Surgeon General's Workshop

Health Promotion and Aging

Proceedings

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SURGEON GENERAL'S WORKSHOP

Health Promotion and Aging

Proceedings

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Note: ***All opinions contained in these contents represent the viewpoint solely of the authors and participants and do not necessarily represent the viewpoint of the Office of the Surgeon General, the Public Health Service and its constituent Agencies, or the Editors.***

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PREFACE

As with any effort that seeks to take a somewhat disparate body of knowledge and attempt to create uniformity and concensus, the final product may not be exactly what was expected. In this instance of trying to assimilate all of the scientific knowledge and experience about health promotion activities in aging populations into a coherent body or recommendations and policy options, the product is more than expected! In addition to the insight that the 180 invited guests for this Surgeon General's Workshop on Health Promotion and Aging were able to provide individually, the cohesive and often synergistic results of their deliberations have given the Public Health Service and the much larger aging audience a view of what is possible.

Instead of individual agendas, the larger picture has been shaped before us and the vision is clear. That vision is the ability to provide research, support and services that will allow the years in later life to remain as full and fruitful as those in the earlier years. Although the prospect of death is certainly inevitable to all of us, that period prior to death may well afford some of the truly golden years of life. In addition to these years being golden for the individuals, the ability to use their wealth of personal knowledge and experience to enrich society and the extented family units and communities is immense.

The seed of ideas and potential areas of activity are presented in this final report with its recommendations. The participants at the Workshop present to the much larger audience of interested parties our blueprint for the nation in health promotion and aging. I join with you in seeking now to implement these ideas and options so that our aging society is provided with the maximum impact of our corporate knowledge for the benefit of the health of all senior members.

C. Everett Koop, M.D., Sc.D.
Surgeon General

CONTENTS

Opening Plenary Session

Keynote Address
Surgeon General C. Everett Koop 1
United States Public Health Service

Address
Carol Fraser Fisk, Commissioner 5
Administration on Aging

Address
Assistant Surgeon General T. Franklin Williams 9
Director, National Institute on Aging

Plenary Session

"Health Promotion and Surgeon General's Workshop" 14
Assistant Surgeon General David Sundwall, Administrator
Health Resources and Services Administration

"Year 2000 Health Objectives for the Nation" 20
Assistant Surgeon General J. Michael McGinnis, Director
Office of Disease Prevention and Health Promotion

"Legislative and Administration Interests in
Geriatric Health Promotion" 26
Roger Herdman, M.D.,
Assistant Director for Health and Life Sciences,
Office of Technology Assessment
U.S. Congress

"Setting the Pace in Geriatric Health Promotion"

"Healthy Older People" 35
Susan Maloney
Office of Disease Prevention and Health Promotion

"Project Age Well" 41
Anthony Vuturo, M.D.
School of Medicine, University of Arizona

"International Geriatric Health Promotion Study/Activities" 49
David Macfayden, M.D., former Manager
WHO Global Programme for Health for the Elderly

Charge to Participants
Surgeon General C. Everett Koop 54
United States Public Health Service

Plenary Session

Recommendations of Working Groups:
Alcohol 57
Dental (Oral) Health 60
Physical Fitness and Exercise 63
Injury Prevention 67
Medications 70
Mental Health 74
Nutrition 80
Preventive Health Services 84
Smoking Cessation 88

Response to Recommendations 94
Surgeon General C. Everett Koop
United States Public Health Service

List of Participants 103

OPENING PLENARY SESSION

Keynote Address

Presented by C. Everett Koop, MD
Surgeon General, United States Public Health Service
Sunday evening, March 20, 1988

Thank you, Dr. Abdellah.

I want to personally welcome you and thank you all for coming to this Surgeon General's Workshop on Health Promotion and Aging.

We have three days of serious deliberation, illuminating discussion, and—I sincerely hope—innovative thinking ahead of us. The outcome should help point us—and society—in worthwhile directions for the future.

Many people have worked long and hard to make this workshop happen. If I had an extra hour or so, I would gladly name and thank each one of them personally.

That's not possible. However, with your understanding and permission, let me—at the very least—extend a word of special thanks to Dr. Faye Abdellah, Deputy Surgeon General of the U. S. Public Health Service, whose guiding hand has been subtle but essential throughout the planning process, and to Senior Pharmacist Steven Moore, lent to us from the Food and Drug Administration, who accomplished all the thousands of planning and administrative details that enabled us to get here today—equipped and on time.

To both of you ... thank you very, very much.

I do not want to monopolize the podium and steal time away from my good friends and colleagues, Commissioner on Aging Carol Fraser Fisk, and Dr. Frank Williams, Director of the National Institute on Aging. So I will limit my remarks to a brief review of how we got here ... and why ... and for what purpose.

Early in 1984 the Department of Health and Human Services launched a major initiative to encourage the public and private sectors—at all levels, national, regional, state, and local—to work together on promoting the health of America's older citizens.

The U.S. Public Health Service and the Administration on Aging shortly thereafter signed an agreement in which we pledged to do a number of things together in order to invest this health promotion initiative with increased momentum and importance.

And there *has* been a great deal of momentum generated throughout the country on behalf of older Americans:

- Every state now has a lead agency of its own to spearhead the health promotion effort...

- There are some 35 state interagency coalitions at work to promote the health of older Americans...
- A National Public Education Program, called the "Healthy Older Persons Campaign," has raised the consciousness of tens of thousands of older men and women concerning the benefits of promoting their own health, instead of just passively waiting and hoping for the best...
- At the Federal level, the agencies and offices of the U. S. Public Health Service itself have been actively engaged in this cooperative effort, but chief among them has been the work of the Office of Disease Prevention and Health Promotion, directed by Dr. Michael McGinnis. You'll hear more about that tomorrow morning.

A key element of this P.H.S.—A.0.A. cooperative venture is our mutual pledge to do what we can to help prepare all health professionals—physicians, nurses, dentists, nutritionists, social workers, pharmacists, and so on—for the eventual "graying of America."

I don't have to repeat the demographic projections. I'm sure you're quite familiar with the numbers.

But those projections are much more than mere numbers. Those are projections about the lives of real people—flesh-and-blood men and women who will be old and who will need a certain level and type of health care that, I'm afraid, is still not very well understood, much less practiced, in our society today.

And that's why seven components of the Public Health Service and the Administration on Aging agreed to jointly plan and conduct a "Surgeon General's Workshop on Health Promotion and Aging."

I'm delighted to add that the Henry J. Kaiser Family Foundation and the Brookdale Foundation are supporting the workshop.

Also, we have included six graduate and professional students who will be pursuing careers in geriatrics and will serve as working group members.

We wanted it to be a workshop in which the spectrum of health care disciplines would be well represented and all of them would be challenged to think creatively and pro-actively about ways to promote good physical and mental health among people age 65 and older.

That's the kind of workshop we wanted—and, I'm pleased to say, that's the kind we got.

The emphasis here is emphatically upon the promotion of good health. But let's be clear on at least one point.

We don't believe health promotion needs to take place *at the expense* of good curative medical care.

And it ought not to occur at the expense of good rehabilitative medicine.

And certainly not at the expense of good research into the disease processes and disabling conditions that often interfere with the normal and healthful processes of aging.

Rather, we believe that health professionals can put much greater emphasis on health promotion without compromising *in any way* the more traditional and still effective approaches to health care.

We believe that this *must* be done ... we're here to say that it *can* be done ... and by noon on Wednesday, we will tell the health community *how it might be done* on behalf of the elderly and the very old.

I don't expect us to be prescriptive in this workshop. But I *do* hope that the recommendations generated by the work sessions tomorrow and Tuesday are clear enough and direct enough that health professionals everywhere can immediately see the relevance of the health promotion concept to their own particular disciplines or practice.

What then should we keep in mind?

First, we ought to focus on ways to sensitize the health professions to the specific risk factors of older people—and then how to reduce or even eliminate those risk factors from the lives of one's patients.

Second, we need to re-examine the way we organize and deliver our medical, dental, nursing, and other health-related services to see if we can change—once and for all—their built-in *post facto* bias. Health care ought to be just as effective—or even *more* effective—*before* illness strikes.

And third, we need to do these things with some sense of what we hope to accomplish *overall* for our country's older citizens.

Older people—like people of all ages—do not live in a vacuum:

- They work in places that are pleasant—and in places that aren't so pleasant...
- Their human relationships may be loving and caring, or difficult and stressful ...
- They may have financial independence, or they may be totally dependent on family or Government to provide all their basic needs ...
- And finally, the phrase "the graying of American" can be misleading. *More* of us will have gray or white hair—(or no hair at all). But *most* Americans—about 80 percent of the population—will be young or middle-aged. Hence, older people will still be living in a society in which *all* age groups compete for attention ... and for resources.

I was reminded of this just the other day, when I read that the rock star Bruce Springsteen is going on a nationwide tour that will earn him millions and millions of dollars.

And while he's singing to enthusiastic audiences of young people, another group will also be on a national concert tour of their own. In fact, I saw them on TV last night in New Orleans. They're the so-called "Rat Pack"—Frank Sinatra, Dean Martin, and Sammy Davis, Jr.. We are told that these gentlemen also expect to earn millions of dollars from the enthusiastic sextugenarians who will show up at *their* concerts.

It was an interesting juxtaposition of news items. And whether or not you'll attend either or neither of those concerts, you still have to be impressed by the inter-generational vitality that is already emerging in our society ... a vitality that is, in itself, a reflection of generally good physical and mental health among the American people.

In other words, we have every reasons to be optimistic and adventurous in our thinking at this workshop, because we're not here to *reverse* the direction of America's health status, but rather to be built on—and

accelerate—the progress in health that Americans have achieved over the past decade or two.

This is an exciting period in the history of health care in America:

- The yield of the research community has been prodigious, with much more yet to come.
- The nation is more health-conscious and more *pro*-health than at any time in our history.
- And it's a period in which *all* Americans are more sensitive and more responsive to the health needs of their fellow citizens ... regardless of race, sex, ethnic origin, *or age*.

We have, therefore, an extraordinary opportunity to help our citizens not only to live a few years longer, but also to make those extra years—and indeed *all* the years of their lives—good and healthful years.

Now it's time to hear from my two distinguished colleagues, Commissioner Carol Fraser Fisk and Dr. Frank Williams. But rest assured, I'm not ducking out. In fact, I'll be back at this podium tomorrow to present my "charge" to the working groups.

Then, on Wednesday, Commissioner Carol Fraser Fisk, Dr. Williams, and I will return to hear your recommendations and speak to the next phase of this initiative. But we will not be inactive meanwhile.

You will also note from your agenda that things don't end there either. Following the close of the workshop on Wednesday morning, there will be an afternoon public hearing, one of a series of such hearings that have been held throughout the country.

At this Washington, DC hearing, our workshop recommendations will become part of the development of our National Public Health "Objectives for the Nation for the Year 2000."

Thus, we will make sure that aging concerns are given the prominence they deserve in the evolution of those national objectives.

You're all invited to that open hearing and I hope many of you will attend.

Between now and then, we've got a lot of work to do.

So let's do it. Let's do it together. And let's start now.

Dr. Abdellah, the microphone is yours.

Thank you.

Address

Presented by Carol Fraser Fisk
Commissioner of Aging, Administration on Aging
Sunday evening, March 20, 1988

Good afternoon. It's a pleasure to join in welcoming you to this important meeting. This conference is a very significant event, for through it I hope we will help more older Americans have a healthy old age.

Over the past several years, we have made significant progress in making health and social service providers more aware of the concepts of health promotion. Through this joint AoA/PHS initiative, countless numbers of older persons have participated in health promotion activities. Now it is time for us to take a look at what we have learned from these and other activities and to chart a course for future action.

It is a special pleasure to join Surgeon General Koop and Dr. Williams in this venture. The vision of the Surgeon General has helped mobilize the Public Health Service and all of us to undertake health promotion activities, including those which led to our having this conference. The creativity of Dr. Frank Williams has helped us forge even stronger collaborative ventures. And, the vigilance of the Deputy Surgeon General, Dr. Faye Abdellah, has helped us produce practical results time and time again. It is indeed an honor for me to join these distinguished national leaders here today.

As Dr. Koop has already said, we know a good deal about the older population. Let me highlight just a few statistics that may startle you. Today, one in nine Americans is over sixty years old. By the year 2030, one in four persons, or twenty-five percent of our population will be over sixty. In fact, in the next twenty-five years, the population over sixty will more than double. Among the elderly, the fastest growing segment will continue to be that over eighty-five years. Today, one in fifteen is over 85. By the year 2030, one in ten will be over 85 years old.

The impact of those demographic changes in society today is significant, and that impact will continue to grow as the numbers of older Americans continues to increase. All segments and institutions of our society will need to change as our population ages. As I look into my crystal ball, I see various areas of our lives which will need to change as more and more of us live longer lives.

The lengthening of the lifespan will cause a continual increase in the size of the general population. The average age and the median age of the population will continue to move upward. Of necessity, there will be more focus on the needs and the talents of our mature citizens. Older

people, even a growing and a vocal force, will keep reminding us of the challenge and opportunities they offer.

The increase in longevity already has and will continue to have an impact on American families. There will be more generations, and new roles for them in the family. In some families, more grandparents will become caregivers for their grandchildren while the middle aged generation is working. In many other families, adult children will continue to serve as caregivers for their parents and even their grandparents.

The graying of America has many implications for the production and allocation of resources, too. Both the work force and the marketplace will be affected.

People will have longer working lives, although they may have several different careers, different working hours, shared jobs and different working places in their later years. Changes that allow elders to stay in the work force will be essential. With fewer well trained younger workers as well as with more older people who want or need to be employed in later life, the work environment will need to change. By the year 2000, we will have an equal number of persons entering and leaving the work force. We will not be able to waste the talents of our older citizens.

Work force benefits will have to change accordingly. Employers will have to structure benefit packages differently because of different assumptions about retirement, health care, and caregiving responsibilities, to name just a few considerations. Corporations will have to expand their efforts to help keep current workers, young, middle aged, and old, productive and healthy. They will also increasingly look for ways to reduce health care expenses incurred by retirees.

An aging society will also mean that different types of products will be demanded and consumed. For example, one change could be in the packaging of food products. Instead of microscopic labeling, manufacturers should soon realize that older persons will be more likely to buy their products if they could read the package contents. Large print will be more common, as will better lighting.

Other changes might include affordable long-term care insurance, cars with mirrors to compensate for the loss of visual acuity, personal convenience and comfort items, home shopping services, grocery delivery services, and better timed street crossing lights.

Health care and social service delivery systems must change too. Current institutions and organizations may not be appropriate or adequate for the needs of an aging society.

We are already seeing changes in the use of acute hospital beds and increasing needs for long-term care services and facilities. Community caregiving organizations will be severly strained by the increasing patient load, *especially* if they must care for AIDS victims simultaneously. To combat this pressure, we must find ways to reach people more effectively in their homes. Such progress would be particularly important in isolated rural areas.

Our manpower needs will certainly change as we will need more persons in new types of careers. Technology will cause changes in the way

we deliver care and our needs for various types of care changes with age. But that new technology won't address all the issues of an aging America.

Families and friends will continue to serve as caregivers, and they will need training as well as respite services. They may also need innovative ways to cover the costs of health care expenses. Individuals will need to begin planning earlier and personally take more steps to assure a financially secure old age. Perhaps we will even see more incentives for those who pursue healthy lifestyles.

With an increased older population, society's attitude toward longevity and the quality of life in later years will continue changing. The assumption that being old means being sick and frail is disappearing. It is being replaced by the notion that most older persons are healthy, vital, and want to stay well and functioning as long as possible.

More and more of us will realize that we have the ability to chose how we live. The relationships between such factors as nutrition, exercise, preventive health and disease mean that we can take a more active part in our own health care. Each of us will need to be more pro-active in working with health professionals, staying well, and when ill, taking part in our recovery and rehabilitation.

This brief glimpse into the future reinforces my strong conviction that it is *our* job to take the message of the value of health promotion and wellness for older persons to the leaders and citizens of our communities. Our society must stay healthy. Our elders must stay healthy.

Dr. Koop has challenged us in three areas:

> First, we need to assist doctors, nurses, and other health professionals to incorporate health promotion into their regular plans of patient care. Older persons are particularly sensitive to messages from their doctors. Why not begin here? What recommendations can we develop that makes that a reality?
>
> Second, we need to educate older persons to the value of health promotion and wellness at any age. We must get the message out that changing habits, even in later life, will produce significant and tangible benefits. I ask you, how can we reach more mature citizens with this important message?
>
> Third, we need to build partnerships to help educate people of *all* ages to get ready for later life. Public, private, and voluntary groups must combine their strenghts in each community across the nation. What better place is there to start than taking care of one's health.

