessory units) so that older people can age in place in their communities.											
		Develop housing guidelines for older Americans, which encompass low income/limited assets and supports intergenerational communities and provides incentives to governments (local, state and federal) to adapt zoning.											
		Support the passage of S. 705 sponsored by Senator Paul Sarbanes, the Interagency Council of Housing and Service Needs of Seniors. A federal interagency council is needed to increase the availability of affordable housing and link supportive services and care.											

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		Fund home modifications so low and moderate income, elderly people can remain safely in their homes and communities. (2) The House must support the passage of S. 705 to increase the availability of affordable To support available senior housing and link supportive services and care and adequately fund home modifications through housing health, long term care and federal insurance programs (Medicare), so older people can age in place. These strategies apply to both the current cohort of older adults and the anticipated wave of aging boomers.											
		Expand 202 program, providing low interest loans for the development of 55+ housing, including adaptations to assisted living. Increase the housing supply and housing options for seniors through combinations of governmental initiatives and tax credits encouraging the private sector to provide housing in corporate campuses, as well as by encouraging the revamping of land use laws that inhibit the growth of senior housing.											
		Develop new residential models of housing that meet universal design standards, including new housing that is accessible, adaptable and affordable for a diverse population. Encourage public/private investment – available congregate living. Elderly housing should be kept to elderly housing. 202 rules should state this. Any federal financing should reflect this.											
		Work with municipalities to identify and acquire land for use in shared housing projects, which will allow for ranch style construction of homes where 5 or more residents will have their own space but will share common areas of the home. Construction must be close to available services in area. Encourage public/private investment in small community based residential style housing alternatives in order to have available congregate neighborhood living. Make federal, state and local policies more favorable for developers of housing (55+),including building additions like "Granny Flats."											

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		To address lack of available housing for low income elderly, conduct community needs assessments of available or potentially available housing slots. Increase tax credits to build or renovate and preserve existing housing. Ensure regulations allow inclusion of supportive services. Streamline regulations and codes to reduce barriers. Consider cultural needs in development.											
		Increase funding for Section 202 program and the modernization program. Increase the number of affordable units produced by the federal government (Section 202/515).											
		Ensure design, location and service coordination in responsive to special communities and their neighborhoods including cultural, language and other special considerations.											
		Enable seniors to continue to reside in their own homes or their chosen housing rather than being forced into institutions, such as requiring government funded senior housing (or such housing from which a tax credit is derived) to provide service coordinators, providing Medicaid waivers to permit the states to provide home care services, and providing a one-time credit for caregivers to retrofit their homes so that one or more senior relations may reside with them.											
		Institute a program financed by public/private/individual funds that helps seniors move to a small group living situation in their community – freeing their homes for affordable housing for families.											
		Eliminate barriers to construction by (a) eliminating unduly burdensome regulations; (b) streamline government bureaucracy to eliminate redundancy; (c) develop incentives to businesses, including tax credits for building senior-friendly housing.											
		Require HUD to limit their funding for homes that incorporate universal design and smart-wired homes.											

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28	**National and Community Service Act: Reauthorize the National and Community Service Act to Expand Opportunities For Volunteer and Civic Engagement Activities.**	**Overview:** **Over 27.7 million persons age 55 and over render some form of volunteer service on an average of 3.3 hours per week (4.8 billion hours per year) for an estimated $71.2 billion value. Older adults have consistently volunteered at much higher rates than younger age groups in roles that support health, education, civic, religious, community and public information goals. Baby boomers approaching retirement age expect and desire expanded opportunities to make positive contributions to the nation and their communities as a means of remaining vital, healthy and independent, and to avoid becoming dependent on public services and resources. There are thousands of national and community service and membership organizations dedicated to the full spectrum of human, civic and community development goals through both public and private partnerships. The National and Community Service Act provides the most comprehensive network of integrated volunteer service opportunities for older persons in the nation through the Corporation for National and Community Service (CNCS). Older volunteers provide, through private and membership organizations, valuable assistance in financial education, literacy and money management, community service job skills development, tax preparation, basic education tutoring and mentoring, assistance to residents of nursing homes, and driver safety.**											
		Implementation Strategies:Simultaneous with reauthorization of NCSA, reauthorize the DVSA. Increase the quality, quantity and diversity of volunteer opportunities available to current and future seniors through FGP/RSVP and FGP by requiring that at least half of funds appropriated for demonstration/innovation activities be awarded through existing local FGP, RSVP and SCP programs.	X										

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		Simultaneous with reauthorization of NCSA, reauthorize the DVSA with the following changes: a. Increasing the total number of volunteers serving in FGP, SCP and RSVP to one million by 2010 b. Beginning new RSVP programs in unserved areas and expanding existing RSVP programs so every county in the country is served by RSVP. c. Using an expanded RSVP program and its experienced volunteer recruitment and management infrastructure to enable faith-based and other community organizations nationwide to actively use volunteers over age 55 in accomplishing their missions. d. Requiring annual administrative cost increases for FGP, RSVP, and SCP grantees commensurate with annual increases in the CPI. e. Authorize funding for the expansion to the level of 1 million RSVP, FGP, SCP volunteers in unserved and existing programs (currently at the $5000,00 level) and at least half of the appropriated dollars for demonstration/innovation activities be awarded through existing local RSVP/FGP/SCP. f. Include authorized funding levels that allow for requiring annual administrative increases for RSVP/FGP/SCP, and increases for RSVP/FGP/SCP grantees commensurate with annual increases in the Consumer Price Index.	X										
		As part of the NCSA reauthorization, broaden the range of incentives for older adult volunteerism to include: a. Increase the non-taxable stipend for FGP and SCP volunteers due to the cost of volunteering. Offer non-cash incentives, such as tax breaks or silver scholarships, to RSVP volunteers and Americorps members volunteering a minimum of 600 hours per year b. Transferable scholarships for older adult Americorps members c. Silver scholarships d. Provide tax credits for travel and volunteer hours e. Provide professional liability coverage for volunteers serving in a professional capacity, e.g., nurses f. Require diversity in Americorps programs – age, culture, etc	X										
		Develop and implement a national advocacy campaign to reauthorize the NCSA to include public (local and state) officials, media, corporate and nonprofit communities, and national spokespersons. This campaign should be based on the demonstrated value of civic engagement to individuals serving and those being served	X	X	X	X	X	X	X	X	X	X	X

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			Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions										
		Congress to reauthorize the NCSA along with the DVSA with the following changes: a. Increase in non-taxable stipend to FGP-SCP volunteers at least two times during reauthorization period b. Annual increase in administrative costs c. Funding for RSVP so there is one in each county d. Lower age for FGP/SCP to 55 e. Increase income eligibility guidelines for FGP/SCP to 200% of current poverty level. f. Silver Scholarships enacted.	X										
29	**Innovations in Aging Research: Promote Innovative Evidence-Based and Practice-Based Medical And Aging Research.**	**Overview:** **In the last half of the 20th Century, investment in research to improve health provided dramatic returns in prevention, treatment and cures for disease and disability, consequently lengthening life expectancy and enhancing U.S. productivity. Although U.S. health care spending per capita is the highest globally, it does not currently produce the highest quality of health for all its citizens. Substantial growth in the older population drives policy changes at national state and local levels. To inform the decision-making and demonstrate the relative value of various solutions, objective data are needed about the changing health characteristics of Americans. In response to the first wave of baby boomers turning 60 in 2006, we must make a national commitment to significantly increase our investment in research to prevent disease, disability, and injury. A cross-sector research agenda that improves dissemination of health outcomes research, increases the capacity for private-public research partnerships, and removes barriers to cooperation between researchers and health practitioners is important. This stimulation of new ideas and innovative solutions is a means to provide all Americans an optimal quality of life, as free from disease and dependence as possible.**											

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		Implementation Strategies: Research Infrastructure- Develop financial incentives for the corporate community to support aging research being conducted in universities and elsewhere, in order to leverage investment in such research. Promote public/private research partnerships which focus on technological innovations and assistive devices, and repository data base(s) on healthy active aging programs and interventions. Promote translational intervention and service research aimed at establishing and implementing evidence-based practices through dedicated funding and administrative leadership at NIA, NIH, NIMH, other federal agencies, foundations, and public/private partnerships by federal funding at least proportionate to population of older adults and requiring that all federal grants include older adults, similar to requirements for inclusion of women, minorities, and children.	X	X	X				X	X	X		X
		Seek federal policies to devote a stable fraction of health care expenditures to support the National Institutes of Health, and a stable proportion of the Medicare budget for federal support of aging research.	X										
		Provide federal support for research training to encourage career development and entry of new scientists into careers in aging. Promote and identify the next generation of the research workforce, specifically focusing on early career investigators, with special attention to the minority and American Indian/Alaskan Native, etc. faculty and researchers (e.g., maintain early and mid-career investigator awards, Bridge program, and Resource Centers Minority Aging Research).	X		X								
		Decade of the Aging Mind and Body to include doubling of NIH budget devoted to mental and physical wellness over coming ten years (adjusted to inflation) emphasizing interdisciplinary focus on research for older adults (e.g., Alzheimer's, depression, spirituality, and wellness).	X										
		Research models of care for complex older patients in various settings with a stable fraction of the health care budget, with a focus on the rational use of high-tech procedures and devices and promoting the rapid transfer of best practices from research evidence to practice standards. Use evidence-based research on drugs and other health and psychosocial treatments to select the most effective ones and lower costs, linked to outcome research and use of innovative technology for monitoring.	X	X		X	X	X		X	X	X	X

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		Immediately elevate aging research to the highest national priority by creating a DARPA-like (Defense Advanced Research Project Agency) organization on aging that would include such foci as dementia, heart disease and others, to promote innovative aging research and the rapid commercialization of new aging treatments and technology.	X										
30	**Supplemental Security Income: Modernize the Supplemental Security Income (SSI) Program.**	**Overview:** **The Supplemental Security Income (SSI) program provides basic safety net protection for 7 million low-income aged, blind, and disabled adults and children with few resources. The eligibility requirements have not been updated for several years, making it less effective in alleviating poverty. The federal benefit rate for an individual in 2005 is $579, which is 27.4 percent below the official poverty level and the general income exclusion of $20 per month and the earned income exclusion of $65 per month have not increased since 1972 and the resource limits have not been updated since 1989. Approximately 54 percent of SSI beneficiaries have no other source of income besides their SSI benefits. Administration of the program is complex and needs simplification and increased outreach. .**											
		Implementation Strategies:Increase benefit to 150% of federal poverty level in 2008. Increase monthly benefit 5% each year until it reaches 175% of federal poverty level.	X										
		Outreach should be provided by PSAs and state programs and SSA field representatives (reinstate them)—marketing money should be provided by a partnership between federal, state and private (business) entities; outreach should be targeted to low-literate, limited-English speaking and others who cannot easily understand	X	X	X	X	X		X	X			
		Increase the earned income exclusion to 25% of the federal poverty level. Redo the formulas related to income exclusion of $65 per month in order to provide incentives for individuals to work and contribute to the program.	X										

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		Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions											
		Simplify application process and appeals process. Simplify it with particular attention for those with limited English, low literacy rates, limited cognitive and or emotional disabilities. The Disability Determination Process should be simplified and accelerated to include greater consideration by physicians, geriatricians, therapy specialists (OT, PT, etc.) and the use of functional requirements. Establish a quality control review process for denied disability claims.	X	X									
		Allow refugees age 65 and older to retain SSI for the duration of their life, regardless of naturalization status. Restore SSI benefits to all immigrants whose status would have entitled them to benefits prior to 1996 welfare reform law. Permit documented immigrants who have paid into the system to collect SSI if they qualify under rules before 1996.	X										
		Hold beneficiaries harmless when rep. payees does not follow SSI responsibility rules. Make Social Security responsible to be the representative payee when there is no one else. Dock the SSA worker for errors and reward for accuracy.	X										
		Cohabitation. Treat applicants as individuals, not as couples. Raise SSI payments for elders living with family members to the standard of individuals living alone. Support families who have elders on SSI living with them by raising SSI payments to match SSI grants for those living alone.	X	X									
31	**Older Adult Caregivers of Children: Support Older Adult Caregivers Raising Their Relatives' Children.**	**Overview:** **In the U.S., there are more than 2.4 million grandparents who are primarily responsible for meeting the needs of more than four and a half million grandchildren under age 18. They are the primary caregivers because the children' parents are unable to care for them. The number of grandparent-maintained households without either parent present increased by 30 percent between 1990 and 2000. The demands of caring for young children may lead to increased physical, emotional and financial challenges for grandparents. Because care of children by grandparents and other relatives prevents children from going into the formal foster care system, conservative estimates show these arrangements save taxpayers more than $6.5 billion dollars each year. These caregivers take on this role often at great personal sacrifice and face a range of challenges related to securing basic services and provisions for the children in their care, including difficulty accessing medical care and coverage, securing mental health services for the children, obtaining legal services, enrolling**											

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		children in school and securing special education services, and securing appropriate housing. Supportive services are needed to help these caregivers to continue to provide safe and nurturing homes for these children without compromising their own health and financial security.											
		Implementation Strategies:Encourage state school boards, Departments of Education, Departments of Health and Human Services to allow a relative caregiver without legal custody or guardianship to submit affidavit to enroll child in school and to consent to medical treatment on his or her behalf.		X									
		Ensure that government programs, including navigator programs include array of services including: Legal, Housing, Health care, Education advocacy, Counseling and respite care	X	X		X							
		Outreach and education that is culturally and socio-economically sensitive, directed at caregivers, schools and public at large.	X	X		X							
		Provide for adequate funding for grandfamilies: Title IV-E foster care and for subsidized guardianship, NFCSP—Lower age limit, increase funding, and support national , housing: HUD and NAHASDA and Legacy	X										
		Reauthorization of Indian Health Care Improvement Act	X		X								
		Lower the age requirement for NFCSP in order for grandparents and other relatives who are under 60 and are raising children to qualify for supportive service.	X										
		Educate caregivers of children to establish legal guardianships and establish programs to assist caregivers to negotiate the legal system.				X	X						
		Allow states to use federal Title 10-E funding for payments for children living with grandparents and older relatives. This provides the financial resources needed to meet the needs of children and lighten the financial burden	X	X									
		Amend the law to provide a legal role and responsibility of grandparents. Work with the court system to be more grand-parent and child friendly. Amend court-orders to support blood relatives (take abuses out)	X	X		X							