The legacy of this conference must be manifested in several areas: new directions in program areas; sharing of information about methods of prevention and treatment; the development of a health promotion and wellness agenda for older persons for the coming decade; and a commitment to implement these recommendations. We have a lot of work to do over the next three days.

You have a unique opportunity to bring your knowledge and expertise to the forefront of this effort. Over the next few days, I ask you to develop

recommendations which you will take back of your communities, your organizations and your colleagues. I urge you to develop ways to assist your designed State coalitions on health in achieving their agendas. I encourage you to organize local coalitions which sponsor health promotion and wellness activities for older persons. Finally, I challenge each of you to personally set a good example of health promotion practices.

You are here because you are leaders in your field and I congratulate you on all that you have done thus far. But I urge you to do more. The needs of our older population today are significant. The talents of older people today are exciting. In the future, both those needs and that talent pool will grow. What makes a difference to each of us as we age is what happens in the community and neighborhood where we live and work. I urge you to seize the opportunities that are before you to help make those communities better places for all of us to live and to mature today and in the future.

Working together—we can do it! Thank you.

Address

Presented by Assistant Surgeon General T. Franklin Williams
Director, National Institute on Aging
Sunday evening, March 20, 1988

Dr. Abdellah, Dr. Koop, Commissioner Fisk, and colleagues:

It is indeed an honor to be part of this important Surgeon General's Workshop in Health Promotion and Aging. I am particularly glad that Dr. Koop has focused attention on these very significant public health issues.

In the 1970s, the orientation toward age and aging of many persons in fields of medical research and health policy began to assume new directions. This change in focus was primarily due to three growing realizations. The first, and perhaps most apparent, was the tremendous growth in the number of people who were living—and living well—past their 65th birthdays. As a result of this phenomenon new questions arose. Would this trend continue? What would be the far-reaching implications of such a demographic change in the United States, and perhaps around the world?

The second realization was that, regardless of how many people were achieving healthy old age, aging was still looked upon with dread. If you were turning 50 or 60 you expected physical and mental declines. Just as unfortunate, so did your physician. Myths about aging prevailed. Many in our youth-oriented society even viewed 30 as being past prime. The question: What could reasonably be expected from people as they age?

The third realization was that many older people did, in fact, suffer physical and mental declines. But, considering the large number of healthy older people, it became apparent that some illnesses might be avoided.

There were many gaps in our scientific knowledge of the aging process. On May 31, 1974, to respond to growing concerns in this area, Congress enacted the Research on Aging Act creating the National Institute on Aging (NIA) with a mandate "to conduct and support biomedical, social, and behavioral research and training related to the aging process and diseases and other special problems and needs" of older persons. In July 1975, the Adult Development and Aging Branch and the Gerontology Research Center were separated from the National Institute of Child Health and Human Development and were made the core components of the new NIA.

Investigators now had the direction from Congress to discover which aspects of aging processes might benefit from medical intervention. The goal was, and still is, to be able to understand normal aging processes and develop ways to improve the quality of life for all people as they grow

old. Irrational myths and fears needed to be replaced by reliable data on physiological, psychological, and social changes which often take place during one's lifetime.

NIA research is conducted by scientists at the Gerontology Research Center in Baltimore and in the National Institutes of Health (NIH) Clinical Center in Bethesda, and through multidisciplinary grant programs which give support to research institutions throughout the United States and, to a limited degree, in other countries. Additionally, several interagency agreements, for example with National Center for Health Statistics and the Bureau of the Census, have expanded our ability to develop more precise information about the older population.

Since its inception, NIA has developed priorities based upon the concerns which led to the Institute's formation. Research on aging is potentially unlimited in scope, so judgments must favor areas which show scientific promise or which society deems to be important public issues.

Priorities, of course, evolve over time but a continuing major emphasis at NIA is to understand aging processes and how aging *is distinct* from disease. The passage of time imposes change on everyone but it is vital to understand which changes are inevitable and which are open to modification. The Baltimore Longitudinal Study of Aging, conducted at the NIA Gerontology Research Center, was initiated in 1958 to permit repeated observations of the same subjects over time. Results of numerous studies there have shown that if one can identify and separate out people with disease conditions and focus study on healthy aging, changes with age are far fewer than previously thought. Increasingly, studies demonstrate that older people do not necessarily suffer heart and kidney problems, nor do their personalities change with the passing of time [Rodeheffer, Lindeman, Costa]. In fact, these studies show that very few, if any, changes occur uniformly to all people as they age. Aging is highly individual. It is for this reason that I object to and do not use the term "the elderly" as it implies, erroneously, that older people are all alike—a stereotyping term.

Other research results from around the country support this perspective. For example, Dr. K. Warner Schaie at Pennsylvania State University and others, in evaluating intellectual and cognitive changes over time, have found that many people do not suffer loss of intellectual function, and those who do can often benefit from cognitive training programs that reverse or decrease their intellectual decline [Schaie, Baltes, Rodin].

Epidemiologic studies have contributed greatly to our understanding of the aging population. Data from the Established Populations for Epidemiological Studies of the Elderly (EPESE), supported by NIA, includes information on over 13,000 participants in four communities: New Haven, Connecticut; East Boston, Massachusetts; two rural counties (Iowa and Washington) in Iowa; and an enrolled predominantly black population in the vicinity of Durham, North Carolina [Cornoni Huntley]. These studies are presenting detailed, longitudinal information on healthy older people living in the community.

Once we accept the notion that people do not inevitably become frail or demented as they grow old, we can examine ways to maintain a person's health, independence, and function into later years. This, then, is another priority at NIA. Can positive changes in a person's attitude and lifestyle affect health and vitality later in life? In many areas we are just now beginning to collect data. In the area of nutrition, for example, we generally support the Dietary Guidelines of the National Research Council, but these guidelines are based on studies of persons under the age of 51, and we simply do not know whether or how nutrient requirements differ for older people. NIA is participating in a seven-institute collaborative follow-up of the National Health and Nutrition Examination Survey (NHANES). This survey should provide key information—and the largest archive of data to date—on patterns of health and disease related to nutritional habits.

Careful research studies have given us some answers to questions about health promotion and disease prevention. John Holloszy of Washington University in St. Louis and his colleagues have shown that when previously sedentary older people enter a fitness program, approved by their physicians, their aerobic capacity improves as much as that for younger people. There also are accompanying improvements in blood lipids and glucose tolerance. Studies by Gail Dalsky, also at Washington University, show that in women between the ages of 55 and 70, the typical decline in bone mineral content of the spine can be minimized or eliminated by following a sensible exercise regimen [Holloszy, Seals, Dalsky]. This finding has important implications for prevention of fractures in older people. We also know that smoking cessation, good medical and dental care, moderate, if any, alcohol use, a good mental outlook, and a knowledge of drugs and their possible adverse effects can benefit a person's health. At the same time, much further research and program development at NIA and other agencies, such as the Office of Disease Prevention and Health Promotion, Office of Technology Assessment, the Food and Drug Administration, the National Institute of Mental Health, and other Institutes of NIH, are critical to our full understanding of what is possible in health promotion for older people.

The NIA also focuses its research, training, and information dissemination efforts on the common disabling conditions of older people—those which threaten loss of function and loss of independence. Rehabilitative efforts, i.e. restoration or improvement in function in these situations to the maximum extent possible, are also a part of health promotion.

Probably the greatest threat to personal independence in older people is dementia. Between 5 and 10 percent of all people over 65 suffer from Alzheimer's disease, with the numbers increasing substantially among the oldest age groups. Research on the etiology and pathogenesis of dementia is crucial to eliminating this terrible affliction. Through sophisticated techniques researchers are beginning to gain a better understanding of the changes that take place in Alzheimer's disease. Diagnostic capabilities have been increased. In response to Congressional legislation, the NIA now

supports ten Alzheimer's Disease Research Centers which bring together some of the best basic and clinical research in the field. Congress also has directed NIA to establish an Alzheimer's Disease Education Center and Clearinghouse to assist families, health care professionals and the general public in obtaining the most up-to-date research results. We also are working with the World Health Organization (WHO) which has made this area a top priority.

Other problems which often threaten loss of function as people age include incontinence, falls and hip fractures, osteoarthritis and osteoporosis, and losses of hearing and vision. We have made some progress. For example, studies by Drs. Bernard Engel, Kathleen McCormick and their colleagues in the Gerontology Research Center have shown that urinary incontinence can be controlled through pelvic floor exercises and related strategies in about 80 percent of affected women living within the community [Burgio]. In the area of falls and fractures, we now have better understanding of the multiple risk factors that can lead to repeated falls in older people [Radebaugh, Tinetti]. More attention is being given to research on deafness, blindness, osteoarthritis and osteoporosis in older people.

In relation to all these efforts we need to expand the training of personnel in geriatrics and gerontology. The recently completed study on personnel for health needs of older people through the year 2020, conducted at the request of Congress by NIA, the Bureau of Health Professions, and other federal agencies, documents these needs and in particular the urgent need for more academic leaders and teachers in these fields [Personnel]. The Institute of Medicine of the National Academy of Sciences has recommended that NIA support development of "Centers of Excellence" for research and training in geriatrics, to help meet this need.

The Institute on Medicine has also recently proposed a study of "Health Promotion and Disability Prevention for the Second Fifty" [Report]. The purpose of the study would be to establish a solid body of knowledge on selected health risk factors for older people and measure the efficacy of health promotion and disease/disability prevention interventions beginning in the middle years and extending on through the last half of life—a purpose quite congruent with that of this workshop. These workshop sessions should provide current information on health promotion in older people in relation to medications, alcohol, dental health, preventive health services, mental health, nutrition, physical fitness and exercise, smoking cessation, and injury prevention. Further research on these topics is of immense importance if we are to gain a full understanding of what it means to grow old healthfully and vigorously. Old myths about aging are being replaced by fact. Sessions such as this should help us all to develop a realistic picture of what growing old is all about.

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PLENARY SESSION

"Health Promotion and Surgeon General's Workshop"

Presented by Assistant Surgeon General David Sundwall
Administrator, Health Resources and Services Administration
Monday morning, March 21, 1988

Thank you, Dr. Abdellah. And thank you, Dr. Koop, for calling together this group of distinguished professionals.

It's a pleasure, as well as an honor, to be a participant in these workshops on health promotion and aging. I want you to know I respect the work you're doing here and elsewhere around the country. And I admire your concern for older Americans and your dedication to their welfare and health.

This forum provides a unique opportunity to focus on health promotion and disease prevention in aging individuals. You've heard Carol Fraser Fisk describe what the Administration on Aging is doing in this area and Dr. Frank Williams describe the activities of the National Institute on Aging.

I've been asked to review some of what we're doing for older Americans in the Health Resources and Services Administration, particularly as it relates to health promotion and disease prevention.

That HRSA should be involved in health promotion activities is appropriate in light of our designated mission. So that you'll better understand how we fit into the Public Health Service and, particularly, into health promotion activities, let me briefly outline what that mission is. It comes in two parts. Simply put, the first half has to do with resource building and the second with service delivery.

We're charged with helping to assure that this nation has the necessary resources, both facilities and health professionals, to meet the nation's current and future needs.

In this capacity, we support the education of health professionals through guaranteed student loans, scholarships for minorities and the disadvantaged, and a variety of grants to institutions for developing and supporting health education and training programs.

We also administer the Hill/Burton indigent care program. Much of the hospital construction that took place between the end of the Second World War and 1973 was financed with Hill/Burton funds. Even though Congress discontinued funding for the construction portion of the program, many Hill/Burton facilities retain their obligation to provide free care to qualifying low income individuals.

Our new Office of Rural Health Policy is another good example of what we're doing to help build the nation's health care resources. Congress

appropriated $1.2 million for FY'88 for grants to develop Rural Health Policy/Research Centers. These Centers will collect, develop and disseminate current information on rural health and conduct policy research and analysis of rural health issues of national significance.

We also support organ transplantation activities and 7 regional educational centers for training health professionals in the prevention and care and treatment of patients with AIDS. Taken together, these programs are instrumental in developing essential health resources across the nation.

Now, the second half of HRSA's mission is to support the delivery of health services to special populations and those who, because of lack of resources or geographic location, are unable to obtain appropriate services for themselves.

America's homeless population is a prime example. HRSA recently awarded $46 million to 109 communities that demonstrated the ability to provide comprehensive health services to homeless individuals.

Another population of Americans having difficulty obtaining appropriate services is that infected with the AIDS virus. HRSA's AIDS related activities bridge the two segments of our mission. Whereas, our 4, soon to be 7, area education centers fall under the resource building portion, the 11 AIDS Services Demonstration Projects that are designed to build on existing resources to provide comprehensive services for AIDS patients fall under the health services portion.

The homeless initiative and the AIDS Service Demonstration Projects are relatively new compared to our participation in maternal and child health programs. We've had a long history of involvement in this area. HRSA administers the MCH Block Grant as well as numerous other initiatives, some of them designed to reduce the incidence of infant mortality.

Many of the services provided by HRSA's nearly 600 Community and Migrant Health Centers are for mothers and their children. And although they provide traditional curative medical care, increasing emphasis is being placed on preventive health services as a means of improving the health status of their clientele.

There's a lot of truth in the old saying—an ounce of prevention is worth a pound of cure. Frankly, I believe it's worth more than a pound, both from the standpoint of cost as well as from pain and suffering.

Now, if preventive medicine is important to the general population, it's of even greater significance to senior citizens because of its potential for improving the quality of life during the senior years while conserving scarce health resources.

Right now those 65 or older are 12 percent of the population but account for more than 30 percent of the total cost of health care. This percentage is projected to increase as the number of older Americans, and particularly those 85 years of age and older, increases through the end of this century. Therefore, the topic of these workshops is of utmost importance, not just for senior citizens, but for the health and well-being of the U.S. treasury that will spend about $145 billion on health care this year.

About $1.5 billion of that will go for HRSA programs—many of them having geriatric components.

At HRSA, we recently established a Committee on Aging-Related Issues. Because many of the bureaus and divisions administer programs with geriatric components, the Committee's goal is to coordinate these internal initiatives in addition to coordinating with other governmental agencies that administer programs for senior citizens. It will also develop a plan to increase relevance and accessibility of HRSA programs to the aging population. It will keep abreast of aging-related activities within the private sector. And it will develop and maintain an inventory of HRSA aging-related activities.

Many of these aging activities are found in Community and Migrant Health Centers. Nearly ten percent of their clientele is over 65. And, although the percentage is remaining relatively constant, there is an increase in the number of elderly obtaining services at CHC's that parallels the expansion of the older population.

Traditionally, Community Health Centers have emphasized primary and preventive care, but recently they've been more aggressive in efforts to actively incorporate prevention activities into their service regimes for senior citizens.

In 1984, we awarded $1.7 million in supplemental funds to 57 Community Health Centers to assist these Centers in developing and implementing preventive health programs to serve as models for other Centers.

To build on this, HRSA and the Administration on Aging are jointly sponsoring a networking initiative between State Primary Care Associations and State Agencies on Aging. For those who are unfamiliar with State Primary Care Associations, they're made up of Community Health Centers and other nonprofit organizations, including some state health departments, that provide primary care services.

State Units on Aging working with State Primary Care Associations will develop an action plan that correlates with local circumstances and health care needs. To help participants formulate these plans, we sponsored a series of 10 planning seminars that were completed in December of last year.

Now that the first stage of the program is completed with the working plans—hopefully—"signed, sealed and delivered" we're in the process of contracting for a study to evaluate their implementation and effectiveness.

We hope to improve collaboration and cooperation among the various administrative and management levels of the aging and primary care network, whether they're local, state or federal, so that we'll be better prepared to meet the health care needs of the expanding older population.

By linking Community Health Centers to the aging network and making the Centers more sensitive to the unique health care needs of older individuals, we'll enhance our ability to provide appropriate, comprehensive Geriatric care.

We're so confident that this networking relationship between HRSA and the Administration on Aging will prove to be effective—that it will improve accessibility and quality of care for aging citizens—that we're in the process

of drafting a Memorandum of Understanding that will cement our official ties and build and expand upon our earlier collaborative efforts.

The Memorandum has 5 stated objectives. They are:

- To support states and communities in the development of improved health care systems serving older persons;
- To promote expanded education and training opportunities for health personnel serving the elderly;
- To collaborate with the private sector to improve health care for the elderly; and
- To promote the maintenance and expansion of health services for older persons living in rural areas.
- To support model programs for older HRSA and AoA employees and employees providing care to older family members.

Although it's still in the negotiation stages, we hope to soon finalize the formal agreement even as we continue our joint objective to improve quality and accessibility of health care services for older Americans.