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		We must make state laws more malleable and less restrictive for grandparents to take care of individual children's needs (a "loosening up" of government control of healthcare issues, school issues and leisure activities). A strategy for children, state legislature/governor using the 2005 WHCoA Resolution #26 as the basis of the strategy. Each individual of this session assumes responsibility for moving Res. #26 into the hands of the legislator that appointed them or if at large, your legislator. The delegate(s) hire contact other legislative delegates and organize an advocacy WHCOA 2005 Advocacy group for #26 Delegates get legislative communication by e-mail etc. Res.26 Delegates get legislative timeline and be sure this resolution gets a legislator(s) timeline and be sure this resolution gets a legislator(s) sponsor both R&D parties. Work the process, i.e., building support groups using AAAs as guides, expand advocacy contact Governor's Office		X									
		Enhance and expand available services to kinship caregivers: a. Lower age requirement for kinship caregiver to include those under 60 b. Allow funding of kinship caregivers caring for children with disabilities who are over 18 c. Double NFCSP initial appropriation d. Increase OAA funding and allow greater flexibility in AAA use of funds. e. Expand definition of "kinship" to non-blood relations.	X	X									
		Promote cross-training between the aging and child welfare networks.		X		X							
		Address financial burden on caregivers by: a. Creating tax incentives b. Strictly enforcing child support laws c. Promoting consumer direction in the use of public funds.	X	X		X							
		Greatly increase the appropriation level for the NFCSP so that more kinship care families and businesses and the long term care industry benefit from this vital program.	X	X									
		Increase moral and community support for caregiver families (especially those no in foster care) through community leadership, advocacy, local fundraising community awareness; portray the reality. Create/build community and moral support for caregivers. Inform public about realities, recruit leadership, champions, funding; develop partnerships.				X	X	X	X		X	X	

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32	**Veterans Healthcare: Ensure Appropriate Recognition and Care For Veterans Across All Healthcare Settings.**	**Overview:One fourth of all Americans over age 65 are veterans. Ensuring that veterans who are eligible and entitled to benefits and services, particularly healthcare, are recognized in all settings is a national priority. Ensuring that veterans are recognized in all healthcare settings is a national priority, both to ensure that they are informed of benefits available to them through the Department of Veterans Affairs (VA) and to allow appropriate honor and recognition for their service to our country. Benefits and services are delivered through a nationwide network of Department of Veterans Affairs (VA) benefit offices, veteran centers, outpatient clinics, medical centers, and nursing homes. Each State has a Director of State Veterans Affairs that works with VA to facilitate the delivery of these benefits and services as well as benefits and services that are offered to veterans by the state. This network includes over 3,000 veteran service representatives employed by county governments. Veterans are also being treated and provided services by public and private providers who are unaware that they are serving a veteran who may be eligible and entitled to benefits and services through the VA. These public and private providers are often unaware they are serving a veteran of the United States military. Additionally, veterans who seek benefits and services outside VA may not be aware of their eligibility and entitlement. It is imperative that steps be taken to improve the coordination of veteran eligibility and entitlement to benefits and services at all levels and then to provide the most efficient and cost effective delivery of those benefits and services.**											
		Implementation Strategies: Simplify the system by: a) using a one stop application process; b) better explanations of benefits in VA hospital as well as public and private facilities; c) more available to vets; d) use the Federal Employees Health Benefits plan as a model for provision of health benefits for all honorably discharged veterans without means or status testing; e) coordinate local, state and federal agencies, including Veteran service officers/re: benefits; f) improve VA benefits with- public relations/marketing campaign to create awareness among general public and veterans; benefits should not be related to income, regional funds allocation should not be diminished as older Veterans die, special consideration for POWs and specialty populations (i.e. purple hearts); g) require every medical form to include the question: "are you a veteran?" so that veterans can be recognized and honored in all health care settings.	X										

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		Access to VA Services with central locale, ombudsman, Veteran Service Officers, Increased Services in Rural Areas, Expand Availability beyond VA hospitals, Consider Contract Services, care in the community Vets live in, including LTC, update and keep open VA hosp. & clinics. Educate veterans and their families, using modern technology. Greater use of the VA to offer healthcare by promoting aging in place, home & community based services. Community Based Outpatient Clinics (at any location), increase mileage to gov. rate, increase the # of clinics, add mobile units (pilot program) for homebound and rural vets. Coordination of civilian health care providers, citizen soldiers, use of VSO and State Dept. of Veterans Affairs, educating civilian provider to identify veterans and assist in VA Eligibility, this includes local hospital as well as doctors, civilian provider to have access to veterans' health information.	X	X	X	X	X		X		X		
		Coordination of Benefits, Medicare, Tricare, VA, DOD, HHS- to avoid losing MDs to lower payments, legislation to eliminate SS offset for surviving spouses, health insurance, disability insurance, pensions. Ensure appropriate recognition and care for veterans across all health care settings, mandating integration of electronic health records across all VA federal and state healthcare systems, DOD, and private sector facilities to enable efficient and effective care across the continuum. Coordination of veterans healthcare services including Indian Health Services, DOD, and contracted non-VA provider services	X	X	X	X	X		X		X		

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		Funding reforms of formulas to address growth in states, adequate health care staffing, mental health funding, women's health clinics, outpatient clinics (CBOC), homeless veterans and other outreach, long term care, available new generic drugs, serve all veterans (no means test). Reimburse private/public facilities for emergency care for veterans to avoid lengthy trips to VA hospitals & develop appropriate funding mechanisms. VA healthcare for elderly veterans should be strengthened by making the VA healthcare system a place of choice for geriatricians and allied healthcare professionals in gerontology with specific incentivization, such as improved Title 38 (and hybrid title 38) professional salaries for geriatricians at the highest tier, strengthen and expand geriatrician-initiated interdisciplinary research, increase geriatrician manpower – 1 geriatrician per 500 frail veterans, expand geriatric healthcare team, including a chronic disease case manager and patient registry manager, student loan forgiveness and scholarships for geriatric and gerontology linked to pay back service in VA, all major VA teaching hospitals should have a fully funded geriatric research, education and clinical center (GREEC) or equivalent.	X	X	X	X	X		X		X		
		Veteran Housing – End of Life- more VA homes and more VA cemeteries	X	X	X	X	X						
		Statutory/Regulations flexible to allow for creative use of under-utilized VA facilities; eligibility for services such as HUD housing, Medicaid, etc. should NOT include VA disability payment in means test.	X										
		Aggressive outreach strategy to Vietnam Vets and all prior wars, National Guard and Reserve and all vets as they separate	X	X	X	X	X						

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33	**Encourage Redesign of Senior Centers for Broad Appeal and Community Participation.**	**Overview:** **An estimated 10 million Americans access an array of services and opportunities through senior centers. These Americans represent a diverse mix of people, by mobility, education, culture, and economics. However, the appeal of senior centers may not be broad enough to attract the next wave of aged Americans or the participation of the communities at-large. One of the main purposes of senior centers is to provide seniors with access to the community in a fashion that enables dignified and supportive engagement. If senior centers are to continue this function, they need to be redesigned for broader appeal and multiple uses. Furthermore, their management needs to evolve, to better engage the entire community and be even more responsive to those they serve now and in the future.**											
		Implementation Strategies:											
		Coordinated national communication and PR/marketing campaign to re-brand senior centers as community focal points includes the following: accredited and educating users (current and future); including increased and more flexible OAA funding, support and involvement.	X						X		X	X	
		Support an expanded role for senior centers as focal points for community based services and civic engagement for senior centers as independent service: (a combined service for all economic levels, cultural competence and diversified populations and generations (volunteer opportunities, transportation, nutrition, etc.) and mental health services; (b) NISC accreditation.				X	X						
		Support efforts to modernize and upgrade facilities and programming that will attract and serve existing and new generations: (a) Healthy Aging – physical, emotional, mental health services; (b) Civic Engagement to provide community support; (c) Design for all economic levels and capabilities.				X	X				X		

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		Support policies and encourage efforts to create and expand opportunities and partnerships that integrate senior centers, health care systems, service providers, communities, business, public and private to serve culturally diverse populations across all social and economic lines.				X	X		X	X	X		
		Create a separate and distinct title in OAA for multipurpose senior centers which are a system serving older adults, caregivers, and their families.	X										
		There shall be a federal requirement that all 50 states, territories and tribes establish statutes defining "multipurpose senior centers" as THE community based focal point for planning and coordination for the organization and provision for a broad spectrum of services suited to the diverse needs and interests of self determining older persons.	X										
34	**Awareness of Disparities: Reduce Healthcare Disparities Among Minorities by Developing Strategies to Prevent Disease, Promote Health, and Deliver Appropriate Care and Wellness.**	**Overview:** **Minorities suffer disproportionately from cancer, HIV, diabetes, heart disease and other life threatening illnesses compared to non-minority counterparts. These disparities require improvements in the delivery of health care to meet the needs of African Americans, Hispanic Americans, American Indians, Alaska Natives, Asian Americans, and Pacific Islanders. Factors contributing to disparities include lack of access to care and transportation and difficulty navigating a complex healthcare system. Low-income elders with linguistic and cultural barriers often seek help too late, if at all. Even if they seek help, they are less likely to properly follow prescribed treatments because of miscommunication. These differences may explain higher rates of morbidity and mortality in minority populations, as compared to others. Examples of health disparities include prostate cancer rates 2 times higher in African American men under 65 compared to like White men, highest rates of tuberculosis among Asian Americans and Pacific Islanders, and diabetes nearly 3 times higher in American Indians/Alaska Natives than others.**											
		Implementation Strategies: Work with appropriate accrediting bodies to develop a cultural competence curriculum for inclusion in geriatrics and other health-related training programs at all levels.											

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Eliminate barriers to access to healthcare including: Transportation, Healthcare education outreach, Affordable healthcare, Lack of insurance, Language, Lack of cultural competency, Income, Gender, Sexual preference	X	X	X	X	X	X	X	X		X	
		Promote and support community-based participatory research to gain better understanding of health status and identify best practices for older adults of various races, ethnicities, cultures, and different communities.	X	X		X	X						
		Integrate within the reporting requirements of government-funded health plans and health organizations performance measures on health outcomes that specifically address health care disparities affecting gender, cultural and ethnic minorities. Require that these results be publicly reported. Establish these performance measures with the help of expert stakeholders.	X										
		Outreach to minority communities to work with them to determine their needs and to empower them with what they need to manage their care. While in the minority community, recruit for current and future professional health care workers. Emphasize early training of students as future health care givers for minority seniors creating a continuum of healthcare for future generations. Institute a mentoring program as part of the training.	X	X	X	X	X	X					
		Expand the definition of minority populations to include—gays, lesbians, bisexuals, transgenders and seniors with disabilities and increase federal funding to NIH, CDC, Title 3 and other federal agencies to reduce health disparities and promote health promotion programming for all minority populations.	X	X	X	X	X	X					
		Tie federal health care dollars that flow to the states to a reduction in health disparities. For example, each state should have a benchmark to meet in health improvements for minority populations. If states did not meet their target, their dollars would be reduced by the amount of target they missed.	X	X						X		X	

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		Promote healthy lifestyles in diverse communities by providing health education and wellness intervention through Medicare and Medicaid that is culturally competent, is provided in the appropriate language and addresses individual racial, ethnic, GLBT, religious, national origin and disabilities needs.		X	X	X	X	X					
		Encourage partnerships with and between health organizations and community-based organizations including senior centers, libraries, and churches, focused on educating consumers to take control of their own health needs.											
35	**Issues Surrounding the End of Life: Educate Americans on End of Life Issues.**	**Overview:Issues of importance at the end of life include medical, legal and ethical choices and decision making as well as cultural considerations. Respect for different cultures and individual older adults requires addressing the unique mix of patient and family needs to relieve suffering, promote autonomy, and maintain independence at the end of life. Palliative care and hospice services are provided to prevent and relieve suffering and to support the best possible quality of life for patients and their families. The legal aspects of end of life decisions are intricate and confusing to the majority of the population, and laws affecting decisions vary across government jurisdictions. The major decisions about wills, medical treatment, and decision-making authority are difficult to resolve when one is facing family crises or diminishing capacity. Additionally, the unexpected costs involved in end-of-life situations can quickly deteriorate a family's finances. While many services are available to seniors with very low incomes or who are financially well-off, middle income seniors may be financially ineligible for certain forms of assistance, and at the same time, are unable to pay for the services outright.**											

Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions: Federal through Technology columns.

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Implementation Strategies: Education of public and professionals. Educate the public and legal and health care providers on end of life the legal and ethical obligation to follow advance care directives. Make grants available to help train health care professionals in the care of patients both serious chronic, eventually fatal illness, including palliative and hospice care. Through public and private partnership, educate the public on the availability of hospice and palliative care and the Medicare benefit associated with it as well as other payment optios like third party insurance, self-pay, sliding scale. Mandate at least 3 academic hours on end of life curricula for nursing, medicine and other health care professions, including cultural differences, pain and symptom management, palliative care. Federal agencies that accredit schools should mandate a core curriculum in end of life care as part of the standard nursing, allied health and medical school curriculum, including management of physical symptoms, spiritual issues and legal considerations. Require practitioners to have C.M.E. credits to maintain licenses.		X									
		Community education- educate people about hospice and palliative care, when/where hospice is used, the benefits, how it is paid for, the role of the family, and how to talk about it, what they can reasonably expect when they choose certain end of life options; and the outcomes of their decisions. Develop health care and community collaborations with faith-based communities, aging service and other community providers to promote advance care planning and completion of advance directives for all individuals, thus targeting the Medicare beneficiary as well as the family. Provide, through public education, mandatory courses on aging and end of life issues targeting elementary, junior high and high school students. College courses and community-based courses should target working and retiree populations. Note: Education on Aging must begin early in order for younger Americans to develop respect for older Americans and to increase awareness and preparedness with respect to financial and Health literacy in the older years.		X	X	X	X	X	X				

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		Public awareness campaign- launch a public awareness campaign nationwide about the importance of planning for end of life issues. Educate religious leaders whose support is needed when educating a diverse population. Provide venues for public awareness campaigns on hospice and palliative care in order to empower the public to demand appropriate care for themselves and loved ones with serious, eventually fatal chronic illness. Establish a multi-cultural, cross-denominational educational program from grade school through secondary education to educate about dying and end of life issues in an effort to de-stigmatize dying and end of life issues. Provide single web site for rules and regulations regarding end of life issues for each State. Have a National Education Campaign for the Public on End of Life Issues and Rights including internet access.	X		X	X	X	X	X				
		Adopt Physician Orders for Life Sustaining Treatment (POLST) recommendation as a nationwide end of life planning document. All states should establish a uniform POLST type approach to documenting and implementing advance care plans as medical orders and ensuring that they follow patients across care settings and across state lines. Ensure that patient and family wishes are respected across care settings. Establish a web based information clearing house and registry.	X	X	X	X	X	X	X				
		Congressional initiatives: The WHCoA supports passage of the Living Will with Fatal Chronic Illness Act of 2005 and the Advanced Directives Improvement and Education Act.	X										
		Reduce barriers to advance directive care planning. Clarify mandatory for requirement reduce barriers to people putting end of life wishes in their own words. States should simplify advance directive laws to ensure that any authentic expression of a patient's wishes is respected and followed.		X									

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36	**Health Information Technology: Develop Incentives to Encourage the Expansion of Appropriate Use of Health Information Technology.**	**Overview:** **There are at least five promising areas for changes in aging services technologies: 1) prevention, 2) early disease detection, 3) compliance assistance, 4) independent living, and 5) caregiver support. Technologies addressing home health, disease management, tele-health, and independent living will be important in preparing for the demographic changes facing our nation. Health IT can encourage more informed consumers, caregivers, and providers. Given the high number of medications seniors take, it is critical that they have access to their personal health records. Although health networks have been slow to adopt electronic exchange of information, due to privacy and cost concerns, the federal government is leading a move to expand the use of information technology in healthcare through the U.S. Defense Department and Veterans Administration. For example, evidence-based, outcomes-oriented demonstration projects are being supported to evaluate the effectiveness of telemedicine programs for selected physical and mental health conditions. Management information systems and standardized patient health information databases are used in large national healthcare systems to coordinate, manage, and evaluate a broad range of services provided across the continuum of care. Creative approaches to healthcare delivery such as tele-health self-management techniques, assessment across programs and electronic records, and the use of telemedicine are being tested and used in national clinical care systems.**											
		Implementation Strategies: Create a National commission to operate over the next 2 years to develop common national standards and incentives in technology use and development to include reciprocity and reimbursement sources between states; EHR standards; interconnectivity of technology products; funding for research; accelerated depreciation and other tax incentives for equipment; encourage public and private partnerships; ensure competitiveness and leadership in development; provide health premium reductions or tax credits for consumers who utilize health information resources through technology and other health technology for cost reductions and efficiency across the continuum of care.											