One of the real stumbling blocks to doing this is the documented shortage of health professionals with geriatric training. At the request of Congress, we recently conducted a study entitled "Personnel for Health Needs of the Elderly Through Year 2020." The study was jointly sponsored by the Bureau of Health Professions and the National Institute on Aging.

Congress specifically requested that the report contain recommendations on—first, the number and training needs of primary care physicians and other health and human services personnel required to provide adequate care—and second, the necessary changes in Medicare and other third-party reimbursement programs to support such training.

The published report to Congress contains 16 findings and 5 comprehensive recommendations. Even though they're vitally important to the aged and their health care, I don't intend to review them individually because they all don't relate directly to health promotion. However, one of the more sobering is that the demand for services for older Americans will double by the year 2020 if current utilization rates are maintained. Approximately 2 out of every 3 patients will be over 65. Geriatric personnel requirements will greatly exceed the current supply.

That's the bad news, ladies and gentlemen. The good news is that the increasing demand for geriatric services will coincide with an anticipated growth in the supply of health care practitioners. Our challenge is to make sure that they will he prepared and well-trained in geriatric medicine.

That's not going to be easy because one of the reasons we don't have a cadre of health professionals trained in geriatrics is that we don't have the faculty to train them. In fact, the report estimates that we only have from 5 to 10 percent of the faculty we'll need to train the number of health professionals that our projections estimate will be needed to meet the health care needs of the expanding aging population.

At HRSA, we have several initiatives specifically designed to address both shortages.

Over the years, our Bureau of Health Professions has supported the education of health professionals in a variety of ways, including scholarships, student loans and grants to educational institutions.

Now that we have a surplus of physicians in most medical specialties, we no longer indiscriminately support medical education. We now target our limited resources toward shortage areas—those where the greatest needs occur. Our sole remaining scholarship program is for minorities and the disadvantaged. And most of our grants support programs in family medicine, primary care and geriatrics with requirements that recipients implement aspects of disease prevention and health promotion into their curricula.

We fund grants to schools of medicine and osteopathy; teaching hospitals; and graduate medical education programs to train physicians and dentists who plan to teach geriatric medicine or geriatric dentistry. The institutions themselves then award fellowships in geriatric retraining programs for physicians who are faculty members in departments of internal medicine and family medicine.

In addition, we're funding several programs to develop curriculum models in geriatrics, all of which contain elements of health promotion.

One of our grants funded a program where over a six-month period, 22 family medicine physicians participated in a 4 week mini-fellowship program in geriatric medicine. The participants were then required to evaluate the program. Using the feedback from the mini-fellowships, a curriculum resource package is being prepared and will be made available nationally to assist family medicine faculty or faculty in other specialties involved in teaching residents.

We also support geriatric training in dentistry, family medicine, general internal medicine and preventive medicine. A number of programs support the development of geriatric nurse practitioners and physician assistants.

In addition to these grants, HRSA funds 31 Geriatric Education Centers that are strategically located around the country. The Centers are generally a consortia of several academic institutions, a broad range of health professions schools and a variety of clinical facilities. They will be funded at about $9 million for FY'88.

The Centers stress the multidisciplinary approach with an emphasis on health promotion. Their main objective is to train and prepare faculty to teach geriatrics to various health care providers. However, they do participate in continuing education for practicing health professionals.

Now that I've given you a sketch of what HRSA's doing in geriatrics and health promotion, I want to assure you we are practicing what we preach. HRSA's Division of Federal Occupational and Beneficiary Health Services is the federal focus for health promotion programs for federal employees right through the time of retirement.

The Division functions primarily as a consultant for the various federal agencies. It conducts studies, advises management on health promotion activities, and sets up programs for employees.

For example, right in HRSA we sponsor a annual health fair for all employees. Among other things, we have nutrition analysis and counseling, weight reduction counseling, and high blood pressure, cardiovascular and cholesterol screening.

We also operate health units and employee counseling units in many federal agencies. These units offer a wide range of counseling services and routine physicals and health screening programs for federal employees so that we can incorporate the principles of health promotion into the lives of federal employees.

I want to reemphasize that health promotion is a vital element in each of HRSA's geriatric programs. With increasing longevity and rising health care costs, wellness is becoming more and more important to our financial as well as our physical health.

We believe that by combining health promotion activities with miraculous new technology and curative powers, we can help assure that the last years of life are spent in better health than ever before. We have the tools to help change what once were "the declining years" into "the golden years."

HRSA is dedicated to this objective. And our geriatric programs are targeted toward this end. We want to work with related government agencies and those of you in the private sector to promote the health and well-being of America's senior citizens.

I look forward to this joint endeavor and to reviewing the conclusions of this workshop. Thank you again for inviting me to participate.

"Year 2000 Health Objectives for the Nation"

Presented by Assistant Surgeon General J. Michael McGinnis
Director, Office of Disease Prevention and Health Promotion
Monday morning, March 21, 1988

I would like at the outset to pay special tribute to the Surgeon General for his insight and timing in convening this workshop. As you—the experts in health promotion and aging—know, one of the gravest challenges this Nation faces is how to ensure the vigor of its expanding aging population. I am here today to tell you that much of our success in meeting that challenge will depend on what we do now—and in the intervening years before the baby boom retires—to prevent disease and promote health.

My job this morning is to discuss with you a framework within which we can collectively channel our thoughts on how we would take on those challenges—within the context of the Year 2000 Health for the Nation objectives setting initiative.

The application of the tenets of health promotion/disease prevention to older adults is a relatively new notion. This workshop, however, is one of the signals of the growing recognition that there are benefits to be gained through the adoption of healthy practices and behaviors at most any age.

Part of this recognition comes from learning how to see aging for what it is—and isn't. Many of the so-called signs of old age are actually the sequelae of disease. And the most prevalent diseases, furthermore, are those which derive from lifestyle and environmental factors, factors within our control. The interplay of these factors as we age accounts in large part for the wide variation between chronological and physiological age we see in the older population.

In addition to separating aging from disease, the scientific evidence is building a strong case that preventive practices and healthy behaviors can have a substantial impact on the quality of later life, through less premature disability, shortened periods of acute illness, and less need for long term care. While research in prevention is just starting to address older people, a substantial body of knowledge has been developed over the past 20 years linking personal behavior to health status.

I would like to review briefly, if I may, some of the milestones bringing us to this point today—with the humble acknowledgment that some of the foremost experts and scientists who have contributed to these efforts are amongst us.

A pioneering study to demonstrate the correlation between cardiovascular disease and the risk factors of smoking, obesity, and hypertension

was the Framingham study, begun back in 1948. This study continues to provide valuable scientific support for health promotion and disease prevention programs. For example, researchers found that the rate of coronary disease for men with sedentary lifestyles is about three times higher than that for active men.

In the mid-1960s, Lester Brewlow and his colleagues looked into the personal habits of 7,000 people living in Alameda County, California, and found seven health habits to be related to physical health status and mortality. The longest living turned out to be those who followed most or all of seven common sense practices: they did not smoke; maintained a reasonable weight; ate breakfast; rarely snacked between meals; drank alcohol in moderation, if at all; slept seven to eight hours a night; and took part in some sort of regular physical activity. Between 1965 and 1974, the death rate for men observing all seven good health practices was only 28 percent that of men who followed three or fewer. For women, the comparable statistic was 43 percent. What's more, the survival rates were substantially the same for those age 65 and above, as well as for those in younger age groups.

In the 70s, new ground was broken by the Stanford Three Community Study—setting the benchmark for the public education campaigns we see today. They took on a problem which has often confounded the public health community—that of how to bridge the gap between getting people to know what is a health risk and getting them to actually reduce their risk through behavior change. The Stanford field study in three California towns found that cardiovascular risk scores were reduced through a combination of mass media appeals and were further reduced in those people who received both mass media and personal communications.

Prompted by the new insights into the links between risk factors and disease, Federal policy-makers both here and in Canada began paying parallel attention to the relative importance of lifestyle factors to health status. The Canadians came first, issuing a report in 1974 which held up the modest gains in health status attributable to medical care against the potential gains from changes in environmental or lifestyle factors.

The next year, the Fogarty International Center of the National Institutes of Health and the American College of Preventive Medicine cosponsored a National Conference on Prevention here in the U.S. A growing consensus was developing around the need for a national focus on disease prevention and health promotion. The next year, the Office of Disease Prevention and Health Promotion was created to coordinate Federal health promotion programs.

As other research initiatives were launched, including the Hypertension Detection and Follow-up Program, the Multiple Risk Factor Intervention Trial (MRFIT), the Lipid Research Clinics Coronary Primary Prevention Trial and many others, prevention climbed up the national agenda.

The evidence linking lifestyle factors and health led to the conclusion prominently emphasized in the 1979 Surgeon General's report *Healthy People* that further improvements in the health of the American people

would not be achieved from increased medical care and greater health expenditures alone—but through a renewed national commitment to efforts designed to prevent disease and promote health. Broad goals were set to reduce death and disability rates by 1990 in the different age groupings.

For older people, however, the explicit goal was to improve the health and quality of life and reduce the average annual number of days of restricted activity by 20 percent, to fewer than 30 days per year. Implicit was the goal of allowing each individual to seek an independent and rewarding life in old age, unlimited by many health problems within his or her capacity to control.

The approach chosen to achieve these national goals outlined in the Surgeon General's report was to draft a comprehensive national prevention strategy based on 226 measurable objectives in 15 separate priority areas. Specific targets were set to be achieved by 1990 for improving health status and reducing risk for disease, disability, or death in areas encompassing preventive interventions, health-related behaviors, and changes in the physical environment.

Over the past eight years, the so-called 1990 health objectives have been used to spotlight problems, set priorities, and allocate resources at the local, State, and national levels. And we have shown some progress.

Midway, in 1985, we were pleased to report that despite problems in pregnancy and infant health, family planning, and violent behavior, about *half* of the objectives had either been achieved or were on the path to success. The greatest progress was made in areas such as high blood pressure control, prevention of injuries, smoking reduction, immunization, and control of infectious diseases. In the past 15 years, we've seen a 25 percent reduction in tobacco use, a 15-20 percent decline in the consumption of saturated fat and cholesterol, a 40 percent drop in salt consumption, and a two- to three-fold improvement in blood pressure control.

But, perhaps the more dramatic conclusion which can be drawn from the mid-course review is that people are not dying as they did before. There has been a 55 percent decline in stroke deaths and a 40 percent drop in heart attack deaths. With five years left to 1990 at midway, we were already 70 percent on the way to our goal of reducing infant deaths, 90 percent on the way for child mortality, 90 percent for adolescent mortality, and 70 percent for adult mortality. This is good news, to be sure.

But what does all this mean for older Americans? Indeed, some claim that the factors which have led to reductions in mortality will not yield overall improvements in health status. Prolonged longevity by itself, goes the argument, could simply mean that more people will spend longer proportions of their lives afflicted with chronic and degenerative diseases.

I join those who posit another view. It is exactly the elders of the Year 2000 who will be the beneficiaries of healthier lifestyles and behaviors in their early and middle years and of advances from research in treatment and rehabilitation. So it is quite reasonable to expect that the benefits of a lifetime of healthy practices, carried into the later years, will lead to fewer chronic diseases and ameliorate those which do occur. Certainly that constitutes a worthy goal.

So where do we go from here? As I mentioned at the outset, we are now beginning to set new health objectives for the Year 2000 and a special concern is setting targets for older Americans. The 1990 objectives did not adequately address this population because of the attention given to premature mortality and morbidity. But the Year 2000 gives us the opportunity to make such adjustments. This time we know more about the aging process, we know more about the aging population, and we know more about the value and effectiveness of a variety of health promotion strategies in general, and for this age group specifically.

Furthermore, we are compelled to take special notice. Between 1985 and the Year 2020, the population 65 and older is likely to increase by almost two percent a year, an average of about 750,000 additional older persons per annum. The oldest-old—the 85-plus generation—are projected to increase at an even faster rate, at about three percent a year. In contrast, the total United States population is anticipated to grow each year by less than one percent.

While the rate of growth of the 65-plus population is expected to be somewhat greater after the Year 2000, between 1985 and Year 2000, the oldest-old will grow faster, at an average rate of about four percent a year. Then, as the baby boomers ease into the elderly category, we can expect a nearly three percent growth rate in the young-old, the 65 to 74 age range.

Although the majority of older adults in the future are expected to be relatively healthy, most will develop one or more chronic health problems. Many of these conditions should cause few difficulties but others could result in severe disabilities. A widely used measure of disability among older persons is the number of persons with activity of daily living limitations (ADL). Data from the 1984 Health Interview Survey aging supplement show that over 22 percent of older persons living in the community have some degree of disability.

We also know that the impact of chronic health problems increases with age. More than 60 percent of those age 85 and over reported some degree of limitation. Since we will have more people living longer in the Year 2000, NCHS projects a 30 to 50 percent increase in the numbers of older persons with some limitations in activities of daily living, if current patterns of disease continue.

The sum of these trends, then, is that we have a growing high risk group whose only option to health care currently is expensive, and not always appropriate, acute care medical treatment. So clearly, one national strategy must be to balance the prevailing focus on curative medicine with attention to preventing disease and promoting and maintaining health.

The leading chronic conditions afflicting older people—arthritis, hypertension, hearing and visual loss, and heart problems—are conditions we know have the potential in many cases to respond to health promotion interventions such as exercise, healthy diet, and early care. And at least two of the three most debilitating conditions which lead to a need for long term care—stroke and hip fracture—could be prevented.

For those people already ill, our goal should be to maximize function and prevent further deterioration. Changes in diet, exercise, and other health behaviors—may have an impact on function and ability to cope with the demands of daily life, even beyond their gains in health status.

So when planning for the Year 2000, we must broaden the perspective which has been applied to the younger ages of preventing morbidity and premature mortality. The challenge is not how to prolong life, but how to extend *active* life expectancy. What can be done to delay the onset of disease? How can we maintain function and independence in those older adults with chronic and degenerative diseases? How can we *measure* functional independence? How do we set priorities amongst preventable problems? What do we know about the *effectiveness* and *efficacy* of such strategies in the 65-plus group?

Over the next few days you are going to be giving a close look to the range of behaviors and practices identified to be of the most benefit to the health of older people. It is my hope that we will be able to take the work you will be doing here and use it as the groundwork for designing Year 2000 objectives which address the specific preventable problems of older Americans.

Let me just touch briefly on how that will actually happen. First, you should know that the Public Health Service is collaborating in the Year 2000 effort with the Institute of Medicine, under the guidance of a steering committee representing all the PHS agencies who will have the ultimate responsibility for carrying out the objectives. The first step of this process has been one of gathering information. Regional hearings are being held around the country to solicit grassroots testimony about preventive health priorities in the coming decade. Special hearings are also being sponsored by interested organizations at their annual meetings. In addition, we are convening a special hearing to focus on the needs of older people following this workshop on Wednesday afternoon. If you are not already planning to attend, I invite you to do so. We are expecting to hear first from Dr. Koop—who will be sharing the recommendations from this workshop with us and entering them into the record. We'll also hear from the American Association of Retired Persons, the National Council on the Aging, the ... and many other interested groups. There should be time following the scheduled testimony to hear from you and I encourage you to come forward.

Once all the hearings have been held, the task of drafting the actual objectives will be assigned to those agencies within the Public Health Service who will have the lead responsibility for a given area. We anticipate that a draft of the objectives will go out for review and comment by the end of this year and that the final Year 2000 objectives will be issued at the end of 1989.

In closing now, I'd like to thank you for the opportunity to share with you what we are doing and I certainly am looking forward to hearing your recommendations two days hence.

As we rise to the challenges of our demographic destiny, we must acknowledge that neither knowledge nor change come easy. But with the collective spirit, wisdom, and commitment of people like you, I believe we will be successful. If I may, I'd like to close with a quote from the last line of *Healthy People*, the Surgeon General's report on health promotion and disease prevention which got us started, with one alteration:

> "If the commitment is made at every level, we ought to achieve out goals, and *older* Americans, who might otherwise have suffered disease and disability, will instead be healthy people."

Thank you.

"Legislative and Administration Interests in Geriatric Health Promotion"

Presented by Roger Herdman, MD
Assistant Director for Health and Life Sciences
Office of Technology Assessment, U.S. Congress
Monday morning, March 21, 1988

The title of my talk, as listed on the program, is Administration and Legislative Interests in Geriatric Health Promotion. However, I believe it would be a bit presumptuous of me to speak about the Administration's interests or views, especially considering the individuals preceding me this morning. Also, I make no pretense of speaking for the Congress in any political sense. That said, it is my goal to present some thoughts about health promotion for elderly people and the forms of recent Congressional legislation in this area.

In many ways, there should be difference between a legislative interest in geriatric health promotion and that of the executive branch. In general, it is clear to all parties that health promotion is a worthy goal. While all segments of society are struggling to meet rising health care costs, it is equally clear that we may not want or be able to pay for preventable illnesses.

Divergences in viewpoints and thus "interests" become important when policy makers seek to turn the concept into reality. Actually, it would be more accurate to say "seek to *help*" since we should not by any means fall into the trap of thinking the federal government—whether legislative or executive—is the only actor in the process.

From the federal perspective, making expanded health promotion a reality involves a long (some would say cumbersome; others would describe it as necessarily cautious) sequence of events. It includes exploration of specific goals, information gathering about means of reaching those goals, technical analyses about programs and methods that might accomplish health promotion, decisions about how much and what types of health promotion programs are to be supported or otherwise encouraged, compromises on who will pay for programs, enactment of any needed statutes, actual implementation, and then evaluation of the success of the programs in bring about desired changes.

Congress has an interest in every one of those steps, but it has more capability and more of a mandate in some than in others. Clearly, the Congress has a large role in play in setting goals, since this is the first crucial step in lawmaking and goals must flow in large part from the needs of the elderly population. Identifying and reacting to this population-based

need is one of Congress' traditional roles. This must be supplemented by "technical" information (for example, on disease and demographic patterns and on behavioral characteristics) that in significant part can only be derived by application of the expertise and far larger resources of the executive agencies.

Similarly, Congress often must rely on executive expertise and research concerning the technical means to achieve the goals. This reliance is not as heavy as it once was; Congress has improved it informational resources over the years and now can turn to the General Accounting Office, the Congressional Research Service, the Office of Technology Assessment, and in certain cases, the Congressional Budget Office. But the fact remains that the resources of all the technical support offices of the Congress are extremely small compared to those of the executive branch.

Congress, of course, also has access to expertise in academia and the private sector. Here again, Congress has enhanced it capacity recently with respect to Medicare and Medicaid related issues by creating research and policy advisory bodies such as the Prospective Payment Assessment and Physician Payment Review Commissions. But still it is the executive branch that generates or supports much work in those sectors. The specific, relevant point here is that in an emerging, increasingly visible and important area such as geriatric health promotion, the ability of Congress to make informed choices depends to some degree on the quality and form of the information generated by the executive branch. The novelty is the continuing tendency of the Congress to increase its own research and external advisory capacities.

In shaping the debate about how much and what types of health promotion programs are to be supported or otherwise encourages, I believe that Congress and the Administration both have large roles to play. Congress plays its part through hearings, investigations by staff or by support agencies, interaction with constituents, and commissions.

Congress, of course, then must make it own decisions concerning enactment of authorizing statutes and of appropriations bills. This is one of the primary roles that Congress plays in health promotion. It is certainly not the only one—the oversight process can be significant— but it is one that distinguishes a legislative interest.

In the remainder of my presentation, I would like to accomplish three purposes. First, I would like to examine the context in which the Congress considers geriatric health promotion. I would then like to describe some of the efforts that have pursued by Congress to enact legislation in this area. And I would like to conclude by discussing some of the issues that the legislative branch must address in deciding which activities to support and at what level.

The ways in which the Congress seeks to further health promotion are in large part determined by broader concerns of the institution itself. At least two such concerns affect health promotion for older Americans. The first is the tendency to make incremental changes in existing programs rather than to enact a comprehensive strategy to achieve a particular goal.

In part, this tendency may be borne out of an appreciation for the complexities of implementing broad new programs as was done twenty years ago. However, the overriding cause of Congress' reliance on incremental strateiges may be fiscal reality. As I will explore further in a moment, concern over the federal budget during the past few years has made it more difficult to garner the political support within Congress to establish large, new programs. Indeed, the bipartisan efforts of the legislative and executive branch to provide protection for the elderly against catastrophic health expenses are one of the most successful attempts at "comprehensiveness" considered by Congress in recent years. And they are really an expansion of optional coverage under the Medicare program.

As we shall see, most Congressional efforts for geriatric health promotion in recent years have taken the form of incremental changes in four existing federal programs: Medicare, Medicaid, social services under Title XX block grants (all of which are authorized under the Social Security Act), and grants authorized by the Older Americans Act.

Proposals for changes in Medicare and Medicaid almost all seek to expand reimbursable health services for beneficiaries. By focusing its attention on insurance coverage, Congress emphasizes the importance of payment for services in the promotion of geriatric health. However, changes in Medicare and Medicaid can have influences far beyond the marginal increases in coverage for these programs' beneficiaries. As the largest single payer of health services, the policies adopted by the federal government will receive serious consideration by other insurers. This phenomonen has occurred since Part A of Medicare adopted a prospective payment system for hospital charges.

In the area of health promotion, the influence of the federal government as a major payer extends even farther. Proposals to expand Medicare and Medicaid coverage represent an explicit recognition by the federal government of the importance of health promotion and disease prevention. Coverage may educate the public about those activities that can improve or maintain health, and it may encourage behavior to bring it about. For example, proposals to pay for disease screening or immunizations under Medicare could thrust the federal government into a leadership role in encouraging all consumers to seek such care or health professionals to provide it.

I have already alluded to the second characteristic of Congress that shapes recent proposals for geriatric health promotion—the major role of the budget process in determining the Congressional agenda. The necessity for fiscal responsibility has set the terms of debate for recent proposals in geriatric health promotion. Much legislative support for disease prevention and health promotion lies in the hope that paying for prevention now will avoid more expensive treatment costs in the future. Hence, in carrying out its legislative duties, the Congress has an obligation (much like that of the executive branch) to consider both potential benefits and potential costs.

A great many health promotion activities are "worthwhile," and a fair number are "compelling" in their perceived value. Recent proposals to provide Medicare coverage for routine mammography are one example

of this debate. As the Office of Technology Assessment recently found, mammography coverage is unlikely to reduce Medicare costs in either the short or long run. However, it has tremendous potential in detecting early cancers and prolonging life. Other work conducted by our office on the regular use of outpatient pharmaceuticals suggests that Medicare coverage of "medically critical" drugs may reduce hospital costs and actually save money for Medicare. The Congress will ultimately weigh all this information in deciding whether to support these activities and at what level.

Even if one argues that a proposal is "cost-saving," the meaning of this statement can be ambiguous. The real question should be "cost saving for whom?" The costs of health promotion can be borne by an individual beneficiary, by a particular program by the federal government, or by society as a whole. A given proposal may reduce the costs of one program while increasing those in another. The net effect of the federal budget could be either positive or negative. Given the distribution of jurisdictional authority within the Congress, the ways in which these costs fall may have much to do with the success of a given proposal.

The budget process itself has numerous complicated steps. In general, the Congress passes an annual budget resolution in the spring or summer that sets broad spending limits. Appropriations bills provide funds for specific, authorized programs. Reconciliation bills allow changes in the authorizing legislation of entitlement programs to bring their spending in line with the budget resolution. As is probably well-known by this group and the American public as a whole, in recent years the last two steps of this process have been carried out well beyond the start of the fiscal year.

Attempts to contain or decrease the budget deficit have enhanced potential changes in entitlement programs like Medicare and Medicaid that have the potential to realize large budget savings. One would not expect appropriations or reconciliation bills to be vehicles for *expanding* eligibility or benefits of these two programs since Congress requires all components of this particular legislation to be germane to its original purpose. However, because the annual budget resolution passed early in the legislative year provides instructions for budget savings in entitlement programs like Medicare and Medicaid, any proposals to alter these programs become germane to a reconciliation bill even if the changes do not bring about budget savings (Fuchs and Hoadley, 1987). Recent expansions of Medicare to cover immunizations for pneumococcal pneumonia and Hepatitis B made use of this process.

I would now like to talk a bit more systematically about recent and current legislative proposals for geriatric health promotion. I have alluded to a number of changes in Part B of the Medicare program to pay for clinical preventive services such as immunizations and disease screening. In addition to the coverage of routine pneumococcal and Hepatitis vaccines, Congress recently agreed to establish a demonstration project to provide influenza immunications to Medicare beneficiaries.

In the 99th Congress, proposals were put forth to alter Medicare in other ways as well. One bill (S. 358) would have raised the deductible to receive

Part B benefits from $75 to $100, but would allow the cost of disease screening, immunizations and hypertension drugs to count towards that deductible. A companion bill (S. 357) would have lowered the Part B premium by $1 per month for non-smokers. The House considered a proposal (H.R. 1402) that would allow Medicare beneficiaries to purchase a supplemental insurance option to cover the cost of an annual preventive health physician visit. A similar proposal discussed on the Hill recently would provide a well-patient physician visit for new Medicare beneficiaries. In 1984 and 1986, Congress authorized a total of seven demonstration programs to provide community-based disease screening and referral services. Two of these projects have been funded and are currently in operation.

Medicare related proposals for health promotion in the current Congress fall into two categories. The first is the further expansion of coverage under Part B. There are currently five bills that would extend Medicare payment to routine, annual mammography. Two of these bills would also authorize Medicare to pay for annual Pap smears.

The second category consists of provisions in the catastrophic health insurance bill currently under consideration. The Senate version of this legislation (currently under discussion in conference committee) would allow enrollees to count the cost of several preventive services toward the annual deductible necessary to receive catastrophic benefits. These services are screening for glaucoma, cholesterol, cervical cancer by Pap smear, breast cancer by mammography, tuberculosis, colorectal cancer by occult blood in the stool, and immunizations against tetanus, influenza and bacterial pneumonias.

Both House and Senate versions of the catastrophic bill also provide for prescription drug coverage. Although the two versions of the bill vary somewhat, they nonetheless represent a legislative commitment to assist the elderly and disabled in gaining access to needed prescription drugs. In many cases, these drugs may dramatically improve the quality of an older person's life. Many control chronic conditions such as hypertension and prevent more serious manifestations of illness that might require hospitalization. It is interesting and important that this legislative commitment is made without clear-cut evidence that it will save money.

The prescription drug provisions of the catastrophic bills also express concern that pharmaceuticals be used wisely and appropriately. As the Office of Technology Assessment (OTA) recently pointed out, geriatric polypharmacy is now commonplace, with over a third of community dwelling and over half of institutionalized elderly using four or more drugs (U.S. Congress, 1987c). One researcher has estimated that adverse drug reactions play at least a contributory role in 12 to 17 percent of all hospitalizations among the elderly (Lamy, 1984). One version of the bill would assign the Secretary of Health and Human Services the responsibility for developing programs to ensure that drug therapy promotes rather than threatens geriatric health.

Among those proposals for geriatric health promotion not aimed at Medicare are changes in the Older Americans Act of 1965. In a set of

amendments to this act passed last fall (P.L. 100-175), Congress authorized the Administration on Aging to provide grants to states totalling $5 million a year to establish periodic health services within community senior centers. In addition to disease screening, the centers could offer exercise programs, home injury control, nutritional counseling, mental health services and education on Medicare benefits. The amendments also authorized demonstration grants to institutions of higher education for the design of prototype health education and promotion programs. States would be able to draw upon these prototypes in implementing their own preventive services. It is important to remember that each of these activities require that Congress yet appropriate the funds necessary to implement them.

Congress has also recently expressed interest in Alzheimer's disease and related dementias. It has provided funding for basic and health services research and has utilized nationwide expertise to provide the Secretary with particular external advice on this topic. Legislative interest and activity in the growing area of geriatric mental health will likely grow over the next several years.

Block grants to states are another way in which Congress has sought to further health promotion. In 1981, Congress combined eight categorial grant programs together in a Preventive Health Block Grant for public health and health promotion activities. States were given broad discretion in how they decided to spend these funds. This Preventive Health Block Grant is currently awaiting reauthorization. Another block grant uses funds authorized by Title XX of the Social Security Act to provide social services. While some portion of all these grants probably support geriatric health promotion activities, states vary greatly in how they spend their funds. One analysis indicates that 34 states use Title XX funds for health education (U.S. Congress, 1987b). On the other hand, despite its rather specific title, the Preventive Health Block Grants allow states to invest in measures as diverse as rodent control and fluoridation, emergency medical services and home health care in addition to health education.

Legislative activities in geriatric health promotion extend to the Congressional support agencies as well. At OTA, we have tried to help the Congress sort out the merits of activities in this area. In past years, we have examined the cost-effectiveness of pneumococcal and influenza vaccines. We recently completed an examination of health promotion options in large studies of *Technology and Aging* and Alzheimer's disease (U.S. Congress, 1985 and 1987b). Just this past fall, we analyzed the costs and effectiveness of mammography under Medicare (U.S. Congress, 1987d). Over the next year, at the request of the House Ways and Means Committee and the Senate Labor and Human Resources Committee, we will study the costs and effectiveness of up to five additional clinical preventive services that might be considered in the future for coverage under Medicare.

Having talked a bit about the legislative environment in which proposals for geriatric health promotion are considered and having outlined recent Congressional activities, I would like to close by focusing on some of the methodological issues that arise in evaluating various proposals. OTA is

grappling with each of these issues now as it analyzes potential costs and effectiveness. The Congress deals with them as it considers particular pieces of legislation. And you will face them in your deliberations over the next two days.

One of the first problems encountered in evaluating geriatric health promotion is the uncertain efficacy of many proposals. The various authors of the background papers prepared for your use have performed a valuable function in uncovering and synthesizing a diverse academic and clinical literature. In many cases, however, there is a pronounced lack of data about how well specific services work for the elderly (Stults, 1984).

This uncertainty has several sources. For some services, there have not been well-designed, randomized clinical trials. Glaucoma is one example where the efficacy of preventive treatment has not been well documented and clinical trials are badly needed (Eddy, Sanders and Eddy, 1983). In evaluating other services, researchers have excluded the elderly from those clinical trials that do exist (Stults, 1984). Traditionally, they have feared that the multiple morbidities of many elderly would preclude efficient statistical analysis of the activity under scrutiny. The Food and Drug Administration is currently reevaluating its own guidelines in order to expand elderly participation in its clinical trials. Finally, in some cases researchers may have erroneously assumed that treatment does not result in health benefits for individuals beyond a certain age. Smoking cessation falls into this category.

Many times those data that do exist on the efficacy of health promotion activities come from a single demonstration project. In trying to generalize from a particular project to an entire population, one must bear in mind those characteristics of the demonstration that might have contributed to the project's outcome. Such factors might not be reproducible in a program aimed at an entire population.

Efficacy can also depend heavily on the outcome one decides to measure. Traditionally, one examines changes in mortality or morbidity. For some services, however, this approach may not sufficiently measure the impact of the intervention. For example, one would usually measure the effect of screening for hypertension or cholesterol in terms of expected life-years saved or expected reductions in disability. However, the contact with a health professional afforded to the screening patient may have important secondary health benefits. Such contact may educate a patient about additional ways to maintain health or it may improve mental well-being by relieving anxiety about the patients' health. Hence, traditional measures of mortality and morbidity might undervalue the efficacy these health promotion activities.

Measuring the costs of geriatric health promotion also presents some complexities. Since I have already discussed these ideas in describing the Congressional environment for health promotion activities, I will not dwell on them here. I would, however, like to bear in mind that cost-effectiveness is a relative term. One activity can only be cost-effective in relation to an alternative. In a legislative environment that relies on incremental

changes in existing statutes, the cost-effectiveness of a health promotional proposal will likely be its cost per unit of efficacy achieved compared to not making an changes at all.

As I also mentioned earlier, cost-savings depend on the perspective from which one measures them. The Congress or one of its committees may be interested in potential cost-savings for an individual program such as Medicare or a select population such as the elderly or disabled. But such savings to a given program or group may actually be borne by other parts of the federal budget, other groups of people, or society as a whole.

Finally, there are methodological problems inherent in implementing geriatric health promotion activities. The reliance on marginal changes in existing programs may reveal a tendency towards services that fit easily into the established major payer structure, at least for federally implemented programs. Hence, the easiest programs for Congress to consider are those that expand reimbursable clinical services under Medicare or Medicaid. Public education and some counseling services, on the other hand, have little preexisting structure for implementation and are more difficult to execute.

Other disease prevention activities may not be viable under Medicare and Medicaid because of the nature of the disease itself. Osteoporosis screening is one example. While no one would debate the fact that osteoporosis is an important problem among older Americans, particularly women, or that the resulting fractures are seriously disabling, it is not clear that Medicare interventions will effectively forestall or avoid these undesirable outcomes. Rather, interventions need to begin at a younger age. For women, most calcium depletion occurs after menopause but before they become eligible for Medicare. Screening women at age 65 might alert them to their elevated risk of fracture, but it would not result in a substantial increase in bone density.