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		Provide financial incentives for the adoption of process oriented technologies that enhance the effectiveness and efficiency of professional and paraprofessional healthcare workforce, such as telehealth visit included under Medicare/Medicaid; capital pass-through components; low interest loans; tax credits; sales tax exemptions; and private sector awards.											
		Provide health premium reductions/tax credits for consumers who utilize health information resources through technology and other health technology for cost reductions and efficiency.											
		Establish and subsidize pilots in multiple states and localities to understand better how to provide innovative and useful tele-health capabilities with particular attention to how seniors and people with disabilities can access these systems. Include topics such as adaptive techniques; pilot studies on allied health; VA first 1,000 households; CCI rev. 2 on Boomer Technology use rather than paper trails											
		Fully fund AHIC/ONCHIT for 3 years (protected) to drive interoperability, common standard of data exchange, and implementation of electronic health records across the continuum of care, including long-term care.											
		Medicare should adopt guidelines for standards of interoperability, and encourage all insurance carriers to follow. This technology should be integrated among acute care, long-term care, and home services to extend across the continuum of care.											
		Remove barriers and establish partnerships to include lobbying efforts that increase accessibility and decrease cost of health information technology including such areas as regulatory issues like HIPAA. Use state hearings to identify such regulatory barriers and establish code language for consistency and assure long term care high speed internet access. Call multiple senate hearings to address ways to remove the following barriers to agency service technologies: Licensure, Regulation, Liability, Reimbursement. Develop next generation HIPAA guidelines for home and self-generated health and wellness data.											

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		Improve reimbursement strategies for HIT through mechanisms such as malpractice insurance carriers reducing premiums for physicians using HIT in practice, reducing licensing fees for providers that use health information technology in the outpatient setting, allow reimbursement for consultation and maintenance of the EHR electronic system and for telemedicine to improve quality of care at lower cost. These strategies must be available in rural areas, and there must be incentives for adoption by physicians and providers.											
		National commission for developing and implementing technology for aging services similar to Y2K- Develop a national stakeholder commission as a public/private partnership to identify barriers and new technology, encourage development and implementation of affordable e-health technologies, provide grassroots feedback from consumers through educational forums regarding the benefits of technology in provision of medical care and sharing of medical records.											
		Need payments for physicians and providers available in rural areas incentives for adoption by physicians and providers											
		Databases have to be open source and able to read existing databases, such as Medicare Part B, patient databases in counties, national family caregivers support for all federal, state and local entities that currently have databases. Provide connections with data sets among different regulatory agencies and health care systems.											
		Create IT capacity in the health care workforce through grants, funding, tuition reimbursement, faculty enhancement, and incorporating licensure in training programs.											
		Provide fast track grant funding for the acquisition, development, quality assurance of interoperable information technology systems across locations/systems, eg MDS, OASIS, etc.											

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37	**Provider Education on Consumer Healthcare: Prevent Disease and Promote Healthier Lifestyles Through Educating Providers and Consumers on Consumer Healthcare.**	**Overview:** **Consumer health education has a major role in facilitating seniors' capacity for self-care. Effective training is needed for health care workers to provide proper self-care and disease management guidance. The federal government has initiated a number of programs encouraging seniors to maintain healthier lifestyles and prevent disease, including the President's Council on Physical Fitness, the Center for Disease Control and Prevention's (CDC) Senior Wellness Lifetime Fitness Program, and the CDC's People with Arthritis Can Exercise Program. Providers and other care professionals need to be aware of these programs and other developments that support consumer driven health care, self-care, and family-care.**											
		Implementation Strategies: Create a national center for evidence-based prevention to ensure that high quality, tested and model programs are widely available and that their impact on diverse populations is being routinely assessed, and that community-based agencies such as senior centers and libraries, are focal points for dissemination.	X	X		X	X				X		
		Encourage alliance of existing resources to deliver consistent communication. Decrease consumer confusion caused by high volume and inconsistencies in messages regarding nutrition and physical fitness through quality education and patient empowerment and advocacy.		X			X	X	X		X	X	
		Promote healthier lifestyles by engaging all sectors: government, state, private, business and industry efforts to create pilot programs that would educate seniors about nutrition, health and fitness by encouraging active lifestyles within their communities. Focus on education as a vehicle of prevention. Include minority groups by being sensitive to their linguistic and cultural needs.	X	X	X	X	X	X	X	X	X	X	
		Collaboration among state health departments, state aging network and other agencies (business and industry, nonprofit, etc.) working with aging to promote, implement, and evaluate evidence based health promotion and disease prevention programs at the local level for all citizens.		X	X	X	X	X	X	X	X	X	

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		Enhance, coordinate and adequately fund the education of medical and other health care providers and the US public, including minorities and those with limited English proficiency, on the importance of diet, including the use of multi-vitamin/mineral supplements, in the prevention and management of chronic disease such as heart disease, diabetes, cancer and other diseases affecting America's aging population.	X	X					X	X	X		
		Fund and widely disseminate model, evidence-based physical activity and exercise programs that are successful in attracting and serving older adults in community settings.	X	X	X	X	X	X	X	X	X		X
		AAAs should partner with governmental and disease prevention and health promotion programs to implement wellness efforts wherever seniors are found. These efforts should be staffed by credentialed professionals.					X						
38	**Rural Economic Development: Promote Economic Development Policies that Respond to the Unique Needs of Rural Seniors.**	**Overview: Approximately 25 percent of the nation's older persons live in rural America, or some 9.2 million. The total rural population is aging more rapidly due to more elderly aging in place, younger persons leaving for metropolitan areas, and elderly returning home as they age. Major challenges include access and delivery of care to rural seniors, transportation limitations, and poor economic development. Also, rural seniors are among the oldest old and frail, as evidenced by the fact that nearly 40 percent of elderly receiving nursing home care are rurally located.**											
		Implementation Strategies:Community of Care: Expand volunteer services and eliminate liabilities (Good Samaritan Law) Senior Corp programs, RSVP and Senior Companion.											
		Community of Care: PACE model for rural areas.											
		Community of Care: Provide regulatory and reimbursement flexibility and incentives for existing LTC providers to retool, diversity, to provide fuller array of aging services (including tribal elders)											
		Community of Care: Provide menu of vouchers for seniors helping seniors.											
		Community of Care: Home-delivered geriatric mental health services and education by senior mental specialists.											

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		Community of Care: Support/train informal caregivers.											
		Community of Care: Expand nutrition sites to include other functions such as respite care											
		Community of Care: Info & Referral											
		Community of Care: Responsive to local needs (including tribes)											
		Community of Care: Support/protect volunteer workers											
		Transportation: Increase funding for Sec. 5311, block grants, rural transportation assistance, meals on wheels and Separate titles in OAA.											
		Transportation: Expand and strengthen United We ride program, flexibility to use funded vehicles school buses and Head Start buses.											
		Transportation: Expand Good Samaritan Laws, volunteer drivers, NSSC, RSVP volunteer programs.											
		Transportation: Expand and strengthen United We ride program, flexibility to use funded vehicles school buses and Head Start buses.											
		Transportation: Regional Strategic Planning by all stakeholders - public transportation, medical, non-emergency medical.											
		Transportation: Coordinate transportation to Medicaid recipients & non-emergency medical transportation.											
		Transportation: Tribal issue of access – refunding of OAA.											
		Rural Economic Development: Tax abatement, business exemption, i.e. Social Security tax exemption.											
		Rural Economic Development: Equitable reimbursement for rural providers.											
		Rural Economic Development: Flexibility at local level for implementation of how dollars are spent how matched dollars are mandated.											
		Rural Economic Development: Reauthorization and increased funding for Indian Health Care Improvement Act.											
		Rural Economic Development: Create Aging as an industry to attract for profit vendors to provide services.											
		Rural Economic Development: Training incentives for health care practitioners in rural and tribal areas.											
		Rural Economic Development: Rural aging network engaged in economic development – local policy.											

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		Rural Economic Development: Consolidate Federal-Rural programs.											
		Technology: Apply 1930-style rural electrification model to provide broadband access to all rural areas.											
		Technology: Promote long-distance mental health care.											
		Technology: Promote telemedicine.											
		Technology: Promote long distance caregiving.											
		Technology: Promote tribal infrastructure for communication and medical technology.											
		Technology: Education of legislators on rural issues.											
		Economic Development: Funding formula revised to increase weight for rural development.											
		Economic development and revitalization in rural areas; recognize the economic importance of health care facilities to economic development.											
		Economic Development: Develop infrastructure for technology/communication/broadband.											
		Economic Development: Improve access and availability to health care frontier services.											
		Economic Development: Rural health as economic development.											
		Health: Expand mobile clinics.											
		Health: Critical access hospitals in rural settings with the advantages of cost reimbursement primary care and long term care.											
		Health: Telemedicine/Telehealth, address licensing, etc.											
		Health: Better access through coordinated training.											
		Health: Federal qualified medical centers are under used in rural areas…the program is difficult to develop. Make it easier to place FQMCs in rural areas.											
		Health: Distance teleconference learning for low-income rural health practitioners.											
		Health: Address differences in the payment for Medicare and non-Medicare (inadequate payment for geriatric practice cost reimbursement.											
		Health: Integrate primary care and rural health.											
		Health: More/better case management.											

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		Health: Information & referral.											
		Health: Access increase by eliminating barriers to rural areas.											
		Health: Develop critical care hospitals in rural areas.											
		Health: Partner with existing VA hospitals.											
		Health: Better access to healthcare through coordinated transportation to health care.											
		Health: Partnership with libraries to deliver rural medical services.											
		Technology: Telehealth enhanced access to health increase technology training											
		Technology: Telemedicine uses the Farmer's bureau model to expand training in healthcare, and marketable skills.											
		Technology: Computer labs training in senior centers partnering with seniors and youth; also partnership with libraries and also include partnering with the Bill and Melinda Gates Foundation for computer labs in libraries.											
		Technology: 211 non-emergency access to human services, info. Distance learning – community colleges											
		Technology: Telework – training											
		Technology: Issues of Licensing											
		Technology: More broadband (facilitate knowledge of services).											
		Technology: Computer in each household											
		Technology: Incentives for demonstration program.											
		Transportation: Access to transportation – increased & coordinated to retail independence and access healthcare.											
		Transportation: Coordinate and improve access to transportation using existing resources (school buses, day care sites, etc.											
		Transportation: Flexibility in programming: permit local agencies to use funds more flexibility.											
		Transportation: Promote demonstration projects for transportation: "Frontier Nurses" who provide care in far rural communities. Use CTAA/Chamber of commerce partnerships for transportation support. Demonstration projects funded thru grants.											

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		Transportation: Limit liability for volunteers who provide transportation services.											
		Transportation: Foster mobile medical clinics.											
		Transportation: Put RNs in Bookmobile											
		Transportation: Use school buses and other vehicles for senior program transportation when buses are idle during school hours.											
		Workforce: Financial incentives for rural health care professionals: Debt forgiveness for doctors, nurses, etc.											
		Workforce: Improve technical skills for seniors who can work in the community.											
		Workforce: State coverage of malpractice insurance for voluntary providers (decrease liability issues for volunteers)											
		Workforce: Improve cultural competency development for workers.											
		Workforce: Provide telework opportunities for health care workers.											
		Workforce: Increase recruitment for retired military and federal providers.											
		Workforce: Mobility of staff in MOW, mobile library, etc											
		Workforce: Revise funding formulas for rural areas											
		Workforce: Licensing issue – reciprocity between states											
		Workforce: WICHE program (Western Institute/Council of Higher Education program to support training of health car professionals (WY model). circuit riders" to deliver home services.											
39	**Responsive to Mental Illness: Apply Evidence Based Research to the Delivery of Health and Social Services Where Appropriate**	**Overview:** **High quality health care and social services originates from systematic evidence showing its effectiveness. Evidence-based practices face both technical and financial barriers to adoption by hospitals, physicians and other service providers. Some new interventions and treatments are too slowly adopted, while others are diffused too quickly with insufficient evidence that they are useful. Studies show that few guidelines lead to consistent changes in provider behavior. It is important to weigh the benefits of evidence-based care for the individual with the costs and preferences of the older adult and their caregivers.**											

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2005 White House Conference on Aging
Resolutions, Overviews and Implementation Strategies(IS) with Strongest and Strong Support

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Implementation Strategies: Establish pro forma studies sanctioned by CMS using CAST Technology partners in selected representative states across the US to be operationalized in next 3-5 years: 1) diverse populations 2) diverse cultures 3) economically dis-advantaged 4) aged and disabled.	X	X	X	X	X		X	X	X		X
		Within reauthorization of OAA create and fund a center to explore best and promising practices in aging and provide technical assistance for evidence based research and innovation, Not a clearinghouse or a rule to be an obstacle for funding.	X										
		Provide funding for research of diverse populations and apply evidence based research based on complex medical conditions and on different populations (e.g., gender, ethnicity, race, cultural, ability) to the delivery of health and social services.	X						X		X		
		Request an evidence based study of Older Americans Act programs to support requests for funding. Exempted from this and requests for further evidence would be those programs and practices for which broad consensus of effectiveness has been established.	X	X			X		X		X		
		Support dissemination/use of evidence based research results through incentives/reimbursement for services by health care and social service providers based on application of best practices.	X										
		Funded research should include all relevant measures of impact including impact on the consumer, impact on the policy that it affects, impact on the organization providing the product or service, impact on consumer satisfaction and the related impact on caregivers.	X						X	X	X		