Another implementation issue important for geriatric health promotion is the uncertain definition of some services and their potential for abuse. This problem may be especially relevant to expansions of Medicare or Medicaid coverage. Earlier I mentioned proposals that would allow Medicare beneficiaries to receive a well-patient physician visit on an annual basis or when they enter the program. The legislation authorizing this coverage does not indicate exactly what activities would be (or should be) performed during such a visit. The cost of the proposal is dependent on its actual content. In the absence of a better definition or some alternative control, the services provided could use significantly fewer resources than are reflected in the government's reimbursement. Indeed, physicians could provide only a minimal or inadequate examination of their patients, or patients could seek redundant care from providers. While there may be potential health benefits and cost-savings of such visits , legislators will want to design such services to minimize unintended outcomes.

I do not pretend to have described in this paper all of the complexities in evaluating geriatric health promotion as public policy. Rather, I have tried to outline some of the major issues and constraints Congress must

address in considering proposals in this area. My purpose has been somewhat selfish. As I suggested early on, the Congress' ability to promote the health of elderly Americans depends in part on the expertise of the executive branch. Your efforts here in the next few days will greatly aid the legislative branch in its work. I wish you luck in your deliberations and look forward to your conclusions.

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PLENARY SESSION—"Setting the Pace in Geriatric Health Promotion"

"Healthy Older People"

Presented by Susan Maloney
Office of Disease Prevention and Health Promotion
Monday morning, March 21, 1988

As this workshop progresses, I am sure we will be hearing in great detail what is needed to spur the development of health promotion for older people. We'll hear calls for training health and aging professionals to care for today's elders—and to provide the opportunity of better health for tomorrow's; calls for sustained and consistent leadership for building and supporting the networks which provide services for older people; and calls to educate older Americans about how to stay healthy.

In my time with you today, I would like to spend a few minutes looking back to where we were in 1984 when the Federal initiatives in health promotion and aging got underway and examine what impact we've had to date. Specifically, I will be speaking from the perspective which has been gained from the first national health promotion program aimed at older Americans—Healthy Older People. In many ways, Healthy Older People serves as a demonstration of the potential there is out there for promoting the health and well-being of our older citizens—and there are many lessons to be learned.

Let me say at the outset, you would not believe the skeptical reactions I received from colleagues when I began talking about planning a national public education program for older people. Today, the skeptics are becoming believers. Although we continue to debate how best to change behavior, and to refine what we know regarding the potential impact of behavior change in this age group, or any for that matter, health promotion for the aging is moving into the mainstream.

In my view, that was certainly not the case a mere four years ago. In 1984, there was no consensus regarding what topics to address, no widely held view on what to say, and perhaps most basic, no sense that older people were indeed interested and willing to change behavior in order to improve health. Even had all this been agreed upon, there was no system, no network, no way to get the message out—much less provide the opportunity for personal support and encouragement which we know is necessary to change and sustain health habits. It goes without saying that there was no clear or consistent leadership in this area and no system of technical support to bring about such change.

So today, in assessing Healthy Older People, I ask what progress has been made along these lines and what have we learned about what to do next?

As I said before, the Healthy Older People program is a national public education program sponsored by the Office of Disease Prevention and Health Promotion (ODPHP). These programs, of which the Public Health Service has several, are often difficult to describe. While it is relatively easy to describe the materials which are developed and the special activities which are generated, it is difficult to convey how public education programs serve as a catalyst for action at the state and community—the level of real impact.

The primary goal of our program was to inform and educate older Americans about health practices which can reduce their risk of disabling illness and increase their prospects for more productive and active lives. We tackled this challenge in several ways—by producing a wide variety of informative materials for older people; by working very hard to establish and nurture a dissemination system to get the educational messages out; and by fostering the development of local programs serving older people.

First let me tell you what we learned about the importance of clarifying the health information we wanted to deliver and how that information was received. Too often we point to the piles of materials in our offices and to the press coverage of health-related topics, and conclude that there is plenty of information available and people just won't pay attention. I contend that it is not only important, but very difficult to develop understandable, accurate information that people actually can act on.

Before we developed the Healthy Older People materials, we conducted careful reviews of the scientific literature to ascertain in which areas behavior change can be most beneficial to health status in this age group. In fact, many of the areas selected are featured at this workshop: eating right, exercising, stopping smoking, preventing injuries, and using medicines and preventive services wisely. Next, we conducted focus groups with older people to determine how their beliefs and feelings coincided with the science base. We were then able to use public relations and advertising professionals to develop, test and refine the information.

The messages which were developed were clear, taught the skills needed to act, and conveyed a positive upbeat tone to underscore the general theme that health promotion is appropriate no matter what your age. The importance of this was highlighted in the evaluation conducted of the program. The materials were consistently described as "the information people are looking for" and as "taking complicated (nutrition) information and making it easy to use."

The messages were translated into a variety of broadcast and print materials including television and radio public service announcements, posters, and brief consumer fact sheets. Press kits and TV and radio segments were produced for news and talk shows and a variety of supporting materials were prepared for state and local groups on how to use the various media materials.

A validation of the need for and interest in clear health messages is the extent to which these materials were picked up. I must note that participation in the Healthy Older People program was completely voluntary--no State had to get involved. Even more telling is that no money was available from us to conduct programs or even to print materials. We were only able to provide samples of print materials and groups had to find sponsors.

Even with that, the results were excellent. Looking first at the TV public service announcements for which the best data are available, every state distributed the spots with 60% arranging personal delivery to TV stations. The service which tracks airplay of commercials reports that between September 1985 and September 1987 the Healthy Older People spots were aired 4713 times on local stations and all three networks. We saw it on five different Cosby shows alone.

The total advertising value of the spots, according to Broadcast Advertisers Reports, Inc., was $3,221,693. That is what it would have cost us to air these spots if we had to buy time from television stations. At this time, ODPHP's total expenditure for the program has been about $900,000—less than a fifth of comparable campaigns for high blood pressure or cancer prevention.

Though we do not have access to such precise numbers for other Healthy Older People materials, we do have some success stories. The so-named skill sheets proved to be a popular and versatile item. These two-pagers were available as camera-ready slicks and were used in nearly all the States. Not only were they reproduced and handed out to older people at senior centers, libraries, and drug stores, and in retirement seminars and housing units, but Blue Cross of New Hampshire sent them to each of their customers over 65. Hospitals and social service agencies gave them to their clients, and states and "house organs" used the information in their newsletters. As much as we talk "high tech" for information, we are still very reliant on the written word and we seek simple and concise direction for health maintenance.

One frequently reported use of the Healthy Older People materials which I had not expected was how often these items were used for professional training. We must keep in mind that, although we may have this information down pat, most professionals whose primary responsibility is for providing health or social services cannot keep current on the latest health promotion findings even if they recognize the benefits to their older client.

The skill sheets were also described as having a cross-disciplinary focus. We heard: "Both the health types and the aging types liked the sheets. For the first time, they both got behind the same product."

Bringing together the health and aging fields under the common banner of health promotion for this segment of the population was perhaps our greatest challenge and one of the most rewarding aspects of working on Healthy Older People. The quality of the materials helped—but ahead of that I'd place the opportunity to work jointly toward a common goal. This is how a public education campaign is able to foster the support network needed to provide programs and services.

You have already heard about the Federal call for the establishment of coalitions on health and aging. Speaking from the perspective of Healthy Older People, we have learned a great deal about how the coalitions were formed and what they are doing.

Early in the program we contacted each Governor's designee and worked our way through the bureaucracy to identify those who would be our own program contacts. These people were most often staff of either the health or aging department although sometimes the Governor asked both agencies to be involved or sometimes one agency decided to enlist the support of the other. We encouraged collaboration at regional training workshops, and via a toll free hotline, in a bi-monthly newsletter about the program, and through technical notes for professionals on various program development topics.

Eighty five percent of the states in which we conducted evaluation formed coalitions—many adopting the name of the program. Today, for example, we have Healthy Older Virginians and Michiganders and Iowans. The makeup of the coalitions varies. In three states, membership is limited to staff from state agencies. In just over half, the coalitions include state and local agencies and service providers such as hospital associations, university geriatric centers, the American Red Cross and AARP. Eleven states formed even broader coalitions which include private sector representatives. Among the six states which chose not to establish coalitions, two—Connecticut and Rhode Island—said their small size already facilitated close coordination. Eight of the state coalitions went on to foster the development of local coalitions.

The coalitions identified health and aging resources within the state and, most important, established viable, programmatic linkages which they expect to continue even when Healthy Older People is no lonqer around. Most coalition leaders reported that this was one of the first times there was effective collaboration between the health and aging sectors in their state. In some states this collaboration has led to an increasing interest in health promotion among older adults. I am just beginning to get calls from some of the state contacts asking for help in thinking through how to approach upcoming meetings within their departments about integrating health promotion more widely in existing programs. This represents a distinct shift from an initial focus on simply conducting an information program.

In addition to what we were able to do to support the formation of coalitions, we also tried to encourage the development of programs—and always to stress the need for local, accessible activities to encourage maintenance of healthy behaviors. Program development was enhanced by collaborative activities with national membership and voluntary organizations—organizations with ready access to our audience: older people. Two activities stand out—a series of training conferences on community health promotion programs sponsored by AARP and two teleconferences for health and aging professionals done in conjunction with the American Hospital Association.

It is in the area of program development that Healthy Older People exceeded my expectations. In all the states evaluated—41 of 50—program development of some type occurred. It appears that tens of thousands of older persons were reached in this way. Of the forty-one states queried, 15 reported doing needs assessments and compiling resource inventories; 38 described special events to educate consumers such as fairs, workshops, or "nutrition days"; several have developed their own video-taped programs which are shown on cable stations and in sites such as senior centers and community colleges; 31 states conducted provider education principally through statewide workshops and in an ongoing fashion through newsletters; and 35 of the 41 reported providing some type of wellness services to seniors.

How the different Healthy Older People topics were integrated into community programs is also worth noting. The greatest amount of program activity reported by our evaluation team must be categorized as wellness or health promotion for older people. Thirty-seven of the 41 states reported the adoption of this multiple risk factor focus for programs. Contacts liked the economy of scale in linking the topics, both in terms of limited staff and resources, and in terms of limited opportunities to provide activities for older persons. After wellness, the most frequently addressed single topic was exercise and fitness with walking events being the most popular. Special activities on the safe use of medicines and preventive health services were reported by twelve states, and nutrition by ten.

One factor which influenced selection of topics was familiarity with an issue. For example, the public health agencies found it easy to use their public health nurses to conduct risk assessments and health screening. The aging agencies, on the other hand, said they were intimidated with the medical topics, but felt they had a lot to offer in nutrition. The topics which could be made fun—or social—held great appeal. They also stood a better chance if they addressed a serious health risk or led to an easy intervention.

Given that last caveat, it should be noted only one state, Rhode Island, focused on smoking cessation. Since some of the definitive research on the benefits of quitting at a late age have only recently been published, I guess this is not surprising, but clearly more could be done in this area.

In assessing a national public education campaign in which participation is voluntary and schedules and activities are conducted as deemed best by a very decentralized network, it is difficult to tease out the impact of that program from concurrent events. For the 41 states evaluated, we developed a rating scale to determine how Healthy Older People fit in with other activities and priorities. Four categories were developed. In seven states, there had been no pre-existing activity in health promotion for the aging. Healthy Older People was cited as a direct impetus for program development. In eight states there was pre-existing activity, but Healthy Older People caused a reexamination and modification of strategies to reflect the national program. In 16 states, the existing priorities were maintained and resources, materials, and ideas were incorporated from our program. In ten states, Healthy Older People activities were conducted in

parallel, but not really related, to other health promotion activities. As of last August, there was no state in which Healthy Older People had no apparent impact. Indeed this spring we see the launching of two more major state initiatives—in Pennsylvania and Indiana.

The biggest lesson we've learned, I would say, is that Healthy Older People demonstrates the ability of the Federal government to establish a national agenda through a modest, but ambitious, program of this type. I would add that the success of this program in doing just that is that we had the right combination of the right people at the right time—not only the audience we wanted to reach: our aging population—but the talent and commitment of health and aging professionals who have recognized the need for and value of health promotion for this special population. As a result, we see a firm beginning of an interdisciplinary network of health and aging agencies and organizations committed to this initiative. And I think you will agree with me that we are further along in clarifying what information older people need in order to change health behavior.

Nevertheless some things are left undone—or I guess we would not be here today. Among them are professional training, national media attention, technical support for community programs, policy directions, and research and demonstrations to assess the impact of activities on health and functional status. The workgroups will help expand that list.

So we have a good beginning. We have captured the attention of professionals and have whetted the interest of older people in health promotion. But we know from experience that the substantial health benefits of behavior change do not come quickly or easily. Healthy habits and actions must be reinforced through repeated refrains from doctors, social workers and the local TV anchor person. We need to encourage fitness and good nutrition at the most personal level—in local parks and supermarkets, restaurants and neighborhoods.

I want to thank Surgeon General Koop for his leadership in convening this meeting because it is through opportunities such as this that we can help move health promotion for older adults up on the national agenda. And with your work here today and tomorrow—and your work back home—we eventually will see older people becoming healthier people.

Information about the Healthy Older People program is available from the ODPHP National Health Information Center, PO Box 1133, Washington, DC 20013, 800/336-4797, 301/565-4176 in Maryland.

"Project Age Well"

Presented by Anthony Vuturo, MD
School of Medicine, University of Arizona
Monday morning, March 21, 1988

Good morning, ladies and gentlemen. It is a pleasure to join you this morning in Washington and participate in the Surgeon General's Workshop on Health Promotion and Aging.

My task this morning is to give you an overview of Project Age Well. Age Well is a comprehensive project of the College of Medicine at the University of Arizona. This program is a coordinated approach to preventive geriatric care. It attempts to compress morbidity, reduce health care costs, and enhance the quality of life in older Americans.

In 1981 the Department of Family and Community Medicine began to develop primary health care efforts at apartment complexes devoted to the elderly. Eventually clinics were established at four city sponsored apartment complexes ranging in size from 75 to 450 apartments.

As with any good university enterprise, we initially focused on the three-pronged thrust of academia—teaching, service and research. Medical students and nursing students had the opportunity to enhance their educational experiences; service was provided both to the community and to the senior population; and new research projects were initiated, particularly in expanding our understanding of osteoporosis.

In the early 1980's the major driving mechanism for the service component of the University was our desire to add geriatric health care services to University Famli-Care, the health maintenance organization established by the Department of Family and Community Medicine.

We soon recognized that the traditional medical models were not capable of providing the scope of services required. We also believed that many of the health problems we were seeing in our elderly were preventable and could be anticipated. If targeted health issues could be promoted, we believed our clientele could anticipate a higher state of wellness in the aging process. This should reduce the potential financial risk to future HMO involvement.

In 1983 we took our modest proposal to New York and presented our ideas to the Brookdale Foundation. With the support and endorsement of the foundation and its board, as well as a commitment from the City of Tucson and the encouragement of the Area Council on Aging, we proceeded to enhance our commitment to the approximately 1,000 senior citizens with the initiation of a new activity called Age Well.

Our initial objectives were to provide and expand health maintenance and to promote wellness. We wanted to support those individuals who needed various types of rehabilitation. We recognized that we needed to define new professional roles and still be identified with the College of Medicine. It was important for us to create settings not just for the education of medical students and residents, but also for the training of nurses, pharmacists, nutritionists and exercise physiologists. We made a commitment from the outset to make our model widely available and to disseminate our activities.

We focused initially on prevention. In 1984 we felt most comfortable with a model that emphasized hypertension, cancer prevention, osteoporosis, depression, and control of iatrogenic diseases, and we wanted to introduce health promotion to counteract the belief that illness is inevitable.

By 1987 we had undergone significant changes in our focus areas. Rather than hypertension, it became apparent to us that it was possible to focus on the full spectrum of cardiovascular diseases. Our program of mental wellness grew beyond a focus on depression and now deals with bereavement, anxiety, loss, loneliness and stress. Clearly the leading iatrogenic problem was related to medications. Visiting people for about 4 years in their apartment complexes, seeing their furnishings, their kitchens, the way they kept house, and assessing the types of morbidity that we were beginning to see over time, we developed a vigorous campaign for safety promotion and accident prevention.

The intervention strategies that we identified include enhanced nutrition, education, a program in exercise, a strategy in community-based and peer-based health education, group and individual counseling methodologies focusing on medication and diet, health maintenance screening and stress management.