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40	**Consumer Driven Health Education and Health Literacy: Improve Health Decision Making Through Promotion of Health Education, Health Literacy, and Cultural Competency.**	**Overview:** **Active participation and involvement in the community and integration in the population requires access to information. Many Americans have difficulty obtaining and understanding information needed to make appropriate decisions regarding their health. If patients cannot comprehend health information, attempts to improve quality of care and reduce healthcare costs and disparities may fail. Health literacy includes reading, writing, listening, speaking, arithmetic and conceptual knowledge. Another important barrier to information among the older adult population is limited English proficiency. Expectations of patients, and patient self-determination and preference needs continue to increase, making health literacy important in a patient's ability to access care. Health care providers have a duty to provide information that patients can access quickly, understand, and use effectively.**											
		Implementation Strategies: Develop innovative and educational models on prevention and health throughout the life span using e-learning, web technologies, libraries, medical associations, schools, ethnic groups and government agencies. Fund technical demonstration projects at centers where diverse populations meet to increase technology competency.			X	X	X		X	X	X		X
		Provide cultural sensitivity training of health and aging professionals/service providers of importance of and techniques for assessing needs of individuals and groups and obtaining and/ or designing materials and messages and information in terms and forms that individuals and groups understand and can use. This includes training of bilingual workers through vocational English as second language.		X	X	X	X				X		
		As health literacy/education projects/campaigns are developed, include a phase to pilot ideas/messages with the target populations in the form of focus groups or demonstration projects; as well as to allow time to observe and possibly incorporate the terminology used by the target populations to describe the intended health message.		X	X	X	X			X	X		

Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Pay for and conduct health education campaigns in low literate and limited English speaking communities through one on one contact, ethnic media, religious organizations, flyers in stores and gathering places, group presentations (in native language or with interpreters as needed in all language groups to ensure understanding). Undertake outreach initiatives with cultural competence to remove barrier obstructing access to quality health care by underserved communities, including rural areas and low income populations, with eye-catching "how to …." and "Where to go…" messages. Develop a national collaborative network in communication marketing professionals and advocacies groups and educators that promotes innovative communication approaches and educational opportunities.		X	X	X	X		X	X	X		
		Provide financial incentives to states and other stakeholders.	X										
		Training in communication strategies (to include giving clear instructions, working with interpreters and assessing patient understanding should be implemented for all healthcare staff professionals and administrative to ensure that all patients accurately summarize the information they need to safely care for themselves and demonstrate how the information can be applied to their daily life.)		X	X	X	X	X			X		X
		Stress prevention in all health matters to boomers by emphasizing quality of life issues enhanced so they age by prevention—use cultural diverse actors and promotions. Media campaign stressing nutrition, exercise, personal awareness of their own health—How their life will be more fun so they age through prevention.		X	X	X	X	X		X	X	X	
		Promotion of preventive drugless health care disciplines that teach early healthy habits in the 5 pillars of health: 1) proper nutrition, 2) proper exercise, 3) proper rest, 4) positive mental attitude, 5) proper nerve system function. Support this with funded research across age groups showing efficacy of a healthy lifestyle incorporating these 5 pillars of health.		X	X	X	X	X	X	X	X		

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		All U.S. prescription drug labels should be standardized. Congress should establish a public-private expert panel to develop the uniform format (similar to nutrition labels) which should be validated by consumer focus groups (including consumers with limited literacy and limited English proficiency). Accurate translations in multiple languages should be available for all retail pharmacies to use. Make side by side translations available.	X										
		Develop educational programs that are culturally and linquistically appropriate and relevant for health decision making.			X	X	X				X		
		Raise funding to per capita levels equal to the general public for Indian Health Service which provides the health care and education for American Indians and Alaskan Natives to address prevention efforts and not just acute care in collaboration with the National Resource Center for American Indian, Alaskan Native and Native Hawaiian Elders and the National Resource Center for Native American Aging.	X		X								
41	**Social Security Disability Insurance: Strengthen the Social Security Disability Insurance Program.**	**Overview:** **The Social Security Disability Insurance (SSDI) program provides benefits to disabled workers and their families based on previous employment covered by Social Security, and primarily is financed through Social Security payroll taxes. As of August 2005, more than eight million disabled workers and their families received $6.3 billion in monthly benefits. Current trends make clear that more and more baby boomers may need to rely on this program. The Social Security Trustees, who oversee the financial operations of the Social Security Trust Funds, estimate that the number of disabled workers and their families receiving benefits will increase by 50 percent by 2030, primarily due to the aging of the baby boom generation. The Social Security Administration has been making significant strides in the modernization of the SSDI program and operations. However, the scheduled increases in the normal Social Security retirement age, morbidity, and factors leading more and more Americans to work later into their lives, add to the challenges facing the SSDI program. The efficiency of this program and its solvency will be important to the economic security and well-being of millions of Americans over the course of their life spans.**											

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		Implementation Strategies:Create incentive and programs to facilitate Return to Work (RTW). Extend Medicare and Medicaid coverage for period of time after RTW. Create incentives for employers and nonprofits to help beneficiaries RTW. Enhance vocational rehabilitation services for beneficiaries. Eliminate disincentives for RTW such as: short trial work days, part-time employment penalties, definition of substitution gainful activity	X	X					X	X			
		Improve the SSDI Benefit by: 1. Eliminating waiting period by: beginning cash benefit on onset date and make Medicare available on onset date; 2. Do not take attorney fee from back benefit. Award attorney fees from separate fund as in Equal Access to Justices Act.	X	X									
		Improve the SSDI by 1. Creating expert resources to adjudicate difficult claims; 2. Streamlining the appeals process by a. Using more presumptive awards, b. Create financial and medical protection during prolonged appeals process; 3. Better exchange of information among disability systems; 4. Simplify application process; 5. Create a system of reimbursement for health care providers to assist patients in application process.											
		Provide medical or private insurance policy early in the claim (by 1st 30 days). Develop network of insurance companies using group purchase power.	X	X					X	X			
42	**Geriatric Health Care Continuum: Evaluate Payment and Coordination Policies in the Geriatric Health Care Continuum to Ensure Continuity of Care.**	**Overview:** **Medicare and the private sector are exploring various ways to better coordinate care for seniors with multiple conditions across the continuum of care. For example, the care of patients with complex conditions is being studied under a new Medicare demonstration to see if costs and patient outcomes can be improved. In addition, geriatric health care must meet the special needs of a broad array of services for the elderly with continuity across the continuum of care. Incentives that encourage Medicare service providers to serve recipients with complex needs in a high quality, cost-effective manner will become increasingly important as the baby boomers age.**											

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		Implementation Strategies:Congress should authorize a new geriatric assessment and care coordination benefit for frail elderly persons with multiple medical conditions or one medical condition and cognitive impairment that reimburses qualified providers that conduct one assessment and patient designated primary care providers who are responsible for coordinating with other providers, one patient and caregivers	X	X									
		Congress should commission a study to examine the current reimbursement structure for evaluation and management services, particularly as it applies to primary care providers and interdisciplinary teams, and how it serves patients with multiple chronic and complex conditions	X										
		Congress should mandate that the Centers for Medicare and Medicaid Services conduct demonstration projects: (1) that do not put providers at risk to evaluate reimbursement structures for interdisciplinary team care for beneficiaries that have multiple chronic conditions and (2) to evaluate reimbursement structures for interdisciplinary geriatric care, without putting provider participants at risk.	X										
		Promote increased use of electronic health records technology to ensure optimal communication and coordination of health care services to seniors across sites of care with all health care providers.				X	X	X	X	X	X		X
		To ensure stable funding sources, Congress should explore fiscally responsible approaches to combining social insurance, private insurance, individual saving and social welfare in new and innovative ways.	X										
43	**Shared Health Information: Encourage Appropriate Sharing Of Health Care Information Across Multiple Management Systems.**	**Overview:** **Agencies are exploring ways to share health information to support individual and population health care and referral needs. Ideally, health care providers would share information easily through a single gateway system. An electronic health record would allow providers in different locations to review a history of the patient's medical condition, current medications, and other records of care. Seniors with access to their electronic health care record could easily share copies of their histories with new health care providers or treatment facilities as needed. A one- stop gateway system would facilitate information and referral for elderly patients and their families during critical transitions in care. At the population level, exchange of**											

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		health information is crucial if systems are to detect and respond to outbreaks of disease and public health emergencies. Health and social support networks, however, have been slow to support and adopt electronic exchange of information.											
		Implementation Strategies: Establish incentives for development and implementation of health information technology (HIT) across all settings, which includes: the review of laws and regulations that serve as obstacles to establishing a single continuing care record with privacy and security attention; funding for such efforts; provide incentives to states that integrate health, community support and medical services into one statewide system; mandate that hospitals/health systems share data in a relational format and allow secure access for information exchange of electronic health record (EHR) wherever patients are shared between systems/providers.											X
		Create national/state/local databanks for health data, accessible to authorized users, with statistics like: recent test results (avoid expensive duplication); organ donation permission; advance directives; and define universal data set to be used. Establish national or regional standards for best practices, data sets to be maintained, and information portability in case of relocation (e.g., Katrina disaster).	X	X		X	X						X
		In one year, establish health data exchange standards (like dotnet, EDI) that must be used by providers in order to receive payment from government sources. Standards include records and pay information. All Medicare payments and billing will be part of the standards. They will be open standards available without cost penalty. All co-insurers must comply with the data exchange.	X	X									X

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		Establish universal standards with core elements for interoperable electronic exchange of personal health, wellness, long term care, clinical care, social services and disability information, with incentives for compliance and link payment in a timely fashion. This should include developing universal interfaces (middleware) to convert data elements from one system to another.	X	X									X
		Incent healthcare providers to keep notes, labs, directives, etc., in electronic format, and create a universal indexing system for that data.		X									X
		Federal and state regulatory agencies must make accommodations to review electronic medical records digitally without requiring providers to create redundant paper versions or burdensome conversions.	X	X									X
44	**Care for Seniors with Disabilities: Ensure Appropriate Care for Seniors with Disabilities**	**Overview:The American health care system is increasingly challenged to meet the community-based health care needs of the expanding population who are aging with or aging into disability. The lack of a seamless system of health care services and appropriately trained health care providers (including geriatricians, gero-pharmacists, and rehabilitation specialists) who understand the special health care needs of middle-aged and older adults with disabilities can all too often result in serious medical conditions and premature deaths due to incorrect diagnoses, inappropriate drug therapy, and inadequate management of secondary conditions resulting from a disability that could have been prevented. By providing early prevention and wellness services along with a seamless system of health services that ensures access to needed health care, the special needs of older adults with disabilities can be addressed effectively. The result can be a more effective, efficient system of health care that helps individuals with disabilities reside in the community, potentially prevents clinically unnecessary hospitalizations and nursing home placements, and potentially eliminates excessive health care costs.**											
		Implementation Strategies: Increase access to home and community-based rehabilitation services for individuals with disabilities who reside in the community (Medical Doctors, Occupational Therapists, Physical Therapists, Speech Language Therapists) that is, non-institutional long term care.	X	X	X	X	X	X	X	X	X		

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		Develop and implement training for direct service providers and for adults with disabilities, whether lifelong or late-onset, so that these providers and caregivers are better prepared to monitor and maintain the nutrition, wellness, medication management, and other health-related needs of these adults. Such training shall be funded initially by new federal demonstrations grant monies to all states, with special focus on family caregivers with low educational levels.		X		X	X						
		Amend the Older Americans Act to mandate the development and delivery of accessible assistive and universally designed technologies and environmental interventions to support living in least restrictive environments for people aging with a disability (including those aging with a disability and those developing a disability in later life).	X										
		Provide the information technology and linkages to facilitate integrated health care services to older adults with disabilities among all routinely engaged providers (eg. Geriatricians, internists, pharmacists, social workers, physical therapists, counselors, etc.)											X
		Promote replication of the ADRC (Aging Disability Resource Center) concept to include promotion of the clearinghouse approach for professionals, consumers and family members.	X										
		Amend the Older Americans Act to enable Americans with lifelong disabilities who experience premature aging before age 60 because of physical or intellectual disabilities, or a combination of both, to participate fully in the services and programs of this Act.	X										
		Congress shall provide funding to states to support a community-based health care system to meet the needs of aging individuals with disabilities by: a) allowing health care organizations to assist individuals in their own homes to the maximum extent possible. b) allowing payments for services rendered by family members and community organizations.	X										
		Establish mandatory requirements for the inclusion of disability-specific and gerontology-oriented educational curricula in formal training programs for all health and rehabilitation professionals and adapt their information for use in the training of informal care providers.	X	X									

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45	**Prosecution of Financial Crimes: Strengthen Law Enforcement Efforts at the Federal, State, and Local Level to Investigate and Prosecute Cases of Elder Financial Crime.**	**Overview:** **To effectively resolve cases of financial crimes against seniors, a variety of interdisciplinary expertise from the public and private sector (e.g., social, medical, legal, financial) must be brought together for collaboration. During the time it takes for a complicated case to reach trial, a victim's cognitive or physical heath may decline to the point that they are unable to testify. Successful outcomes in these cases often require close cooperation across traditional jurisdictions and professional boundaries. Law enforcement at the state and local level continues to face challenges in the identification, investigation, and prosecution of financial exploitation by persons known and trusted by their victims. Various studies have attempted to quantify estimates of financial exploitation, but have suffered from methodological challenges including non-uniform definitions of financial exploitation across state jurisdictions, and the lack of a standardized national reporting system.**											
		Implementation Strategies: Pass Elder Justice Act: Enact and fully fund comprehensive justice legislation to address elder abuse, guaranteeing protection for older Americans and building the capacity of APS programs in every state. a. Clearing house for support training b. Expand APS funding to ensure adequate case managers to investigate and support the coordination of cases and prosecution. Include better training for workers. c. Increase penalties for those who are prosecuted for crimes against the elderly. d. National model for APS and definitions for abuse & monitoring.	X	X		X	X	X	X	X		X	
		Develop a national adult protective office within DOJ to oversee development of accessible and interdisciplinary training for judges / prosecutors / law enforcement in detecting and prosecuting crimes against the elderly and vulnerable adults on the state, local, tribal level for a coordinated approach.	X	X			X	X				X	
		Promote elder abuse awareness including a postage stamp (similar to breast cancer stamp).	X										

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		Use proven models and enact legislation and funding to create rapid response financial abuse specialist teams nationwide to increase prosecution of financial crimes.											
		Enact and fully fund comprehensive elder justice legislation to address elder abuse, building capacity of APS programs nationwide with specific funds & focus on elder financial abuse exploitation.	X										
		Create public / private partnership for the training of police officers. Conduct a Public Awareness campaign using PSA's, the press, and other media outlets to educate the public about: a. Training b. Education c. National hotline d. Scams prevention e. Database Management.	X										
		Fund research in all aspects of elder mistreatment including financial exploitation, self neglect, physical & sexual abuse, and caregiver neglect. Include research competency issues, cultural sensitivity issues, and evaluation of programs. Widely disseminate research results.	X										
		Establish Regional rapid response task forces to include prosecutors, law enforcement (federal, state, local), and social workers to assist victims and follow-up	X	X									
		Strengthen the justice system to include better competency evaluations, guardianship reform, and coordination and alignment with the national caregiver system. Expand victim advocate programs for specially trained staff to work with elder victims.	X	X			X						
		Consequences for perpetrators: a. Vigorously prosecute; force restriction when convicted b. Background checks for those working on the elderly abuse cases c. Prioritize when we have DNA materials	X										
		Strengthen federal laws and programs addressing elder abuse, including the Elder Justice Act, social services block grant, the OAA (especially Title VII, including first time funding of the Native Americans Program), the victims of crime act and the Violence Against Women Act by increased appropriations and improvements through reauthorization.	X	X	X								