From the birth of Age Well in 1982 to the present, we have seen on our campus a major expansion of interest in the field of gerontology. We have campus committees on gerontology and interdisciplinary groups functioning in numerous areas, one of which is a long-term care gerontology center. The traditional departments within the College of Medicine have supported the expansion of our concerns for the elderly by creating a Division of Restorative Medicine which combines the disciplines of podiatry,medicine, ophthalmology, orthopedics, rheumatology, and an active outreach program which evolved out of Family Medicine.

Project Age Well is conducted at two types of sites. The first, as I have mentioned, are apartment complexes which have anywhere from 75 to 400 apartment units. Apartments may have single people or married couples. (As a matter of fact, we have seen romances blossom and marriages occur during our short involvement with Project Age Well). In addition to the residential sites, we also conduct our formal activity in two community centers, one located close to the central library and the second located within a major school district in metropolitan Tucson.

Promoting health in the elderly cannot be done in a vacuum. Project Age Well began a detailed and time-consuming process of networking with

many groups and interested parties around our community. Our initial objectives were to pass on some of the things that we were learning, as well as pick up new ideas and new thoughts in promoting a more fit lifestyle in our older population. We linked with the Pima Council on Aging, and with private local foundations dedicated to wellness. The Tucson Parks and Recreation Department linked with us, particularly in the area of physical fitness through walking, aerobics and stretching. We collaborated with the Wellness Council of Tucson, which had been established to promote worksite wellness. Numerous organizations, not all of which had exclusively elderly constituencies, became advocates and promoters of our activities.

Cable television adapted a new program called "The Prime of Life," which began to telecast many of our activities to the entire community. The Interfaith Coalition on Aging became involved with Age Well. Pastoral counseling students received instruction and the staff began to work with ministers and rabbis within the interfaith Coalition. Before we knew it, the process of health promotion was beginning to expand beyond the boundaries of the retirement communities into the churches throughout the community.

During the mid-1980's the notion of worksite wellness grew. Members of the Age Well team served on the Board of Directors of the Wellness Council of Tucson (WELCOT). At the moment, there are over 100 industries with 50,000 employees involved in health promotion, doing many of the things that we are involved with in Project Age Well. What had initially started off as a geriatric-focused health promotion and prevention project began to move in multiple directions. The Arizona Association of Community Health Centers, which is a statewide health promotion coalition, sought our assistance. The Arizona Area Health Education Centers began to provide the Age Well model with selected components throughout the state under the AHEC umbrella. The Hispanic Council on Aging in our city and state began to see unique applications crossing cultural dimensions. Through the Brookdale Foundation our network spread as far as New York City, where we shared information, videotapes, and assessment instruments with the commissioner of the Department of Aging in New York.

By word of mouth and through our presentations at various meetings, the word spread and crossed national borders. Visitors from the Government of Japan have come on at least two occasions to see the project firsthand. Three months ago we were guests of the government of China in Beijing, exchanging information and seeing which of their traditional health practices could be incorporated into our community-based and residential-based complexes to promote Age Well.

Now the Age Well and health promotion network is huge, reaching rural and urban communities and using all methods of communication, including television, newspapers, newsletters, fairs, walks, church and synagogue participation, school districts, peer awareness and national and international linkages.

What has evolved has been a unique mixture of professionals providing their various talents and skills in an interdisciplinary fashion to the needs of older people. At the present time we have nutritionists, pharmacists, nurse practitioners, exercise physiologists, pastoral counselors, social workers, anthropologists, and physicians involved in the team approach to Age Well.

One striking effect of the program is the interdisciplinary educational opportunities that have been created. We find students collaborating not only in health promotion and care, but also in research and scholarly inquiry. Students involved with Age Well are from many disciplines, including anthropology, medicine, nursing, nutrition, pharmacy, rehabilitation counseling and social work. The by-product of the educational experience is that we believe we are helping train the next generation of citizens to address the issues and questions of our aging population in thoughtful and informed ways.

Within Project Age Well we focus on primary, secondary and tertiary prevention, along with health promotion and functional assessments. You are quite familiar with primary prevention, including influenza, pneumococcal and tetanus vaccines, smoking cessation and diet modification. In secondary prevention, our emphasis is on early detection and treatment. This includes hypertension; cancer of the breast, colon and cervix; sensory deficits, particularly in vision and hearing; mental health, focusing on dementia, alcoholism and total mental wellness; social support; drug therapy; and numerous miscellaneous prevention activities directed at urinary incontinence, hyperthyroidism, podiatric problems, and osteoporosis. To date, our focus in the area of tertiary prevention has been in the areas of rehabilitation and physical medicine.

Our attention in health promotion has been on accident prevention. We have provided assistance and advice in the design of many of the apartments, with particular concern to the floor coverings, lighting, and bathroom engineering. In physical fitness and nutrition, our emphasis has been on walking, stretching, and endurance. Our nutritional promotion program includes some of our most popular activities. We have explored the introduction and use of microwaves, the packaging of food products for the elderly, and food wastage by older people.

Functional assessments include psychological, cognitive, perceptual and personality support. Within our assessment of the social support structure of our elderly clientele we have been able to enhance our understanding of their places of interest, policies that impede and promote, and economic situations affected by fixed incomes and discretionary spending.

At the University one of our major responsibilities to society is the acquisition of new knowledge through observation, evaluation, basic science inquiry, applied and operational research. It is only through the process of scholarly inquiry that we are able to continue to upgrade our educational methodology and add to those truths passed on to each new generation of men and women.

Our research projects at the moment include investigations into osteoporosis screening, zinc supplementation and its effect on alcohol, exercise

and treatment of hypertension in the elderly, the effect of exercise on the immune system, the role of sunscreen and its use on serum vitamin D levels, protein-calorie malnutrition in the elderly, the effects of endurance training, fee-for-service models and health promotion models, and the acoustic properties of emotional speech in aging.

Also, we study attitudes toward life in the aging, beliefs in health use, post-hospital intervention strategies, reminiscence as a therapeutic tool, peer counseling, spirituality and well-being in the aging, life care at home, cancer prevention in the elderly through the development of quantitative risk assessments, Telehealth and electronic communications, drug-food interactions and case management of the frail elderly.

Despite the diversity of research projects, we believe we have just begun to scratch the surface.

In many respects, health promotion cannot be separated from health education. The roots of health promotion lie in effective and interdisciplinary health education. The ability to communicate by whatever means necessary those concepts, programs, and activities that promote better ways of doing things, has been at the heart of our ongoing educational "classes." Our classes occur in the morning, afternoon and evening, in social settings, and at meal times.

Permit me to share with you some of the titles of the topics that we cover:

Feelings—Let Them Go
Calcium and Osteoporosis
Making the Most of a Visit to Your Doctor
Immunizations and the Elderly
Cough and Cold
Vitamins
Coping With Depression
Nutrition and the Elderly
Medical Self-Care—How To Be Your Own Doctor—Sometimes
Are You Healthy?
What Will Your Medical Exam Tell You?
Stress and Your Well-Being
An Old Dog Can Learn New Tricks
Community Resources: Do You Know What Is Available To Protect and Promote Your Health?
Medications: How They Help and How They Harm
Accident Prevention: In Your Home and in Your Environment
Nutrition: You Are What You Eat
Thoughts and Feelings About Cancer
Stress and Cancer
Eating To Avoid Cancer,

Additional topics include Coping With Death and Loss
Do You Play the Blues?
Learning To Manage Your Stress
If I'm Depressed
Who Can Help? Community Resources for Depression

Antidepressant Medicines and Their Effects
Hypertension (medications, nutrition, stress, exercise)
Osteoporosis (medications, nutrition, exercise)
Bone Scane Information
Leisure Resources
Medicare
Positive Sleep Habits (techniques, medications)
Personal Safety (safety outside the home, first aid)
Arthritis (exercise, nutrition, medications)
Gastrointestinal Problems (nutrition, medications)
Constipation and Diarrhea (diet, medications)
Medications and Aging
Using the Health Care System
Health Care Maintenance
Problem Solving.

Finally, we offer:
Diabetes (medications, nutrition, exercise)
Food Safety
The Grieving Process
Chronic Pain
Medications for Pain
Biophysical Feedback
Stress Reduction Techniques Which Also Can Relieve Pain
Physical Therapy
An Overview of CPR
Normal Sexual Function and Aging
Medications That Affect Sexual Activity
AIDS
Meeting Your Sexual Needs
Marital Therapy
Depression and Anger.

One of the fascinating observations that we have made is that health education is not a one-way street. We have been singularly impressed by how peers become involved in explaining, clarifying, and restating in different words the themes of the topics. We believe that health promotion through peer education, example, and guidance is a tool that should not be overlooked nor underestimated. It doesn't take a doctorate to be an effective communicator and instructor.

We have been with the group long enough to develop close friendships with the people we serve, but it is still possible to step back and from a more academic perspective try to put in perspective what we have learned. There is no question that it is better to prevent and promote wellness than to commit energy and resources to 20-30 years of ongoing care. It appears to us that the physician model of illness intervention through diagnosis and treatment is inadequate for the broadly defined health needs of our older people. We have learned and have been taught that very many older people are not necessarily disease-oriented. Many of their problems and

concerns are preventable. Older people are concerned with coping and with loneliness.

We have found that many people are on too many medications. Given our understanding of the importance of diet, it could be said that their diet is inadequate. Inadequacy is emphasized not only in terms of insufficient calories, vitamins, minerals, etc., but due to the beliefs, customs and the energy related to preparing meals, shopping for food, spoilage of food.

We have learned that the existing sources of public transportation are often inadequate. They don't meet the needs of many older people and can't accommodate chronic conditions that they have, the speed at which they move and the ability and time required for them to enter and exit the vehicles.

We have been surprised to find out that in our population there is more interest in cancer prevention than in the prevention of heart disease. Priority is given to dealing with existing infirmities, taking priority over screening for potential problems. We have found that people can develop a commitment to exercise, and many of our clients have been in programs for more than 3 years. We have observed that those people who bring to the community marginally social capabilities find a way of life in health promotion. We have noticed significant changes in the attitude of professionals, in the way they perceive the aging process, and also in our young people, as we incorporate young schoolchildren into some of our programs.

In summary, while we may have been a bit ambitious in our goals, and while we certainly have been expansive in our approach, it is not because the need has not been there. We have learned over time that the needs of our senior citizens are complex. We are as concerned with the demographic changes and trends that we see as you are. We believe that our understanding of the boundaries of health promotion and prevention are limited only by our imagination and by the time and energy we are able to wish to devote to the needs of this special population group.

We have learned that it is impossible to plan programs unless one has lived, worked and experienced the issues first-hand over a period of time. We have experienced the fact that there is no formal constituency for health promotion. The informal constituency is not limited to the aged but cuts across age boundaries and working class. We have learned that while there is no quick fix to the problems of health care for the aged, there are numerous strategies that improve the quality of their lives.

I would like to thank my senior colleague, Dr. Evan Kligman, who has orchestrated, implemented, negotiated and developed much of what I have told you, to the Brookdale Foundation for their generous support, not only financially but through their insistence that we share our information as widely as possible, even though the last word is not in on many of the strategies and directions we have taken, and finally to the Pima Council on Aging under the direction of Mrs. Marian Lupu, who has played such an instrumental role on networking the activities and actions of Project Age Well.

Finally, I would like to thank the Surgeon General, Dr. C. Everett Koop, for his keynote address and his kind invitation, particularly to a group based

so far from Washington, to discuss the key directions and dimensions of Project Age Well with you.

"International Geriatric Health Promotion Study/Activities"

Presented by David Macfayden, MD
former Manager, WHO Global Programme for Health for the Elderly
Monday morning, March 21, 1988

I have been asked to speak on the theme "International Activities in Geriatric Health Promotion." Geriatrics is a word coined 80 years ago by the New York physician, Ignatz Leo Nascher. Dr. Nascher used the term to cover the same field in old age that is covered by the term pediatrics in childhood. This idea crystallized from his international perspective. On a European trip he observed low mortality in Viennese elderly people whose physicians dealt with them as individuals with needs particularly to their age group, just as pediatricians dealt with children. Thus, a new word, a new discipline and a new philosophy of aging emerged when a first generation American compared health approaches in New York and Vienna. Eighty years on, international comparisons on aging offer the same opportunity for generating creative ideas. As an international physician, I passionately believe that searching for cross-national experiences of healthy aging will benefit all. Indeed cross-national research is indispensable if we are to understand how to remain healthy as we age.

Let me first give you the context in which activities in health promotion have gained prominence in the World Health Organization. In doing so, I should like to emphasize that the recent international movement towards health promotion paralleled moves at the national level, not least of which was that imparted by the 1979 Surgeon General's Report "Healthy People" and the national goals and objectives emanating from that publication.

When the World Health Organization's constitution was ratified few realized that is definition of health would be seized upon by the world's elder citizens. It is now the aspiration of many in this room to transit through their 60s, 70s and even 80s "not merely in the absence of disease, but in a state of complete physical, mental and social well-being." And, on the Organization's 40th anniversary, on April 7, 1988, this aspiration is clearly articulated in the World Health Day theme "Health for all: all for health."

A more recent international anniversary is commemorated in the ten year old Unicef/WHO Declaration of Alma-Ata, which established the philosophy of primary health care. The keystone of this philosophy is that prevention and promotion should be the central focus on health care.

Just as the 1979 United States report was translated into some 223 health objectives, so the WHO policy statements of Alma-Ata were collectively refined by the countries of Europe into 30 time-specific targets. Broadly, the European goals were:

- to add years, by preventing premature death;
- to add health to life, by minimizing disability and preventable disease; and
- to add life to years, to attain the highest attainable level of health for elderly people.

The involvement of European governments in settling collective health targets gave a high political profile to health promotion, witnessed by the Ottawa Charter on Health Promotion and the Second International Conference in Health Promotion taking place next month in Adelaide, Australia.

As stated earlier, what happened internationally was a reflection of what was happening within nations. Advocates for health promotion in older persons spoke with two tongues within nations. There was the voice of rhetoric and the voice of reason. Thus, when the World Health Organization's expert committee on health of the elderly came to consider preventive actions, they were cautious about the rhetoric but nevertheless accorded prevention high priority, based on rational examination of available evidence. Here are some of the conclusions:

There have been great enthusiasm of late for the concept of promoting wellness among the elderly. Recommendations for diet and exercise claim great benefits in terms of improved function and enhanced well-being. Unfortunately, there is very little evidence to support this enthusiasm.

One potential problem lies in confusing risk factors with modes of intervention: they are not synonymous. In some cases, the risk factor may be associated with permanent changes in the organ at risk. For example, diastolic hypertension is a well known risk factor for heart disease and stroke, but its effects may be due to changes in the vessel wall already in place. Lowering the blood pressure may thus have less effect than measures which lower the risk of thrombosis.

Recent data from Sweden describe impressive improvements in the physiological performance of 70 year olds separated by only five years. Although these reports suggest that such improvements are the result of alterable conditions on lifestyle, we have not yet demonstrated which ones produce the desired ends nor how susceptible to direct influence they are.

A number of areas of potential preventive action for the elderly have been identified. Some involve primary preventive strategies, others screening. The former include immunization for influenza and pneumococcal pneumonia, and smoking cessation. Elderly cigarette smokers can markedly reduce their risks of lung cancer and heart disease by stopping smoking even into their 70s.

Screening tests are appropriate if they have a reasonable chance of uncovering medically and economically treatable conditions. Thus vision screening for cataracts can be very helpful. So too can audiometry uncover remediable conditions. Certain laboratory tests such as thyroid screening can uncover treatable pathology. Other candidates for secondary preventive efforts are screening for breasts, cervix and colorectal cancer, oral examination, detection of alcohol abuse, attention to nutritional status, evaluation of blood cholesterol levels, and accident prevention. These areas

deserve further investigation to ascertain their potential benefit for the elderly, but specific trials are required before they can be broadly advocated.

The problem of fractures is an excellent example of the complex nature of preventive activities in the elderly. The growing body of information about osteoporosis suggests that the judicious use of estrogens can retard the onset of the condition with acceptable risks, given appropriate supervision. Exercise may have a useful, if modest, contribution to delaying bone loss. It also seems to improve the sense of well-being and for this reason alone it should be encouraged.

Retarding osteoporosis can reduce the risk of fractures, but other factors contribute to this problem. For example, hip fractures are often the result of falls. Such fractures occur more often in the presence of osteoporotic bone. Preventive strategies can be usefully directed toward reducing the propensity to fall by altering the environment to remove hazards, identifying and treating correctable causes of falling or by teaching older people how to fall more safely.