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46	**Program Alignment and Performance: Review Alignment of Government Programs That Deliver Services to Older Americans Review Alignment of Government Programs That Deliver Services to Older Americans**	**Overview:** **In order to provide effective and efficient program service delivery to older Americans in areas of government funded health care, social services, transportation, and housing programs, it is important that these programs and services are consolidated and aligned within and between federal agencies. Departmental sub-divisions within federal agencies, and programs housed in separate federal agencies, often overlap are duplicative, and may fail to coordinate services. For example, there are 75 federal transportation programs, multiple housing programs with conflicting selection criteria and myriad prevention programs. Yet, in 2001 the Administration created the President's Management Agenda of which one component was the use of performance budgeting to guide agency budgets. The Office of Management and Budget introduced an instrument to measure program efficiency within federal agencies, the Program Assessment Rating Tool. The aging of the U.S. population is expected to increase demand for a broad array of health care and social support services, transportation, and housing programs. The degree to which the nation's federal agencies are coordinated, aligned, well consolidated, and accountable will greatly determine the ability of older Americans to access quality services in the 21st century.**											
		Implementation Strategies: The National Academy of Public Administration should be charged with a review of program alignment, resolution of duplication and overlap drawing on the advice of a panel of experts outside the government for the purpose of making recommendations to the Domestic Policy Council. The Domestic Policy Council will then proceed with an appropriate administrative action and legislative proposals that incorporate the following principles: a. coordinated longitudinal services across the spectrum of medical and social services including housing, transportation, caregiver support, nutrition and medical care; b. integration of funding streams; c. pay for performance for a continuity of care; d. consolidation of databases; e. ongoing evaluation incorporating technological innovation; and f. sunsetting and coordinated reauthorization considering cost effectiveness, assessment of program integrity and results.	X										

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		The President and Congress shall insure flexibility in the use of federal monies for transportation in non-urban communities to insure the most efficient use of resources and to promote coordination of services based on local needs of all older Americans.	X										
		Make sure Department of Labor and AoA work closely to implement Title V program. Ensure national aging organizations (Minority) have a greater voice at table and bigger share of pie. Rationale- Most national aging organizations have suffered since some of the $$ have gone to state and other non-profits. Most Title V participants currently are employed by programs funded under AoA – senior centers.	X										
47	**Capacity for Safe Driving: Support Older Drivers to Retain Mobility and Independence through Strategies to Continue Safe Driving.**	**Overview:Senior-friendly road and vehicle design, older driver screening, assessment, and rehabilitation, and a greater focus on maintaining the "driving health" of seniors is essential to enable Americans to continue driving safely for as long as possible. The ability to drive allows Americans to live, work, and travel virtually anywhere they choose. Drivers over age 70 are about 19 million today, up from about 13 million a decade ago. In 1980, there were nearly 9 million drivers, age 70 and over; by 2000, there were almost 19 million. This is a 111 percent increase in older drivers since 1980. Although each person is affected by aging differently, older drivers may have physical and cognitive changes that will affect their ability to drive safely. Since older Americans rely on their car for 90% of their trips (followed by walking at 8%), functional limitations that affect their ability to drive safely are a major challenge to their independence. In addition, drivers over 65 are more likely to die in crashes than drivers under 64, because of the inability to withstand injuries, so prevention is important. Improvements that help seniors drive safely longer benefit drivers of all ages.**											
		Implementation Strategies: Establish staff and fund a Senior Mobility Office of the U.S. Secretary of Transportation to ensure that the mobility needs of seniors are taken into account in the development of relevant federal policies programs.	X										

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2005 White House Conference on Aging
Resolutions, Overviews and Implementation Strategies(IS) with Strongest and Strong Support

#	Titles/Resolutions	Implementation Strategies	Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions										
			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Ensure availability of coordinated, interdisciplinary assessment of functional skills necessary for driving and for rehabilitation to achieve safe drivers. This includes: a. training of health professionals (physicans, occupational therapists, social workers, etc.) and b. reimbursement for their services, c. educate community (including family members, police, etc.) to recognize and ensure states provide immunity for those who report). Develop multi-level self/prof assessment of older drivers; self-assessment, screening tool by professionals, evaluation by certified driving evaluation. Develop and use community based screening that identifies a person's need for a mid-level evaluation conducted as part of the IADL independent activity of daily living skills and allow graded designation levels of driving restrictions. Support a system for screening, assessment, and rehabilitation of drivers based on their functional abilities (visual) and driving health with the goal of maintaining driving as long as safely possible working with state licensing agencies and public-private sector. Promote graduated driver licensing.		X	X		X	X	X	X	X	X	X
		Safer and easier-to-use roadways, walkways, and automobiles. Provide incentives for state and local governments to incorporate senior-friendly road design into all road upkeep/construction efforts and provide incentives for manufacturers to develop and incorporate vehicle designs that accommodate older driver's needs. Mandate FHWA design guidelines for older drivers incentives for following guidelines for states/communities. Support a system for screening, assessment, and rehabilitation of drivers based on their functional abilities (visual) and driving health with the goal of maintaining driving as long as safely possible working with state licensing agencies and public-private sector.		X	X	X	X		X	X			

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2005 White House Conference on Aging
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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		State and local governments will follow FHWA highway design guidelines for older adult drivers as a condition of receiving any federal highway construction funds. Require (and provide incentives for) all levels of government to incorporate senior friendly road design and pedestrians "into road construction and require manufacturers to follow standards to be established for senior on vehicle design including (but not limited to) headlight brightness and elevation. Build the capacity of the aging network to provide/broker/coordinate older driver safety programs which include education, assessment, rehabilitation, and referral to mobility management assistance to ease the transition to other transportation options. Roadway improvements design to assist seniors to navigate the road (i.e. FTA highway guidelines).	X	X	X	X							
		Support a system for screening, assessment, rehabilitation, and training of drivers (and on their functional abilities with the goal of driving safely longer—include Medicare reimbursement as a funding strategy. Specifically addressed mobility management assistance for services as they transition to other transportation options.	X	X	X	X	X	X	X	X	X	X	X
		Implement driver re-testing across the life-span that includes sensory evaluation and recommendations to maintain safe driving skills. Provide resources and incentives for local community partners, like senior centers, to implement "best practices," like senior safety resource centers and others, to help driver identify options and/or improve driving skills.	X	X	X	X	X	X	X	X	X	X	X
		Develop multi-level self/professional assessment of older drivers; self-assessment, screening tool by professionals, evaluation by certified driving evaluation. Ensure availability of coordinated, interdisciplinary assessment of functional skills necessary for driving and for rehabilitation to achieve safe drivers. This includes: a) training of health professionals (physicans, occupational therapists, social workers, etc.) and b) reimbursement for their services, c). educate community (including family members, police, etc.) to recognize and ensure states provide immunity for those who report).		X	X	X	X	X	X	X	X	X	X
		Provide tax incentives to auto makers/seniors to make/purchase senior-friendly autos—also incentives for car refitting using trained volunteers. Provide funding to adapt vehicles and provide incentives for the consumer to purchase for safe driving.	X				X	X	X	X	X	X	X

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2005 White House Conference on Aging
Resolutions, Overviews and Implementation Strategies(IS) with Strongest and Strong Support

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Incentives for older drivers to complete driver safety education.								X			
		Early cataract and early contrast causes four times increases in collisions in elderly: 1) Instruct Medicare to pay for vision screening. 2). Remove barriers -includes fraud threat to early cataract surgery and other sight restoration.											
		Federal health insurance (eg Medicare) must pay for driving education for older adults, driving evaluation and driver skill training which must be provided by a qualified professional. Evaluation standards and intervention techniques must be based on evidence based research. The goal of this strategy is to extend the period of safe driving.	X	X	X			X	X	X			
48	**Innovative Housing Designs: Expand Opportunities for Developing Innovative Housing Designs for Seniors' Needs.**	**Overview:** **American seniors are demanding innovative housing designs to accommodate their changing lifestyle, mobility needs, and desire for remaining active in their communities. Across the United States, developers and local governments have experimented with housing options that range from home modification to large campus integrated services. Each design reflects regional differences in attitudes, demand, opportunities, and familiarity with emerging innovations. The most common design element is for safety, but the preferences of older Americans are much broader. They include individual choice in interior designs; convenient access to entertainment, family, and services; and opportunities for pursuing physical and mental vitality.**											
		Implementation Strategies: Change zoning and building regulations to allow for good senior housing options including single family housing, congregate living options, shared housing, and public housing											
		Adequately fund retrofitting, rehabilitation and home modifications using universal design principles through housing, health, and LTC so older people can age in place	X										

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			Federal	State	Tribal	Local	Community	Individual	Private Sector	Business & Industry	Nonprofit	Boomers	Technology
		Encourage the incorporation of universal design into new housing for people of all ages and abilities through education and training of builders, developers, designers, local officials, and consumers, and through tax incentives such as tax credits and property tax abatement.	X	X			X					X	
		Encourage local building codes to require universal design, including, but not limited to wide doorways, turning radiuses, lower light switches, barrier-free showers, grab bars, and good lighting		X		X							
		Educate developers, operators, architects, and consumers about housing that incorporates senior and universal design, personal preferences of future residents, that includes technology, accommodation of private supplemental help and that encourages socialization					X		X	X	X		
		Change zoning and building regulations to allow for denser senior housing communities in residential areas.		X		X							
		Improve the constructions of manufactured homes and improve placement of that home on the building site. This is especially true for homes sold into hurricane, chronic flood, and earthquake prone areas.					X		X	X			
		Provide for the education and re-education of, and incentives for remodelers, architects, engineers, and builders to incorporate elements of universal design, home modifications and smart technology in all construction.		X			X						

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49	**Patient Advocacy: Improve Patient Advocacy to Assist Patients in and Across All Care Settings**	**Overview:When one is not feeling well, navigating our health care systems without assistance can be challenging and at times intimidating. The frail elderly, those with cognitive impairments, persons with complex medical conditions or mental illness, adults with disabilities, and people at the end of life often need assistance in order to receive the care they want or need. Many older people, minorities, immigrants, and those with low incomes are disproportionately more likely to have trouble reading and understanding written information and may not know how to get assistance, resulting in poorer care and higher health care costs. At least 4.5 million elderly Americans have dementia caused by Alzheimer's disease, vascular disease and other conditions. More than half of people with serious chronic conditions see three or more different physicians and many see other health and social service providers. Twenty-three percent of Medicare beneficiaries have five or more chronic conditions; on average they have nearly 15 physician visits and fill over 50 prescriptions each year. Health care can be very complicated, confusing and needed most by those who can least advocate for themselves.**											
		Implementation Strategies: Develop an advocacy program that utilizes trained advocates to assist seniors and their families to navigate the health care and social service system. Include access to regional aging and disability resource centers.Utilize trained staff and volunteers, expand the existing long term care Ombudsman program, and work with seniors throughout the continuum of care, wherever they live.											
		States should strive to have compatible information systems that are shared between all health and social services. Information should be direct, to the point and available in accessible and alternative formats.				X	X						X
		Promote and implement independent care navigators (who perform advocacy, coordination, etc) for all those with multiple social and health needs.				X	X						X

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			Target Groups to Implement the Strategy as Suggested by Delegates in Individual Sessions										
50	**Prescription Drug Improvements: Promote Enrollment of Seniors into the Medicare Prescription Drug Program.**	**Overview:Beginning in 2006, the Medicare Prescription Drug, Improvement and Modernization Act (MMA) will offer pharmacy benefits to 42 million Medicare beneficiaries. All seniors, regardless of income, health status, or prescription drug usage, will have access to this prescription drug coverage. In a 2003 national survey of Medicare beneficiaries age 65 and older, more than one-quarter reported no prescription coverage, and nearly half of low-income seniors in some states lacked coverage.Because this new benefit will help seniors live healthier lives and save money, it is important that all Medicare beneficiaries and those who care for them understand the benefits of this MMA coverage. Innovative strategies to encourage enrollment and streamline implementation will be important to the aging population.**											
		Implementation Strategies: Increase outreach education to family caregivers, doctors, pharmacists, and nursing homes utilizing AAAs, Native American program, other volunteers, and long term care ombudsmen with specific instructions on drug companion tools on www.medicare.gov.			X	X	X						X
		Provide adequate funding and other support to community-based organizations to find, assist, and enroll beneficiaries, using benchmarking methodologies to identify and disseminate cost-effective strategies for LIS outreach and enrollment to target funding. Provide special emphasis and funding for groups serving minority and rural populations. Instruct CMS to formalize the implementation role and to fund the Aging Network to provide necessary one-on-one counseling assistance to beneficiaries. Fund state-specific and grass roots outreach and assistance with public education on the nature of insurance and with the education of health professionals on how to help clients use community support.	X	X		X	X				X		

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		Eliminate the asset test for low income recipients to receive assistance. Allow employees with employer plans the opportunity to correct mistakes in enrollment so they retain coverage and allow individuals to switch plans at any time during 2006.	X										
		Extend the period of enrollment without penalty through 2006. Streamline and simplify enrollment.	X										

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CHAPTER 3

DELEGATES AND COMMITTEE MEMBERS

- Delegates by States
- Policy Committee Members
- Advisory Committee Members

Delegates by States

Delegates to the 2005 White House Conference on Aging

ALABAMA

A.J. Benintende .... Gulf Shores
Gayle Boswell ....Montgomery
Sylvia Bowers ....Montgomery
Shari Burnum.......................................Madison
Irene Collins ....Montgomery
Jerald D. Fox .... Huntsville
Randall H. Frost .... Anniston
Melissa Galvin............................... Birmingham
Hon. Jamie Ison ....Mobile
Richard Heinzman ....Montgomery
Jean Ann Moon .... Guntersville
Gray Price ....Montgomery
Nancy Robertson .... Huntsville
Edwina Rogers .... Washington, DC
Betty Ruth..Athens
Herb Sichler .... Lineville
Bill Voight .... Birmingham

Buford Rolin (Poarch Creek)*** .... Atmore

ALASKA

Patricia Branson ....Kodiak
George P. Charles .... Anchorage
Katherine "Mike" Dalton.................... Fairbanks
Laraine Derr ....Juneau
Elmer Feltz ....Wasilla
Gloria McCutcheon .... Anchorage
Ed Zastrow...Ketchikan

AMERICAN SAMOA

Tuiteleleapaga P. Fue .... Pago Pago
Roy Willis .... Pago Pago

ARIZONA

Ruben Alvarez ....Phoenix
Mary Beals-Luedtka .... Flagstaff
Laura Beckman .... Scottsdale
Lee Begay ....Phoenix
Chad Denham.......................................Phoenix
David Dran ....Phoenix
Katie Dusenberry................................... Tucson
Nancy K.Gilliam ....Phoenix
Anna Jolivet .... Tucson
Carol A. Kratz .... Scottsdale

Barbara Matteson .... Tucson
Janet Menke ....Chandler
Kathleen Pagels................................. Scottsdale
Elizabeth Rohn-Nelson .... Sun City
Joseph Skehen.............................Fountain Hills
Melanie Starns ....Phoenix
Lenore Stuart .... Yuma
Daniel Taylor ....Mesa
James Weir .... Scottsdale
C. Harold Willingham........................... Pinetop

ARKANSAS

Marlene Brengard...............................Paragould
Frank Broyles .... Fayetteville
Deborah Carman..........................N. Little Rock
John V. Diaz ....Maumelle
Diane Harry ....Hot Springs
Jean Killian ....DeQueen
Fred W. Ley .... Bentonville
David Lipschitz ....Little Rock
Jack MacDonald................................Fort Smith
Art Robertson...................................Little Rock
Esther Silver-Parker .... Rogers
Beth Vaughan-Worbel .... Springdale
Larry Wright .... Springdale
Randall Wyatt ....Little Rock

CALIFORNIA

Pauline Abbott ....Fullerton
Ernest Ayala................................San Francisco
Maria Bagwell .... Montebello
Donna R. Bashaw .... Laguna Hills
Diana Bethel .... Carmel
Bert Bettis...................................... Sacremento
Eileen A. Bostwick ....Ukiah
Roland Boucher ....Irvine
Jacque Brown ....Grass Valley
Leo Burke ....Stockton
Carl A. Burton .... Sacramento
Pearl Caldwell .... Cupertino
Gloria H. Cavanaugh .... San Francisco
Lawson Chadwick.............................Oceanside
Patricia Clarke .... Anderson
Lora Connelly.......................................Elk Grove
Thomas Craft ....Quartz Hill
Karla Crawford .... Sacramento
William H. Dailey, Jr................................ Fresno
Bobbie Day.................................... Yorba Linda
Castulo De La Rocha ....Los Angeles
Helen M. Dennis......................Redondo Beach
Deborah Dinkelacker .... San Francisco
Marilyn Ditty..............................Laguna Woods
Bernice V. Doan.......................................Visalia
Paul Downey ....San Diego
Sandra L. Dugan-Harp ....Granite Bay
Gloria Duran ....Santa Fe Springs
Ken Dychtwald............................ San Francisco
Celia J. Esquivel .... Sacramento
Carroll Estes .... San Francisco
Luis Farias .... Folsom
Sandra K. Fitzpatrick .... Sacramento
Don Floyd .... Boulevard
Paula J. Fong.......................................Pasadena
Moira Fordyce .... Laguna Niguel
James Forsyth..................................... Hayward
Mary S. Furlong .... Lafayette
Rafael Garcia ....Canyon Country
James M. Glickman....................Woodland Hills
James "Jim" Gomez......................... Sacramento
Bill Gonzalez ....Fontana
Erica T. Goode .... San Francisco

CALIFORNIA (CONTINUED)

Don Gormley .... Atwater
Ted Gregor .... Carlsbad
Therese Grenier .... Pasadena
Michael Gunther Maher .... Sacramento
Jennie Chin Hansen .... San Francisco
Sally Hershfield .... Los Angeles
Colleen House .... Oxnard
Donald Hunt .... Simi Valley
Cecelia Hurwich .... Berkeley
Joanna Kim Selby .... El Cerrito
Laverne R. Joseph .... Long Beach
Mario Juarez .... East Los Angeles
Bruce Juell .... Palos Verdes Estates
Kay Kallender .... Pleasanton
Mitchell Kamin .... Los Angeles
Helen Karr .... Pacifica
Joann Keyston .... Sebastopol
Janice Ivey Smith .... Stockton
Sandra S. King .... Los Angeles
Melodye Kleinman .... Santa Monica
Esther L. Koch .... San Mateo
Mary Ellen Kullman Courtwright .... Long Beach
Tsuann Kuo .... Rosemead
Carmela G. Lacayo .... Pasadena
Henry Lacayo .... Newbury Park
Jorge Lambrinos .... Pasadena
Jim Levy .... Anaheim
Nancy E. Luttropp .... Rohnert Park
Anne Mack .... Palo Alto
Betty Malks .... San Jose
Raymond Mastalish .... Palm Springs
Phyllis M. McGraw .... La Quinta
Billie Jo Medders .... Bakersfield
Mark Moran .... La Quinta
Wesley K. Mukoyama .... Santa Clara
Betty Mulholland .... Oakland
Kori S. Novak .... Turlock
Dolores Olson .... Newberry Springs
Mary Anne O’Neal .... Carson
Deborah Owdom .... San Mateo
Variny Paladino .... Richmond
Betty Perry .... Sacramento
Brenda Perry .... Antioch
Don Peterson .... Oakdale
Paul Peterson .... Gardena
Robert Petty .... Monterey
Cheryl Phillips .... Carmichael
Yolanda Prado .... Bakersfield
Jon Pynoos .... Los Angeles
June Reese .... Rancho Cucamonga
David B. Reuben .... Los Angeles
Ric Rickles .... West Hollywood
Lynn W. Rolston .... Sacramento
Marvin Schachter .... Pasadena
Timothy Schwab .... Huntington Beach
Thomas Shea .... Alhambra
Tim Sheahan .... San Marcos
June Simmons .... Burbank
Michelle Steel .... Palos Verdes
O.V. Smith .... Los Angeles
Sandy Smoley .... Fair Oaks
Sarah Steenhausen .... Sacramento
Marie Torres .... Commerce
Fernando Torres-Gil .... Los Angeles
Laura Trejo .... Los Angeles
Larry W. Trujillo .... Mission Viejo
J.R. “Josh” Valdez .... Thousand Oaks
Richard Wall .... San Francisco
Monika White .... Santa Monica
Cynthia White-Parks .... San Diego
George “Bud” Winslow .... Capitola

Hope Witkowsky .... Torrance
Mary Beth Wolford .... Eureka
Leah Wyman .... Long Beach
Barbara J. Young .... Canyon Lake

Juana Majel-Dixon (Pauma/Yuima)***
.... Pauma Valley

COLORADO

Stephen Bender .... Colorado Springs
Janice M. Blanchard .... Denver
Eileen Doherty .... Denver
Brent Green .... Denver
Cathy Grimm .... Denver
Jeanette L. Hensley .... Denver
Joyce Humiston-Berger .... Mancos
Barb Martig .... Lafayette
Ed Pittock .... Denver
David Rivera .... Denver
Mark Shelton .... Fort Collins
Janet Snipes .... Aurora
Kathleen Turley .... Centennial
Michael Wasserman .... Englewood
John Zabawa .... Denver
Jan Zavislan .... Denver

CONNECTICUT

Elaine Adams .... Enfield
Frederick Biebel .... Stratford
Antonietta Boucher .... Wilton
Pierrette Comulada Silverman .... New Haven
James Crean .... Watertown
Linda DeLorenzo .... Bridgeport
Pamela A. Giannini .... Hartford
Carl F. Gundlach .... Torrington
Deepak Gupta .... Stamford
Michael Karwan .... New Britain
Susan Lather .... Enfield
Kevin Lynch .... West Hartford
Kathleen A. Murphy .... Hartford
Edith Prague .... Hartford
Joyce Ruddock .... Westport
Scott G. Sleyster .... Hartford
Judith Stein .... Willimantic
Sandra Timmerman .... Hartford
Raymond Welnicki .... Hartford

DISTRICT OF COLUMBIA

Ramon Barquin
Ria M. Benedict
Russell Bodoff
Sam Brunelli
James F. Burris
Donna M. Butts
Joy M. Cameron
Elizabeth J. Clark
Judith A. Cranford
Yanira Cruz
William Daroff
Hal Daub
Donald L. Davis
F. John Duncan, Jr.
James P. Firman
Martha E. Ford
Elizabeth S. Fox
Michael G. Franc
Val J. Halamandaris
Alice H. Hedt
Cindy Hounsell
Laura Howard
Andrew J. Imparato
Janet M. Jacobson

DISTRICT OF COLUMBIA (CONTINUED)

Juan Jaso
Jonathan Javitt
David C. John
Patricia R. Johnson
Karyne Jones
Diane Justice
John D. Kemp
James A. Klein
Stephan Kline
Frank "Joe" Lessen
Dr. Ronald F. Levant
Brian Lindberg
Mario Loyola
Stephen McConnell
Charles Mendoza
William W. Millar
William "Larry" Minnix
Hector Morales
Samuel Morgante
Christina Morrow
Hon. Ruby G. Moy
Jane Marie Mulvey
Chris Myrick
Charles E. Nelson
E. Veronica Pace*
Daniel Perry
Anne Phelps
Lino Piedra
Lori J. Porter
Robin Read
Gerald A. Reed
Stephen Regenstreif
Susan Rogers**
Charles Sabatino
Ken J. Salaets
Dallas Salisbury
Kent E. Schiner
Bandana Shrestha
Ethel S. Siris
Betsy M. Sprouse
Anne M. Taylor
Mark J. Ugoretz
Mary L. Watts
Ouida H. Williams
Bruce A. Yarwood
Laurie M. Young

* appointed by Mayor Anthony Williams

** appointed by Del. Eleanor Holmes Norton

DELAWARE

Evangeline E. Austin........................ Wilmington
C. Regina Byers ....Dover
Carolyn Fredricks ....Dover
Sandy Richards ....New Castle
Charles Welch.................................... Hockessin
Allan R. Zaback ....New Castle

FLORIDA

Mary Adams ....Jacksonville
G. Richard Ambrosius ....Middleburg
John Anderson ....Cocoa Beach
Milton Aponte................................. Cooper City
Susan J. Aziz ....Boynton Beach
Samira Beckwith ....Fort Myers
Diane Booth .... Ocala
Cathy Brown...................................St. Augustine
Norm Bungard .... St. Petersburg
Modesto Burgos...Miami
Fran Carlin-Rogers ....Orlando
Bob Carter .... Sarasota
Christine Cauffield .... Sarasota

John Cavanaugh ....Pensacola
Ken Connor ....Leesburg, VA
Marie E. Cowart .... Tallahassee
Janet C. Crozier ....Jacksonville
Faye Culp .... Tampa
Austin R. Curry .... Tampa
Bethany Dougherty ....Jacksonville
Joseph T. Doyle .... Naples
Carl Eisdorfer ....Miami
Linda Engelbrecht .... Sarasota
Jaclynn Faffer .... Boca Raton
Antonio Fransetta .... Wellington
Richard E. Gans ....Seminole
Keith Gooden ....Orlando
Effie Grear ....Belle Glade
James Handley ....Cocoa Beach
Sylvia Iriondo ....Miami
Evelyn Jordan ....Miami
Charles Kane ....Stuart
Debbie Kleinberg ....North Miami
Edith Lederberg ....Fort Lauderdale
Miguel A. Lopez ....Orlando
Barbara Lumpkin ....Orlando
Paul Malley .... Tallahassee
William Mann .... Gainesville
Hon. Ralph Marrinson ....Fort Lauderdale
Sue Maxwell ....Fort Myers
Robert McFalls ....West Palm Beach
Rhonda Medows ....Jacksonville
Peggy A. Miller .... Lauderhill
Carol Novak .... Clearwater
Alice O'Reilly .... Lakeland
Maria Cristina Oliva ....Miami
Ramon Perez-Dorrbecker ....Miami
Luanne Reese .... St. Petersburg
Hannah Robinson ....Spring Hill
Rene Rodriguez ....Washington, DC
Rocky Rodriguez ....Fort Lauderdale
Max B. Rothman ....N. Miami
Sheila Salyer .... Tallahassee
Sen. Debby Sanderson ....Fort Lauderdale
Linda Scribante ....Sanibel Island
Madaline Simpson ....Orange Park
Mary Terrell ....Orlando
Angela Vazquez ....Miami
Gail Weisberg .... Sunrise
Nancy S. Wellman ....Miami
Patrick Whelan .... Safety Harbor

GEORGIA

Jim Anchors ....Marrietta
Rutherford J. Brice .... Decatur
Douglas Burr ....Roswell
Richard Callan ....Augusta
Carleen Cumberbatch .... Lithonia
Wilmer Dickey ....Macon
Kathryn Fowler ....Athens
Pat Freeman .... Gainesville
Maria Greene .... Marietta
Stephanie Grenier ....Auburn
James Harris ....College Park
Kay Hind ....Albany
Warren Jones ....Rome
Becky A. Kurtz ....Atlanta
Edwin H. Morgens ....Atlanta
Abel Ortiz ....Atlanta
Melba Paulk ....Ocillia
Neil L. Pruitt ....Atlanta
Ronald W. Schoeffler ....Augusta
Jerry Stoner .... Fayetteville
Louis Sullivan ....Atlanta
Monica Walters .... Barnesville

GEORGIA (CONTINUED)

Steven Weiniger .... Conyers
Diane Williamson .... Atlanta
William A. Woolery .... Warner Robins
Billy Wooten .... Richmond Hill

GUAM

Vince Atalig .... Hagatna
Art San Agustin .... Mangilao

HAWAII

Albert Hamai .... Honolulu
Brenda Ho .... Hilo
Julie Jow .... Honolulu
Roy K. Katsuda .... Kahului
Carol Kikkawa-Ward .... Honolulu
Karen Miyake .... Honolulu
Remedios S. Rueda .... Honolulu
Pat Sasaki .... Honolulu
Kealoha Takahashi .... Lihue
John Tomoso .... Wailuku
Mark R. Zeug .... Honolulu

Hon. Haunani Apoliona (Native Hawaiian)***
.... Honolulu

IDAHO

Melinda Adams .... Boise
Sandra Ashworth .... Bonners Ferry
Lois Bauer .... Boise
Richard Compton .... Coeur d'Alene
Stephen Montamat .... Boise
Gladys B. Schroeder .... Boise
Brenda S. Shappee .... Hailey
Russell Spain .... Idaho Falls
Frances Symms .... Boise
Kristen H. Tracy .... Boise
Wilfred Watkins .... Nampa
Jenny E. Zorens .... Lewiston

ILLINOIS

Identa Austin .... Yorkville
Diana Burke .... Rockford
Colleen Ceh .... Oak Brook
Charles Crowder .... Flora
Rebecca Cruz .... Chicago
Patrick J. Daly .... Chicago
Julie Degnan .... Chicago
Brenda Eheart .... Rantoul
Elaine Eisold .... Morris
Janet Ellis .... Rockford
Nancy Flowers .... Evanston
Joyce Gallagher .... Chicago
Daniel D. Garrett .... Chicago
Robyn L. Golden .... Chicago
Murray A. Gordon .... Deerfield
Margaret Hastings .... Chicago
Tamar Heller .... Chicago
Jeff Hoffman .... Chicago
Carol Humphries Jones .... Chicago
Nancy Jameson .... Carthage
Charles Johnson .... Springfield
Mary E. Johnson .... Bloomington
Donald Jurivich .... Chicago
Frederick P. Karutz .... Chicago
Paul Kobi .... Jackson, MN
Jonathan Lavin .... Oak Park
Maralee I. Lindley .... Springfield
Pamela A. Macfarlane .... DeKalb
Michael J. O'Donnell .... Bloomington
Elizabeth O'Grady .... Chicago
Kerry Peck .... Chicago

Anthony Perry .... Chicago
Eli Pick .... Des Plaines
Rebecca Reeves .... Chicago
Diane Saunders .... Bellwood
Jane Thomas .... Barrington
Joanne Thomas .... Peoria
Eugene Verdu .... Belleville
Bernarda Wong .... Chicago
Cheryl Woodson .... Chicago Heights
Nancy Zweibel .... Chicago