A major role for prevention in the elderly is the avoidance of iatrogenic disease by interrupting transition from a disease process to a disability. Such prevention is more easily attained when care is provided from a continuous source. The caregiver can then observe subtle signs of change against what is often a busy background of symptoms associated with multiple chronic diseases. With such attention, the caregiver will often notice early signs of degeneration that would otherwise be dismissed as unimportant. Preventive work designed to reduce disability must include attention to the patient's wide range of needs. Sensitivity to such problems as depression, changes in speech and hearing, cognitive impairment and incontinence can lead to timely prevention.

Disability can be reduced even after a chronic problem has developed by careful attention to structuring the patient's physical and social environment so as to promote autonomy. Physical modifications of various types can make things more accessible and manageable, but more subtle effort is required to establish a rehabilitative climate where patients are encouraged to attempt as much as possible on their own. There are strong pressures from regulatory agencies and those concerned with the patient's safety to encourage care givers to do things for patients instead of encouraging autonomy.

Many preventive strategies that benefit the elderly involve efforts best directed at younger groups, who will then be in better health at the time they enter old age. This observation means that resources that benefit the elderly in time may be redirected toward other age groups. It is also useful to appreciate that investments in preventive actions are often difficult to sell to governments more concerned with short term events than with those that may not yield results for some years to come.

There is some danger in withholding preventive services from the elderly on the grounds of lack of demonstrated benefit. In a sense, elderly people are the victims of age discrimination. They have been systematically excluded from most trials of prevention. Thus the absence of evidence may be due to the fact that it has not been sought.

Preparatory to its Expert Committee meeting, the World Health Organization held a meeting in Hamilton, Canada to review the effectiveness of health promotion in the elderly. Frankly, it did not achieve this objective since the participants were torn between applying the strictest rules of scientific evidence and accepting health promotion practices which merely proclaim benefits in terms of improved function and enhanced well-being. In the end, the participants tried to achieve a unity of science with common sense by describing actual health promotion activities in different countries. In South Australia, for example, rational criteria are used to select geriatric health promotion activities for a state-wide program. Priority is given:

- to the most prevalent contributors to disability or death
- the most prominent societal concerns
- interventions likely to yield significant outcomes from resources
- invested conditions which are amendable to intervention in that
- large scale studies demonstrate that sustainable results can be achieved, or
- studies suggest the problem is amendable to intervention but local testing is necessary.

Evidence for the interventions were supported for:

- treatment of moderate to severe hypertension at least up to the age of 70
- influenza vaccination
- targeting breast cancer self examination in older women
- ameliorating social isolation
- relieving the care burden of family members
- correcting unfavorable societal attitudes
- pre-retirement education.

Close liaison was reported in Hamilton between the work of the Canadian and United States task forces on periodic health examination and on preventive health services. Both were exigent in using quality of evidence assessment criteria. On analyzing the evidence, the Canadian task force's principle recommendation was that routine annual checkup be abandoned in favor of a selective approach, based on a patient's age and sex. Accordingly, age- and sex-specific "health promotion packages" were developed and it was recommended that these be incorporated, opportunistically, into visits to a health facility. The package for 65-74 year old men and women includes:

- immunization against influenza, tetanus and diphtheria
- correction of hearing impairment
- measurement of blood pressure
- oral examination
- testing for occult blood in the stools
- two-yearly assessment of nutritional status and
- a condition called "progressive incapacity"

When screening practices from the United Kingdom and Israel were added to United States and Canadian experience there was little to add to the content of the health promotion encounter in the primary health setting beyond social and psychological function and measuring height and weight.

At the same time that the WHO experts were urging caution on the rhetoric of health promotion, the research community was encouraging WHO to develop world wide collaborative studies on aging. This is now formally established as the WHO Special Program for Research on Aging, and is based here at the National Institute of Aging. The central research question in the Program is to identify the determinants of healthy aging. Transitions in health status over time will be related to a battery of identical baseline measurements. Subject to the availability of funds, these prospective studies will be conducted simultaneously in some 8 countries.

Healthy aging, successful aging, effective aging all slip easily into our language. I am not suggesting that we do not use these terms. Indeed it is honest public health practice to do so if we wish to raise the health expectations of people and promote healthy public policy. Few have come to terms with the demographic reality that the third age emerged only some 3 decades ago in the United States and, now, half the women born will transit the age of 81. But aging people, their care providers and policy makers need facts more than exhortation. The collaborative endeavors which the international research community is tackling in harness with the World Health Organization and the National Institute of Aging are designed to generate these facts.

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Charge to Participants

Presented by C. Everett Koop, MD
Surgeon General, United States Public Health Service
Monday morning, March 21, 1988

We've heard much good information last night and this morning and now we ought to get to work ... in our work groups.

I've had the pleasure of convening seven workshops during my 6½ years as your Surgeon General. Some have been very large with a hundred or two hundred people ... some have had fewer than 50 people attending.

But the size has no relationship to the ultimate effectiveness of these workshops—and many of them have been extremely effective.

What's the secret?

Nothing very esoteric, believe me. The first requirement is that each person attending a Surgeon General's Workshop understands that his or her active participation is essential at every step of the workshop process.

If we didn't think you were important to the outcome of this workshop on health promotion and aging ... you wouldn't be here.

So ... please ... jump in and help pull together the kind of outcome of which we can all be proud ... an outcome that will help make a real difference in the lives of older Americans today and in the years to come.

The first requirement for success, then, is your participation.

The second requirement is to stay within the general framework of my "charge" to the workshop. And that's what I intend to deliver right now.

The "charge" is meant to keep everyone generally on track in some reasonably organized way so that—within the tight time frame we have before us—we can produce a set of sound and solid recommendations that can focus and energize the work in health promotion and aging.

This, then, is my "charge" to this workshop.

First, please keep in mind that our work is directed to the attention of the health care community, we want *them* to begin doing some new and different things—or to start doing some old things *better*.

Second, we need to reach the health care community through different avenues. I would think, for example, that some attention ought to be given to the role of professional and educational associations and institutions in this work. What do we want them to do? What kinds of pre-service and in-service educational program would we want them to carry out?

Maybe there are other ways to tell the story of health promotion and aging to health professionals now in the at work health system. Let's get those ideas out on the table and let's talk about them.

Third—and it's related to one I just mentioned—we need to think not only about the health professionals already at work but also about the young men and women who *should* be entering this field ... those bright and dedicated young people who would be most receptive to a recruitment message that talks about a real challenge ... about opportunities for growth ... and about the tangible and *in*tangible rewards of personal and community service.

Again, I'm delighted we have six graduate students with us. They've already chosen a career in geriatrics. I hope they'll help us convince other bright young people to do the same thing.

Fourth, I'm very, very impressed by the background papers prepared for this workshop. And I want to extend to every author of every paper my own personal thanks for taking the assignment very seriously and helping us get off to a strong, running start.

But there's some "background" we still don't have about health promotion ... about aging ... and about both of them together.

At this workshop, we should zero in on the kinds of research that ought to be on our agenda for the future. This has been touched on already by several of the speakers already, but let's do more than just "touch on" this issue.

Let's talk about the areas where new knowledge is vitally needed—in the nature of the aging process, the health care needs of the elderly, or whatever. But let's get *them* down on paper also.

Fifth and finally, we need to speak candidly about the strengths and weaknesses of our nation's system for delivering health services, with reference to the elderly—and especially with reference to the promotion of the health of the elderly.

If this task were being effectively accomplished today, there would be no need for a "Surgeon General's Workshop on Health Promotion and Aging." But it is not—and we are here.

Let's look, then, at the kinds of services we now have ... the kinds of services we ought to have ... and the way these services do—and should—relate to each other in this matter of health promotion for older Americans.

At 9 a.m. on Wednesday morning, we will begin to hear the recommendations of the many work groups. These will be the culmination of our work here this week.

What should these recommendations look like or sound like?

Again, going back to the first "charge" I mentioned a few moments ago, the recommendations ought to be directed to the health care community and ought to be related somehow to the role of that community in promoting the health of older Americans.

Past workshops have been able to handle sometimes dozens of recommendations by arranging them under one or another of three headings: *research, education,* and *service*. I would encourage you to do this, also, because I gather, from talking with many of you, that we're going to have both quality *and quantity* in the recommendations of this workshop.

Try to keep your recommendations tied as closely as possible to specific, do able actions by particular institutions, professions, levels of Government, or other responsible elements in our society.

Finally, while Commissioner Fraser Fisk, Director Williams, and I will be formally receiving your recommendations tomorrow, do not limit your recommendations just to the work of our own respective agencies or even our Department.

Keep them on as broadly applicable a plain as you can. Remember, while you may have been convened by the Surgeon General for a "Surgeon General's Workshop," the actual scope of authority of the Surgeon General—as with any other public official—is carefully circumscribed by law, regulation and tradition.

Maybe some of these ought to be changed. Then say so, but please do not become mired in the details of life in the bureaucracy.

Speaking for my own little "newcastle," I have quite enough coal of my own, thank you.

Now, let me close by indicating what we plan to do with your recommendations.

As with previous workshops, we intend to publish them all—the good, the bad, and the indifferent—without any further editing for content or substance.

Our staff will clean up the grammar and syntax, where such might be necessary: This is the Government and we do have some standards. But we will *not* "clean up" the *thinking* that's *expressed* by that grammar, in deference to any political or other interest.

So, please do your very best. And we will respect that effort.

The final printed document will be distributed to those very associations, institutions, and agencies—public and private—who constitute the "health care community" in American life.

Many of you may be called upon for advice, as we put together our distribution plan. We want to make sure that the people who should act upon the message of this workshop actually get that message in the first place.

I'm pleased to say that we print *and reprint* thousands of copies of reports from these workshops. They tend to be benchmark documents and of great value for policy-makers, decision-makers, teachers, students, and involved persons from among the general public.

I am sure the document you produce here this week will have the same active longevity, appearing in every office and meeting room around the country, where people are serious about providing better health services for our older citizens.

That, ladies and gentlemen, is my "charge" to you. I've made it sound simple and straightforward ... because we need that more than we need jargon, rigmarole, and hot air.

I know you agree. And I know you will be terrific. Thank you.

PLENARY SESSION

RECOMMENDATIONS OF THE WORK GROUPS

Wednesday, March 23, 1988

ALCOHOL WORKING GROUP

Chair: Enoch Gordis, MD
Technical Manager: Susan Maloney
Reporter: Angela Mickalide, PhD
Group Members: Thomas Beresford, MD
Gerald Bloedow
Jacob Brody, MD
Teri Dowling
Barbara Giloth
Edith Lisansky Gomberg, PhD
Marie Gooderham
Millicent Gorham
John Horn, PhD
Robin Room, PhD
Anthony Vuturo, MD
Nancy Wartow
Erma Polly Williams

In the area of education (health care providers), we recommend that:

1. health care providers be educated through CME courses, professional associations, and other networks as to the patterns of alcohol use among older persons, risks and potential benefits of such use, effective detection and intervention techniques, and communicating effectively with their patients about alcohol issues.
2. Federal agencies provide incentives to medical schools and other health professions academic institutions to carry out a plan for education on alcohol abuse within the context of geriatric health care.
3. the content and effectiveness of educational materials on alcohol use among older persons be evaluated by HRSA/NIA/NIAAA to identify gaps and highlight opportunities for material development.
4. Federal agencies responsible for training health care providers and identifying personnel needs stemming from the aging of the population be attentive to alcohol issues.

In the area of education (alcoholism service providers), we recommend that:

1. alcoholism service providers be educated to the potential benefits of treatment at a late age.
2. organizations of service providers, State alcohol authorities and voluntary groups such as the National Council on Alcoholism be asked to include this information in ongoing education and training activities.

In the area of education (social service providers), we recommend that:

1. social service providers, including home health aides, be made aware of the potential for alcohol problems among older clients and of methods of identification and referral.
2. training for caregivers and advice for family members affected by alcohol abuse in older relatives be made readily available.

In the area of education (public), we recommend that:

1. Federal agencies, national membership and voluntary organizations, and associations, e.g., the American Association of Retired Persons, the National Council on Alcoholism, the American Society on Aging, and the National Council on the Aged, be encouraged to develop and disseminate information about alcohol problems among older adults.
2. public and private sector employers providing pre-retirement education include information about alcohol use.

In the area of service, we recommend that:

1. third-party payment for detoxification and rehabilitation be modified to reflect adequate length of time for recovery from alcohol abuse among older people.
2. the relative benefits of treating older alcohol abusers in community vs. hospital-based alcoholism treatment programs and in elder-specific vs. mixed-age alcoholism treatment programs be explored.
3. AoA fund demonstrations to develop broad-based community level programs to address alcohol problems among older people.
4. community-based programs, e.g., area agencies, county and city health departments, and voluntary agencies, develop linkages with the alcohol services network to identify, refer, and treat the older alcoholic.
5. existing State coalitions on health and aging expand their membership to include alcohol-related networks.
6. the Veterans Administration include an alcohol use component in their delivery of preventive services, including alcoholism counseling when appropriate.

In the area of research (epidemiology), we recommend that:

1. cross-sectional and longitudinal studies, including those using indirect measures and qualitative methods, be expanded on patterns of drinking among older adults to determine quantity, frequency, and duration of alcohol intake.

2. available data sets such as the National Health Interview Survey, the NIMH Epidemiologic Catchment Area Study, and the National Health and Nutrition Survey(s) be mined more carefully to answer questions about alcohol use patterns among older adults.
3. analysis of drinking patterns with special attention to socioeconomic groups, minority groups, and women be conducted.
4. in all epidemiologic studies, special attention be paid to attrition rates due to alcohol-related deaths.
5. research be conducted to determine the extent of lifetime versus late onset problem drinking among the aging and to resolve the discrepancy between early and late onset problem drinkers in the general population as compared to clinical, e.g., hospital and outpatient, populations.
6. research be conducted to examine the role of retirement, bereavement, and changes in discretionary income on alcohol consumption patterns. This includes examination of the reasons for the observed reductions in alcohol consumption with age.

In the area of research (physiology), we recommend that:

1. present studies be expanded on the impact of alcohol consumption on cardiovascular disease, particularly hypertension and stroke in the older population.
2. studies of alcohol metabolism in older people be replicated.
3. the interplay of the aging process and alcohol abuse on cognitive functioning in older adults be examined, and further exploration of the "premature aging hypothesis" be conducted.
4. the causal and intervening role of alcohol use in injuries common to older adults such as burns and fractures due to falls be examined.
5. both animal model and human studies be conducted to determine patterns of sensitivity and the acquisition and loss of tolerance to alcohol in older persons.
6. clinical investigators study the alcohol withdrawal syndrome in older persons to discover whether it is more lengthy, severe, and requires different treatment strategies specific to older adults.
7. the relationship between alcohol and nutrition in older populations be explored in terms of appetite suppression/stimulation and interference with nutrient metabolism.
8. current research on osteoporosis be expanded to include the role of alcohol.

In the area of research (other), we recommend that:

1. tax policy research include an exploration of the effects of such change on the alcohol consumption patterns of older people.
2. the role of alcohol in family violence and the behavior of violent older offenders be examined.
3. possible beneficial effects of small amounts of alcohol on eating behavior, mood, and sleeping patterns, and social functioning among older adults be further examined.

4. research be done to determine the role of alcohol in the risk of suicide and victimization among older people.
5. research be conducted on the effect of alcohol on errors in prescription and over-the-counter medication use and medication/alcohol interactions.
6. more reliable and valid screening instruments be developed to detect alcohol problems in older populations.
7. NIA and NIAAA pay special attention to alcohol use among older adults in their prevention research portfolios.
8. this research agenda be widely disseminated to potential funding sources including Federal agencies and foundations and to the research community.

DENTAL (ORAL) HEALTH WORKING GROUP

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The recommendations of the working group on oral (dental) health are based on the following premises:

- oral health implies an oral status that is stable, relatively disease—free, comfortable, and permits adequate function that includes mastication, speech, and swallowing.
- older persons should have access to appropriate oral health education, primary prevention, and oral health services.
- many oral diseases that afflict older adults are diseases of all ages and many preventive regimens, especially community water fluoridation are appropriate for older adults.

- while few conditions pose mortality risks, they may lead to pain physical dysfunction, and psychological anguish.
- many of the systemic diseases and the medications used in their management have direct or indirect impact on oral health and functioning. Because there is an age-related increase in systemic disease and medication usage, older individuals may be at greater risk for orofacial problems.
- in the provision of oral health services, it is recognized that competent older persons have the right to self-determination.
- where appropriate, specific guidelines will be developed to implement the following recommendations.