INDIANA

Joyce Alexa .... Valparaiso
Sally Beckley .... Dillsboro
Connie Beran .... Indianapolis
Robert Bond .... Fort Wayne
Jackie Bouyea .... North Vernon
Elaine J. Brovont .... Lafayette
David N. Frizzell .... Indianapolis
Phyllis Golden .... Kirklin
Nancy Griffin .... Indianapolis
Don Heckard .... Logansport
Anne Jacoby .... Vincennes
Judy Kratzner .... Anderson
Willard Mays .... Indianapolis
R. Matthew Neff .... Indianapolis
Mary Jane Phillippe .... Greenwood
Marie Roberts .... Jeffersonville
Dianne Shappell .... Fort Wayne
Cody Sipe .... West Lafayette
Marilyn Waffle .... Fort Wayne

IOWA

Robert Bender .... West Des Moines
Hon. Nancy Boettger .... Harlan
Howard Cowen .... Iowa City
Pete Conroy .... Mason City
Di Findley .... Des Moines
Richard Freeman .... Des Moines
Gwen Gadberry .... Hoodsport, WA
Donna K. Harvey .... Waterloo
Dana Holland .... Ottumwa
Curley Hultman .... Waterloo
Robert W. Kretzinger .... Johnston
Denise Nelson .... Rock Valley
John Ortega .... Bettendorf
Pat Scott .... Des Moines
Rev. Robert Welsh .... Iowa City

KANSAS

Hon. Bob Bethell .... Alden
Jessie Bryant .... Newton
Rosemary Chapin .... Lawrence
David Geist .... Dodge City
Julie Govert Walter .... Manhattan
Kathy Greenlee .... Topeka
Pamela Johnson-Betts .... Topeka
Colette M. Panchot .... Overland Park
Janet Splitter .... Lorraine
Annette Thornburgh .... Topeka
Barbara Withee .... Manhattan
Debra H. Zehr .... Topeka

KENTUCKY

Kelly Abell .... Louisville
William M. Altman .... Louisville
Barry Barker .... Louisville
Patricia Bingham .... Pineville
Bonnie Boland .... Louisville
Judy Cederholm .... Bardstown
Bill Cooper .... Frankfort
Pat Dressman .... Fort Mitchell

KENTUCKY (CONTINUED)

George Hall .... Fort Thomas
Mary Middleton.................................. Covington
Charlotte Whittaker .... Hartford
Karen Wyan .... London
Isabel Yates ....Lexington

LOUISIANA

Shirley Akers............................... St. Martinsville
Charles Cefalu................................New Orleans
Anthony DiLeo* ....New Orleans
Neill E. Edwards ....Opelousas
W. Patrick Gahan............................Baton Rouge
Paul Glanville .... Shreveport
Marie Martin .... Sulphur
Jim Myrick .... Leesville
Susan Nelson.................................Baton Rouge
Louis Prejean ....Baton Rouge
Howard Rogers...............................New Orleans
Godfry White ....Baton Rouge
Doug Wilkinson .... Port Allen

* Also appointed as WHCoA Advisory Committee Member

MAINE

Paulette Beaudon ....Biddeford
Guy W. Bertsch .... Portland
John Carr .... York
Catherine Cobb.................................... Augusta
Laurel M. Coleman ....Manchester
Nelson Durgin.. Bangor
Steve Farnham .... Presque Isle
Roger Hare..................................... West Buxton
Sue Shaw ....Penobscot

MARYLAND

Amoke Alakoye .... Rockville
Carol Baker..Denton
Patricia Bayliss .... Baltimore
Marianne Hyang Nam Brackney .... Columbia
Judith Cato .... Camp Springs
Donna Crocker ....College Park
Nguyen M. Chau............................. Garrett Park
Arnold Eppel ....Towson
Janie Geer .... Baltimore
Louise Gulyas.................................... Ocean City
Lawrence Herman .... Queenstown
Austin Heyman .... Bethesda
Clyde Horton................................ Gaithersburg
James F. Jorkasky................................. Rockville
Som Karamchetty .... Columbia
Juan Lara .... Silver Spring
Carol Lienhard ....Bel Air
Sherree Marshall..........................Princess Anne
Sabrina Massett ....Frederick
Daniel Mintz .... North Bethesda
Jonathan Musher........................North Potomac
Jean Oberstar ....Potomac
Jean Roesser ....Potomac
Lori Ross .... Arnold
John P. Salmen............................... Takoma Park
Mike Vivirito .... Middle River
Martin Wish.................................. Silver Spring

MASSACHUSETTS

Alan Abrams.....................................Cambridge
Elisabeth Babcock ....Boston
Juergen H. Bludau ....Boston
Jennifer Carey ....Boston
Shirley Y. Chao ....Boston
Yung-Ping Chen ....Boston

Andrea L. Cohen .... Newton
Sandra Cortese .... Pocasset
Maureen Curley .... Medford
Stephen J. Devaney .... Boston
Richard W. DeVaul .... Cambridge
Christine DiPietro .... Malden
Robert Dwyer .... West Boylston
Ronald Feinstein .... Framingham
Elsie Fetterman .... Amherst
Seymour Friedland .... Waltham
Paula K. Friedman .... Boston
Madeleine Gelsinon .... Sudbury
James Gibbons .... Clinton
Jeffrey Gopen .... Swampscott
Joanne Handy .... Charlestown/Boston
Norma Millett .... West Groton
Franklin Ollivierre .... Chestnut Hill
Thomas T. Perls .... Boston
Charlie Sisson .... New Bedford
Peter J. Smail .... Boston
Michael Smyer .... Chestnut Hill
Tillyruth Teixeira .... Boston

MICHIGAN

Norman Abeles .... East Lansing
Ginny Bailey .... Onstead
Paul Bridgewater .... Detroit
Charles Chambers .... Southfield
Nick Ciaramitaro .... Roseville
Kathy Crawford .... Novi
Georgia Durga .... Traverse City
Larry Erlandson .... Holland
Mohamed F. Farrag .... Dearborn
Willie Felder .... Detroit
Michael A. Flory .... Okemos
Sharon Gire .... Lansing
Alison Hirschel .... East Lansing
Lynn Kellogg .... St. Joseph
Jerutha Kennedy .... Lansing
Kathryn Lawter .... Columbiaville
Jonathan Mead .... Escanaba
Marye Miller .... Rochester
Suzan Ogland-Hand .... Grand Rapids
Lori Offenbecher .... Caro
Tene-Sandra Ramsey .... Detroit
Edgar Scribner .... Ann Arbor
Aaron Simonton .... Monroe
Roscoe Stuber .... Howell
Renee Wood .... Caro

MINNESOTA

Sandra J. Anderson .... Minneapolis
Ward Armstrong .... Minneapolis
Allan Baumgartan .... Minneapolis
Hon. Willis Branning .... Apple Valley
Steven Chies .... Cambridge
Loren Coleman .... St. Paul
Thomas Dwyer .... Coon Rapids
Michael Farley .... Minneapolis
Maria Gomez .... St. Paul
Jan Hively .... Minneapolis
Clayton Jenson .... Detroit Lakes
Eugene Kasper .... Annandale
John Mach .... Minnetonka
Jeanette Metz .... Mound
Dan Mikel .... South Saint Paul
Lois Quam .... Washington, DC
Catherine Sampson .... Duluth
Gene Short .... Belview
Julie Storm .... Mankato
Eric Tangalos .... Rochester
John Troup .... St. Louis Park

MINNESOTA (CONTINUED)

Jim Varpness.......... St. Paul

Margaret Moss (Mandan/Hidatsa/Arikara)***
.... Minneapolis

MISSISSIPPI

Bettye Burgess.......... Jackson
Hon. Terry Burton.......... Newton
Freda Bush.......... Jackson
Pat Fordice.......... Madison
Geneise Hitt.......... Oxford
Mark Meeks.......... Jackson
Warren Housley.......... Mississippi State
William Hawley.......... Carriere
Hon. Alan Nunnelee.......... Tupelo
Marion Tutor.......... Jackson

MISSOURI

Ann R. Bannes.......... St. Louis
Janice Bramwell.......... Buffalo
MaryLou Brennan.......... Hannibal
Debra Cochran.......... Chesterfield
David Duncan.......... Mound City
Jeffery Kerr.......... Rolla
Marcia Kerz.......... St. Louis
Lt. Gov. Peter Kinder.......... Jefferson City
Dorothy Knowles.......... Springfield
Brenda Lax.......... Kansas City
Loyd Matthews.......... Poplar Bluff
Nancy McAnaugh.......... Jefferson City
Angeletta McCormick Franks.......... St. Louis
Nancy Morrow-Howell.......... St. Louis
Hila Newman.......... Kansas City
Gregory J. Reynders.......... St. Louis
Hon. Betty Sims.......... Jefferson City
Susan Stark.......... St. Louis
Ollie Stewart.......... St. Louis

MONTANA

Chuckie Cramer.......... Helena
Wally D. Daeley.......... Lambert
Susan Kohler.......... Missoula
Fred Lark.......... Lewistown
Mary Mumby.......... Kalispell
Polly Nikolaisen.......... Kalispell

Rosemary Bremner***.......... Browning (Blackfeet)
Cynthia LaCounte***
.... Bainville (Turtle Mountain Chippewa)

NEBRASKA

Frank Barrett.......... Omaha
Anthony Fulton.......... Lincoln
Paul R. Hogan.......... Omaha
Ritch Miller.......... Omaha
Dick Nelson.......... Lincoln
Kenneth Niedan.......... Hershey
Shirley June Pederson.......... Lincoln
Jan Thayer.......... Grand Island

NEVADA

Janice Ayres.......... Carson City
Marietta Bobba.......... Reno
Socorro Castro.......... Las Vegas
Derek M.D. Chen.......... Las Vegas
Barbara A. Hirshorn.......... Las Vegas
Vivenne Kerns.......... Las Vegas
Ken Lange.......... Las Vegas
Mary Liveratti.......... Carson City
Erik Olsen.......... Glenbrook
Herb Perry.......... Las Vegas

Maggie Petrel ....Henderson
Carol Sala..Carson City
Mary Ann Salmon ....Las Vegas
Lawrence Weiss .... Reno

Larry Curley (Fallon-Paiute Shoshone)***
.... Fallon

NEW HAMPSHIRE

Stephen J. Bartels.................................Lebanon
Juliana Bergeron .... Keene
Paul E. Forte ....Portsmouth
Stephen Gorin .... Canterbury
Hon. Mary Griffin ....Windham
Stephen Mathieu ....Manchester
Barbara Salvatore................................. Bedford
Todd Ringelstein .... Central Harbor

NEW JERSEY

LaVerne Alexander................. Washington, D.C.
Marilyn Askin .... West Orange
Victor Barrera .... West New York
Howard Berger ....Margate
Margaret R. Chester.................. New Brunswick
Bill Crosby ....Somerville
Michael I. Falcon ....Pennington
Bert Goldberg............................East Brunswick
Richard H. Greenberg...................Mount Laurel
Marilyn Higgins ....Spring Lake
Allan M. Kleinman.............................. Westfield
Mary Kuzinski .... Wayne
Sy Larson ....East Brunswick
Althea Lowe .... Mendham
D. Jane Maloney................................Toms River
Mary Ann Martin ....Oceanport
Mary Lou McCutcheon .... Newton
Joy Merulla .... Camden
Robert A. Mosby................................ Eatontown
Marie-Elena O'Connor......................Toms River
Patricia Polansky.................................... Trenton
Paul A. Sarlo ....Wood-Ridge
Sharron S. Schultz .... Salem
Anwar Feroz Siddiqi .... Hillsborough
Douglas Struyk...................................... Wyckoff
Renee Swartz... Rumson
Gloria Willich .... Lawrenceville

NEW MEXICO

Debbie Armstrong .... Santa Fe
Russell Boor .... Las Cruces
Frieda A. Clark.............................. Albuquerque
Salome DeAguero .... Santa Fe
Virginia Huber .... Las Cruces
Ellen Leitzer .... Albuquerque
Mary A. Martinez .... Albuquerque
Traci L. McClellan .... Albuquerque
Bernice A. Morfin............................Ojo Caliente
Mary K. Ousley............................. Albuquerque
Linda Sechovec .... Albuquerque
Ernesto J. Stolpe............................... Las Cruces
J. Alex Valdez .... Santa Fe

Gov. Joe Garcia***
....................San Juan Pueblo (San Juan Pueblo)
Cecilia Nez (Navajo)***..................... Crownpoint
Regis Pecos***.............Santa Fe (Cochiti Pueblo)

NEW YORK

Robert Abrams ....Lake Success
Linda Barrington .... New York
John Beale .... Poughkeepsie
Kathleen M. Beichert........................... New York

NEW YORK (CONTINUED)

Judith Binney .... New York
Angela Blackley .... Middleport
Myrna Blyth .... New York
Patricia A. Bomba .... Rochester
Robert N. Butler .... New York
Suleika Cabrera .... New York
Rev. Eugene Callender .... New York
Ellen Camerieri .... Bronx
Mae Carpenter .... Mt. Vernon
Shian James Chang .... Niskayuna
Geraldine Chapey .... New York
Kathleen E. Christensen .... New York
Edward Creegan .... Levittown
Gloria Coles .... New York
Ann Marie Cook .... Rochester
Michael Cooley .... Cohoes
Lawrence E. Davidow .... Islandia
William Dionne .... New York
Rose W. Dobrof .... New York
Lt. Gov. Mary Donohue .... Albany
Robert Eaton .... Setauket
Eva A. Eng .... New York
Don Ezra .... New York
Msgr. Charles J. Fahey .... Bronx
Lorrie G. Foster .... New York
Lisa Gaudet .... Troy
Diane Gherson .... Somers
George K. Gleason .... Clifton Park
Carl V.Granger .... Amherst
O. Lewis Harris .... New York
Brian F. Hofland .... New York
Carol Hunt .... Jamaica
Rena Iacono .... Lido Beach
Igal Jellinek .... New York
Rev. Carol Jubenville .... New Hartford
Enis L. Jurado-Nieves .... New Windsor
Carl F. Kaelber .... New York
Diana J. Kalman .... New York
Mark Kissinger .... Albany
Dennis Kodner .... New York
Mary Krause .... Canastota
Mark Lachs .... New York
Neal Lane .... Albany
Evelyn Laureano .... Bronx
Edwin Mendez-Santiago .... New York
Ann Merlino .... Staten Island
Elizabeth Mullin-DiProsa .... Rochester
Sharon Mullon .... Uniondale
Joseph Murphy .... Rye
Stanley Nussbaum .... Atlantic Beach
Hon. May Newburger .... Mineola
Alberta L. Orr .... New York
Marilyn Pinsky .... Syracuse
Carol Rodat .... Albany
Vincent J. Russo .... Westbury
Elizabeth Sanders .... Brooklyn
Jeri Sedlar .... New York
Talbott Smith .... New York
William Smith .... Bronx
Susan Somers .... Rensselaer
Alice Spratley .... Brooklyn
Irene Wald Stein .... Ithaca
Cynthia Stuen .... New York
Jeanette Takamura .... New York
Ramon Tallaj .... New York
Frederick W. Telling .... New York
Kimberley Toot .... Belmont
Norman Volk .... New York
Patricia Wojcik .... Cheektowaga
Nat Yalowitz .... New York
Thomas Yandeau .... Catskill

NORTH CAROLINA

Millie Anderson .... Atlantic Beach
Harriett Bannon.................................... Hickory
Herb B. Berkowitz........................... Wilmington
Delilah Blanks.................................Riegelwood
Dan Blazer.. Durham
Hon. Alice Bordsen................................ Raleigh
Roxanne Bragg-Cash ....Louisburg
Dean Burgess ....Winston-Salem
Jan Busby-Whitehead.......................Chapel Hill
Hon. Robert Carpenter......................... Franklin
Anne R. Daniel ....Greensboro
Doris Dick .... Yadkinville
Dr. Anne I. Dickerson .... Greenville
Beverly Earle .... Raleigh
Richard Eldridge .... Salisbury
Karen Gottovi .... Raleigh
Betty Hutchinson Wiser .... Raleigh
Ann Johnson ....Chapel Hill
Carla Marshburn .... Raleigh
Dan Owens..Charlotte
Lt. Gov. Beverly Perdue.......................... Raleigh
Jean Reaves ....Weldon
Leonard Trujillo .... Greenville
Ellen Whitlock.................................Greensboro
Gayla Woody ....Charlotte

Bruce Jones (Lumbee)***......................... Raleigh

NORTH DAKOTA

Frederick Baker................................. New Town
Clayton Jensen................. Detroit Lakes (Minn)
Dallas Knudson...................................... Towner
Clyde Leimberer .... Bismarck
Shelly Peterson .... Bismarck
Kent Yohe... Fargo

Gloria Jetty Lefthand***
........................St. Michaels (Spirit Lake Dakota)

NORTHERN MARIANA ISLANDS

Juan L. Babauta...................................... Saipan

OHIO

Terry Allton....................................... Columbus
Georgia Anetzberger...................... South Euclid
Christine Baumgardner .... Columbus
Robert Binstock ....Cleveland
Judith Brachman............................... Columbus
Richard Browdie ....Cleveland
George Brown .... Batavia
Samuel Burnett .... Toledo
Sharon Burns .... Upper Arlington
Sandy Calvert ....Medina
Toni Dodge .... Columbus
Carol Farquhar .... Dayton
Donna Frederick.............................. Springfield
Merle Griff .... Canton
Ronald Hill .... Twinsburg
Alice Holder.......................................Cincinnati
Leonard Hubert .... Granville
Billie Johnson .... Toledo
Hon. Merle Kearns........................... Springfield
Ronald Levant ....Copley
Rebecca Liebes .... Toledo
Belle Likover.............................. Shaker Heights
Donelda McWilliams ....Defiance
Donald Medd ....Youngstown
Harry Meshel..................................Youngstown
Marva Mitchell....................................... Dayton
Marc Molea .... Columbus
Janice Monks..................................... Columbus
Virginia Ragan.................................. Westerville

OHIO (CONTINUED)

Carol Ridenour................................Wapakoneta
Allen Riggs...Dayton
Judith Saurers.....................................Mansfield
Cynthia Stever.................................... Hamilton
Helene Stone...Lorain
Phyllis Suhar ....Cambridge
Mickie K. Timmons................................. Mason
Carl Wick .... Centerville
Lynn Wieland .... Brooklyn
J. Williams...Springfield
Stephen Wing....................................Twinsburg
Jean Wise ....Edon

OKLAHOMA

Denise Bender .... Oklahoma City
Kathleen Briggs...................................Stillwater
Lynne Bussell ....Enid
Theo Crawley .... Weleetka
Mynan Hutto... Duncan
Mich Magness............................ Oklahoma City
Scott Pilgrim...Edmond
Roger Scott ....Jenks
Mary Lee Warren ....Stillwater
Pat Woods .... Ada
Rev. George E. Young .... Oklahoma City

Maudean Harden***
.....Oklahoma City (Choctaw Nation Oklahoma)
Stephen Wilson***
..............................Okmulgee (Muscogee Creek)

OREGON

Roger A. Anunsen ....Jefferson
James Davis..Portland
Barry Donenfeld .... Salem
Eric Dishman .... Beaverton
Joella Ewing... Eugene
Chris Flammang .... Coos Bay
Nellie Fox-Edwards............................ Beaverton
Bernard Gorter..................................Milwaukie
Lee Hazelwood ....Stayton
Girard Lee... Salem
Lydia Lundberg.................................Milwaukie
Midori J. Monroe .... Portland
Van Moore .... Salem
Verna Porter .... Portland
Florence J. Turner .... Portland

PENNSYLVANIA

Lt. Gov. Catherine Baker Knoll.......... Harrisburg
Sam Bianco ....Vandling
Judith Black .... Pittsburgh
Carole A. Briggs.................................Brookville
Im Ja P. Choi ....Abington
Edward D'Alessio..............................Bryn Mawr
Ruth Damsker .... Norristown
Cynthia Dellecker .... Pittsburgh
John A. Diffey ....Kennett Square
Hon. Todd Eachus............................. Harrisburg
Joseph Farrone.......................................Ashland
Elizabeth Fry ....Reinholds
Daniel Haimowitz..............................Levittown
Kathleen S. Hamby ....Warminster
Lynn Fields Harris.......................... Philadelphia
Mahnaz Harrison............................... Pittsburgh
Stanley A. Holbrook........................... Pittsburgh
William Johnston-Walsh .... Harrisburg
Charles Kane ....Doylestown
Gail Kass .... Philadelphia
Linda Levy ....Ardmore
Arlene Lund...................................... Bethlehem

Barton Margoshes .... Philadelphia
Marvin Mashner ....West Point
William McNabb............................. Valley Forge
Oliver Montgomery ....Verona
Steven Niebler.................................. Gettysburg
John Robb.. Meadville
Pedro Rodriguez .... Philadelphia
Mary Louise Schweikert.................. Mifflinburg
Leonard R. Sempier .... Harrisburg
Alan Smith.. Bedford
Christine Trainer...................................Reading
Ruth Villa ....Jerome
Rodney Williams .... Philadelphia
Bruce Wyman.. Media

PUERTO RICO

Rossana Lopez-Leon ....San Juan
Adolfo Perez-Comas.............................San Juan
Angel Reyes ....San Juan
Ramon Ruiz...San Juan

RHODE ISLAND

Kathleen Connell...............................Providence
Joan Crawley .... Pawtucket
William Finelli................................Narragansett
Anne Gardella .... Middletown
Angelo Rotella .... Smithfield
Corinne Calise Russo........................... Cranston
Terrie Fox Wetle................................Providence

SOUTH CAROLINA

Lt. Gov. Andre Bauer...........................Columbia
Antonio B. Boyd ....Columbia
Gilbert Bradham .... Charleston
Thomas Brown....................................Columbia
Marie E. Cardenas .... Rock Hill
Roberta Combs .... Charleston
Norma Curtis ....McCormick
Harris Davis.................................... Orangeburg
Bill Dukes .... Chapin
Cornelia Gibbons...............................Columbia
Eileen Hayward... Salem
Ollie Johnson......................................Columbia
Nancy J. Muller .... Charleston
Lynn Stockman ....Newberry
Randolph W. Thomas .... Blythewood

SOUTH DAKOTA

David Horazdovsky............................Sioux Falls
Marguerite Kleven .... Sturgis
Elsie Meeks.............. Rapid City (Oglala Lakota)
Patricia Miller..Pierre
Mandy Plucker .... Washington, DC
Richard Schleusener.......................... Rapid City
Terry Shoener.................................... Rapid City

TENNESSEE

John Arriola .... Nashville
Sherry Black ....Chattanooga
Ernestine Bowers .... Nashville
Aaron Bradley .... Knoxville
Deborah Cotney..................................Memphis
Margaret Fleming .... Covington
Lester Gingold.....................................Memphis
Jacquie Holloway .... Oak Ridge
Peggy Houston .... Crossville
Tom Hylemon .... Kingsport
Kenneth Mitchell ....Chattanooga
Nancy Peace .... Nashville
Joshua M. Roman .... Lakeland
Ruthann Shelton..................................Memphis
Kathleen Spears ....Memphis

TENNESSEE (CONTINUED)

Viston Taylor ....Chattanooga
Dixie Taylor-Huff ....Lebanon
Kathy Whitaker ....Johnson City

TEXAS

Isaias E. Aguayo .... Mission
Ivan Arceneaux ....Galveston
Manuela Arroyos...............................Rosenberg
Carolyn Banks ....Bastrop
Lucia Bonno ....Houston
Willie Boone ....Houston
Fran Brown....................................... Carrollton
Winfree Brown .... Christoval
Samuel Ward Casscells ....Houston
Maryann Choi ....Georgetown
Leah Cohen ....Austin
Christopher Colenda .... College Station
Robin Dawley........................... Nacogdoches
Walter J. De Foy................................Sugar Land
Adam Dominguez ....El Paso
Dr. Carmel Dyer ....Houston
Barbara Effenberger .... Seguin
Thomas Fairchild..............................Fort Worth
Allan S. Fox .... Tyler
Oscar Garcia ....Fort Worth
Shirley Garrison ....Lubbock
Meghan Gerety ....San Antonio
Jose Gonzalez.......................................McAllen
Albert Hawkins ....Austin
Carlos W. Higgins ....Austin
Jim Hin ....Austin
Adelaide Horn ....Austin
Larry Imhoff ....Corpus Christi
Charlene James ....Houston
Jodie Jiles ....Houston
Karen Johnson ....Austin
Wilson Jones.. Dallas
Ramona Kennedy .... Flower Mound
Sandra S. Kolb Harris.........................Fort Worth
Suzanne A. Krenz ....Houston
Chris Kyker ....Abilene
Homer Lear ....San Antonio
David Leopard .... Richardson
Jennifer Mason................................ Richardson
Elia Mata ....Houston
Audrey McDonald...........................Georgetown
Karen McKibben .... The Woodlands
Hon. Jane Nelson ....Lewisville
Al J. Notzon ....San Antonio
Dennis M. O`Brien ....Austin
Thomas Oliver ....Austin
Charlotte Parks .... Ben Wheeler
Marilyn Pattillo ....Austin
Jose Perez ....Donna
Glen Provost ....Lubbock
Carolyn D. Rice .... Plano
Adan Rios ....Houston
Steve Saldana ....San Antonio
Miguel San Juan ....Houston
Constance Smith .... Dallas
Betty Streckfuss.......................................Spring
Betty Trotter ....Amarillo
Jill Warren ....Austin
Hazel Wright.. Sherman
Carol Zernial ....San Antonio

UTAH

Bonnie Athas................................Salt Lake City
Myla Dutton .... Provo
Marvin Fifield.. Logan
Hon. Patricia Jones ....Salt Lake City

David Lauritzen .... Bountiful
James Mason .... Farmington
Betty McCarty .... St. George
Alan Ormsby .... Salt Lake City
Kendall R. Surfass .... Salt Lake City

VERMONT

Lt. Gov. Brian Dubie .... Montpelier
Naomi K. Fukagawa .... Burlington
Harriet Goodwin .... South Woodstock
Nancy Lang .... Burlington
Phil Mamber .... Randolph
Joan Senecal .... Waterbury

VIRGINIA

Fred Anderson .... Vinton
Edward F. Ansello .... Richmond
Cheryl Bartholomew .... Vienna
Julia O. Beamish .... Blacksburg
Mara Benner .... Alexandria
Eve Marie Boertlein .... McLean
Lt. Col Ronda G. Bollwahn .... Alexandria
Sally Boofer .... Arlington
Enid A. Borden .... Alexandria
Helen M. Cockrell .... Front Royal
Catherine Colgan .... Virginia Beach
Ann Collins .... Springfield
Scott Daniels .... Richmond
Shirley Darnauer .... Virginia Beach
Ric Edelman .... Fairfax
Charles L. Fallis .... Alexandria
Patti Ferguson .... Chesapeake
Jade Gong .... Arlington
Charles W. Gould .... Alexandria
Richard Grimes .... Fairfax
Leon Harper .... Dale City
Margaret Heckler .... Arlington
Jill B. Kagan .... Annandale
Lucia Bonno .... Houston
Vicken Kalbian .... Winchester
Paul Klaassen .... McLean
Vola Lawson .... Alexandria
Richard Lindsay .... Charlottesville
Sandra Markwood .... Alexandria
Marilyn Maxwell .... Big Stone Gap
Cheryl McQueary .... Arlington
Ruth Nelson .... Fredericksburg
Ruby L. Norris .... Topping
Sr. Alice Marie Quinn .... Alexandria
Jack Rafuse .... Alexandria
Joel M. Reaser .... Arlington
Judi Reid .... Richmond
Katie Roeper .... Richmond
Virginia Russell .... Richmond
Jay H. Sanders .... McLean
Jarvis E. Saunders .... Chesapeake
Miguel Serrano .... Alexandria
Matthew T. Thornhill .... Richmond
Janet S. Trautwein .... Arlington
William Tucker .... Hampton
Gordon Walker .... Charlottesville

U.S. VIRGIN ISLANDS

Dorene James .... St. Croix
Michal Rhymer-Charles .... St. Thomas

WASHINGTON

Amy L. Ai .... Seattle
Ann Ballard .... Seattle
John R. Barnett .... Kirkland
Fran Bessermin .... Nine Mile Falls
Kari Burrell .... Olympia

WASHINGTON (CONTINUED)

Victoria Doerper .... Bellingham
Esther Gregg...Rosburg
Marta Guevara .... Bellingham
Maria Hernandez-Peck .... Spokane
Timothy Hockett.............................Port Angeles
William Holayter...................................Shelton
Norma Kelsey..................................Des Moines
Steve Kofahl..Everett
Kathy Leitch .... Olympia
Connie G. Meyers .... Seattle
Dennis Miller .... Kennewick
Bill Morton .... Bellevue
Carolyn J. North ....Clinton
Will Parry .... Seattle
Charley Reed .... Olympia
Bruce Reeves .... Olympia
Brian Ropp ....Wenatchee
Helen Spencer....................................... Yakima
Mary Skinner.. Olympia
Elizabeth Taylor .... Bainbridge Isle

James DeLaCruz (Quinalt)*** .... Tahola

WEST VIRGINIA

David K. Brown ....Morgantown
William Davis .... Charleston
Vicki Douglas .... Martinsburg
Polly Diller....................................... Charleston
Daniel Farley .... Princeton
Dinah Mills.. Weston
Shirley Roby .... Belmont
Sandra K. Vanin................................ Charleston

WISCONSIN

Pete Crear .... Fitchburg
Roger L. DeMark .... South Milwaukee
Donald Desch .... Burlington
Ricardo Diaz..................................... Milwaukee
Helen Marks Dicks...............................Madison
Donne Eggert ....Madison
Patricia Finder-Stone ....DePere
Tom Frazier ....Madison
Betty Havlik .... Hillsboro
Sandra Mahkorn .... Milwaukee
Mary Nell Mally....................................Madison
Donna McDowell.................................Madison
George McKinney .... Milwaukee
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