In the area of education, we recommend that:

1. all health care providers should be educated in the relationship between oral and general health including the contributions of each health care provider in maintaining oral health and function.
2. educational programs for current and future oral health care providers should improve their knowledge, attitudes, and behaviors regarding primary preventive, treatment, and educational needs of older adults that include culturally and ethnically sensitive aspects of meeting these needs.
3. educational programs should be available to develop competent educators and researchers in all areas pertinent to the achievement and maintenance of oral health in the older adult.
4. appropriate curriculum guidelines and accreditation standards specific to meeting the oral health needs of older adults should be developed and reflected in licensure, certification, and national board examinations for all health disciplines.
5. older adults and their caregivers should be educated to enhance their knowledge, attitudes, and behaviors regarding:
   - the value of primary preventive methods to maintain oral health including community water fluoridation and other fluoride uses;
   - the importance of regular professional oral health services;
   - the uses of scientifically valid personal oral hygiene practices; and
   - oral diseases associated with the uses of tobacco alcohol, and medications.
6. accurate and appropriately designed educational materials and other resources specific to the oral health needs of older adults should be developed or adapted and disseminated through all relevant agencies, services, and organizations.

In the area of service, we recommend that:

1. individual oral health care providers, organized dentistry, Federal, State, and local agencies, and other organizations should continue appropriate preventive, restorative, and rehabilitative services with emphasis on oral health promotion and primary prevention programs for older adults.

2. alternative methods for the delivery of primary preventive and restorative oral health services should be developed to meet the oral needs of older adults, especially the homebound, the institutionalized, and the functionally dependent.
3. long-term care facilities should have an established oral health care program that includes timely and appropriate diagnostic, primary preventive, and restorative services.

In the area of research, we recommend that:

1. more basic and applied research be conducted to clarify relationships between systemic conditions, medications, and orofacial conditions in older adults.
2. studies be done to elucidate and characterize oral changes associated with "normal aging" and assess their impact on oral function.
3. more health services research be conducted to develop, evaluate, and demonstrate methods of health care delivery to improve the oral health of older adults.
4. studies be conducted on the prevalence, incidence, cohort differences and risk factors of caries (coronal, root, recurrent), periodontal diseases, soft tissue lesions, chronic orofacial pain trauma, and salivary gland dysfunction including development of appropriate indicators.
5. studies be conducted to identify adults who are at high risk for orofacial diseases and methods to meet their needs.
6. studies be conducted to determine the relative efficacy and benefits of primary preventive procedures for older adults.
7. studies be conducted on the knowledge, attitudes, and behaviors of older adults in relation to oral health status.
8. studies be conducted to determine the interaction among oral health status, psychosocial function, nutrition, and general health.

In the area of policy, we recommend that:

1. all community water systems be fluoridated.
2. oral health services for older adults be an integral part of public and private health benefits programs, including, but not limited to: Medicare Part B, Medicaid, employee retirement benefits, and other health insurance programs.
3. special efforts in oral health promotion and service delivery be directed to older adults who are currently underserved, such as Native Americans, the homebound, Hispanics, and Blacks.
4. Federal guidelines for long-term care facilities should include:
   - a dental examination within 30 days after admission and annually thereafter;
   - a program in oral primary prevention and health education for residents and staff;
   - access to dental treatment when needed; and
   - oral health status information in residents' medical charts.

   Reimbursement mechanisms should be developed to support these activities.

5. access barriers to prevention and basic oral health services for older adults, such as financing, transportation, and physical barriers be removed.
6. appropriate Federal, State, and other agencies such as NCHS, HCFA, NIA, and NIDR be encouraged to include an appropriate oral health component, e.g., clinical and psychosocial variables, in their existing data collection efforts, and make provision for appropriate data analysis.
7. the VA be encouraged to establish one or more GRECC's focusing on health promotion and disease prevention that include an oral health component.
8. in order to reduce the risks of oral lesions, National efforts continue to discourage use of tobacco and alcohol.

PHYSICAL FITNESS AND EXERCISE WORKING GROUP

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The working group on physical fitness and exercise encourages the U.S. Public Health Service to place a major emphasis on physical activity and serve as a catalyst to encourage cooperation between institutions that can implement the results of exercise research.

In the area of education, we recommend that:

1. educational components be developed that relate to the health benefits of physical activity that can be included as part of existing medical school curricula. Such components should include physiologic effects and health benefits of physical activity.

the development of components within residency and internship programs that relate to the health benefits of physical activity be encouraged. Special areas would include cardiology, pulmonary medicine, physical medicine, orthopedics, geriatrics, etc.

3. continuing medical education programs on health benefits of physical activity be promoted by such means as symposia at national and international professional meetings, courses, etc.
4. the development and use of physical activity assessment, prescription, and follow-up protocols that offer guidelines to the health care provider for increasing physical activity patterns in a wide range of persons be encouraged.
5. opportunities be developed for pre- and postdoctoral programs, and the available pool of expertise in the promotion of physical activity for the older adult be expanded.
6. the development of courses dealing with health benefits of physical activity as it relates to aging for programs of exercise physiology, epidemiology, nursing, physical therapy, health education, physical education, etc., be fostered.
7. physical activity in-service training programs be developed for nursing home care providers to offer safe physical activity to patients.
8. training be supported that fosters interdisciplinary collaboration in the promotion of physical activity in the older adult. Collaborators include psychologists, physical educators, cardiologists, physiologists, health educators, nutritionists, gerontologists, etc.

In the area of service, we recommend that:

1. Federal, State, and local governments provide leadership and support to programs that will promote physical activity for older citizens.
2. leadership be provided in the promotion of physical activity as an important component of a healthy life-style and that all agencies of the Federal Government provide physical fitness programs for their employees.
3. the Federal Government encourage local communities to identify and develop focal points, such as senior centers or other concerned community resources, to coordinate physical activity services to older citizens.
4. health care institutions, such as hospitals and nursing homes, provide encouragement, equipment, and facilities to enhance the physical activity of their staff and clients.
5. health care insurers, including Medicare, provide incentives to appropriate clients to increase their levels of physical activity.
6. designs for all multifamily housing incorporate facilities such as exercise rooms or open spaces and gardens into their housing designs to provide physical activity options. This should be a requirement for Federally funded housing.
7. professional associations develop position statements regarding appropriate physical activity for older persons and educational programs to reinforce those statements.

8. a physical activity assessment be incorporated into regular physical examinations and routine medical visits.
9. local communities be encouraged to assess health-related components of physical fitness of older citizens to raise awareness of the importance of physical activity.

In the area of research, we recommend:

1. research to determine the effects of exercise, independent of other life-style and behavioral factors, on degenerative processes including:
   - cardiovascular disease such as atherosclerosis;
   - endocrine metabolic diseases such as adult-onset diabetes and dyslipoproteinemia;
   - musculoskeletal diseases such as osteoporosis and osteoarthritis;
   - neurobehavioral diseases such as depression; and
   - immune dysfunction such as susceptibility to infection.
2. research at molecular, cellular, organ, and whole body levels to investigate the mechanisms by which exercise exerts its biological effects.
3. multidisciplinary research focusing on the effects of exercise on functional capacity and disease in diverse populations.
4. research to determine the role of physical exercise in the maintenance of functional capacity including muscular strength and endurance, cardiorespiratory function, agility, coordination, and flexibility.
5. research to determine the role of regular physical activity in the maintenance of mental health, well-being, and psychosocial functioning.
6. research to develop guidelines for screening and baseline medical evaluations of healthy people, as well as people who are disabled or have specific medical problems, in order to formulate an individualized exercise program.
7. research to determine the appropriate types and levels of physical activity in terms of intensity, frequency, and duration necessary to safely achieve the potential benefits in health and functional capacity across a wide age span and range of abilities.
8. research to determine the interaction between physical activity and other health-related behavior.
9. research to assess the modifiable behavioral and environmental factors that encourage individuals to adopt and maintain physical activity patterns.
10. research to examine whether there are gender, ethnic, and/or socioeconomic differences in participation and responses to physical activity.
11. research focusing on the effects of exercise on functional capacity and degenerative disease prevention in women, especially in the peri- and postmenopausal period.
12. research to establish reliable and valid measures of physical activity for epidemiologic, behavioral, and evaluation research.

In the area of policy, we recommend that:

1. appropriate physical activity be encouraged for individuals of all ages to maintain functional capacity and protect against the development of conditions such as obesity and disease processes such as coronary heart disease and adult-onset diabetes.
2. regular physical activity, a beneficial behavior, begin at childhood and continue throughout life. However, such activity may be beneficial to individuals beginning at any age.
3. physical activity prescription be recommended in the management and treatment of selected chronic diseases, many of which are common in older adults.
4. specific physical activity recommendations be individualized according to age, health status, and current level of physical conditioning.
5. the development of physical facilities and behavioral programs that lead to increased participation at low levels of physical activity and progression toward more rigorous exercise and activity be encouraged.
6. institutional environments, e.g., schools, medical settings, and workplaces, encourage exercise and physical activity by providing time, facilities, and supervised programs.
7. the Federal Government and private insurers provide financial and other incentives for State and local governments, health care providers, corporations, and other private organizations to make available health screening, physical facilities (including fitness trails and bike paths), and programs to promote physical activity.
8. the Federal Government promote the expansion and development of the parks and recreation systems to provide places for physical activity participation.
9. the Federal Government promote more communications media attention, particularly broadcast media attention, to the promotion of regular physical activity in the aging population.
10. the Federal Government promote the dissemination of gerontological research and training information on the beneficial effects of physical activity and exercise to health professionals.

INJURY PREVENTION WORKING GROUP

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Members of the Injury Prevention Working Group understand that:

- intentional and unintentional injuries have serious consequences for older persons, their families, and the health care system at large
- efforts in injury control must include attention to epidemiology, prevention, biomechanics, acute care, and rehabilitation.
- while there are many commonalities, there are important differences in the extent, causes, and consequences of different injuries occurring in aging persons. Major injury categories important to older persons include falls and fractures; motor vehicular and pedestrian injuries; fires, homicides, assaults, abuse, and suicides.
- while input from many agencies is essential, the Centers for Disease Control, the National Institute on Aging, and the Administration on Aging will coordinate efforts in injury prevention and control for older persons.

Our recommendations in injury prevention and control are based on the following *assumptions*:

- Injury risk must be minimized without compromising quality of life.
- There is great demographic, cultural, and functional variability among older persons.
- Health care professionals should include older persons and their families in decision-making about injury prevention.
- Older persons with functional limitations benefit from more supportive environments than are found in a world designed for younger adults.
- Improvements in safety for older persons will improve the safety for all.

- Research, education, service, and policy in injury prevention require multidisciplinary efforts with participation from experts in gerontology, geriatrics, and specific injuries.

In the area of education, we recommend that:

1. content in injury prevention for the older person be a required component of the academic core curriculum of initial and continuing education of health care professionals and other service providers. Curriculum areas should include, at the least, the significance of injury as a public health problem, risk factors for injury, and presumptive and demonstrated injury control strategies.
2. professionals providing primary care be trained in the clinical assessment of risk for injury as well as the development and implementation of appropriate interventions.
3. professional disciplines, such as architects, engineers, and city planners, receive, as part of their required training, information on the capabilities and limitations of older persons so that these factors are incorporated into designs and standards.
4. the general population, especially children and youth, be education to understand the capabilities and limitations of older persons and their place as valued members of the community. For example, driver education classes and handbooks should provide information on the decreased sensorimotor capabilities of older drivers and the consequent need to share the road in an understanding manner. Moreover, in our youth-oriented culture, we need to reinstall the traditional values of respect for the older citizen, not only as a worthwhile end in itself, but as a means of both reducing the risk of suicide, homicide, and, assault among the elderly and enabling younger people to better accept their own aging.
5. older persons be provided with information concerning risk factors for injury, ways to modify them, and sources of assistance in risk reduction.
6. educational activities be aggressive and comprehensive and utilize existing programs for older individuals, television, radio, and other media, as well as the health care delivery system.

In the area of service, we recommend that:

1. organizations providing services to older persons involve and ensure, through an identified advocate, the input of older persons into decisions which affect them.
2. coordination at the Federal, State, and local level in order to ensure efficient and effective development and delivery of services to the elderly.

In the area of research, we recommend that:

1. new and existing data systems collect information in a standardized way to assess the prevalence, incidence, course, and costs of both intentional and unintended injuries.
2. data linkages be established between medical records and other information related to injury prevention in order to facilitate the

identification of risk factors and the development of intervention strategies.

3. further analytic studies incorporating standardized measurements and definitions be conducted to determine the factors that alter the risk of both intentional and unintentional injury.
4. the rigorous evaluation of risk assessment and prevention strategies to support their dissemination and reimbursement. There are many promising ideas, technologies, and services of unknown efficacy and cost effectiveness, including risk assessment and screen devices.
5. development of specific strategies to reduce injuries in the elderly, such as occupant restraint systems for the frail and automatic water temperature controls on showers and faucets.
6. increased research to identify the etiology of fall injuries including the determinants of age-related reductions in bone strength (osteoporosis), the pathophysiology of falls, and, more importantly, the biomechanical factors that determine injury given that a fall has occurred.
7. studies should be initiated to assess the effect of current strategies for the diagnosis and treatment of injured older people.
8. evaluation of the effect of injury on the psychological functioning and quality of life of older persons (including injury victims, survivors, and significant others).

In the area of policy, we recommend that:

1. agencies that set and enforce safety standards affecting the environments of older persons must take into account the capabilities of older persons.
2. new drugs be evaluated for efficacy in the elderly and that monitoring be done for specific adverse effects such as falls.
3. all hospital discharge and emergency room records require E-coding and that trauma registries be redesigned to be population-based and include a representation of all injury types.
4. the health care system be responsive to the needs of older persons through the following:
   - modifying reimbursement to support preventive clinical services.
   - develop protocols for assessments, evaluations, and interventions.
   - include rehabilitation professionals in primary health care teams.

MEDICATION WORKING GROUP

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The panel recognizes that drug therapy is an essential component of preventive, as well as curative, strategies. It is the least expensive and most cost effective component of health care costs.

Optimal use of medication in the elderly requires certain reconceptualizations: the value of incremental improvement in functional status as an outcome measure and the therapeutic objective of maintaining the highest level of functioning at any given level of illness.

A new paradigm is needed which recognizes the patient as a partner with the caregiver in the use of medications.

In the area of education, we recommend that:

1. health professional schools create an awareness of resources available for the prescriber, e.g., current geriatric text books in concert with PDR, USPDI, AMA-DE, and AHFS, to improve prescribing.
2. identifiable sites for prescribing information be available in all practice settings.
3. a different role for the pharmacist in geriatric medication—an expanded partnership with physicians as essential members of the care-giving team.
4. patients be educated to keep their own medication profile including over-the-counter drugs.
5. programs are needed for the training of family, community, and other home care providers in medication management.
6. prescribers, dispensers, and monitors of medication must understand age-related physiologic metabolic changes. Most important is decline in renal (kidney) function—the most frequently observed age-related

change which can influence the use and safety of drugs that are excreted in the urine.

7. the gerontological community should be encouraged to become actively involved in the drug development process.
8. as a way of improving drug use in the elderly, all professional schools should include in the curriculum for all students' courses in the following areas:
   - nonjudgmental patient counseling skills which recognize individual and cultural differences, and which recognize inherent ethnic differences, particularly in the use of nontraditional therapies;
   - interdisciplinary communication skills; and
   - basic concepts of epidemiology, pharmacology, and therapeutics, especially as relates to efficacy and risk of medications in the elderly.
9. a cadre of health professionals skilled in geriatric epidemiology and basic and clinical pharmacology must be trained.

In the area of service, we recommended that:

1. there be sustained, enhanced, and focused efforts to insure that older Americans have the information and tools they need (and have the right to expect) to be responsible partners in the medication enterprise:
   - the most effective tool for this is direct effective verbal communication, consultation and education regarding benefits, risks, and management of medication.
   - written information must be understood as a complement and not a substitute for dialogue.
2. third-party payors be encouraged to reimburse pharmacy services independent of the act of dispensing or the cost of the product. This includes such services as patient or provider consultation and withholding a prescription pending consultation with physicians.
3. alternative mechanisms of access to medicines for the geographically isolated and mobility impaired elderly. Study is needed of the potential limitations of such systems and the need for supported services, e.g., home health aids to encourage proper medication use and monitoring for side effects.
4. access to medicines and pharmaceutical services must be included as a basic part of broad health care programs for the elderly.
5. third-party reimbursement mechanisms must encourage (pay for) access to medical care appropriate for unique situations of complex medication regimens and isolated patients.

In the area of research, we recommend:

1. research regarding the most cost-effective means of educating the consumer or the home caregiver regarding proper use of and monitoring for side effects.
2. research regarding standardization of the medication profile and drug interaction information in the computer software that supports medication profiling.

3. research in the cost-effectiveness of medication profiling in the elderly.
4. research and evaluation regarding current and promising tools to improve the older Americans understanding and effective use of medications (compliance), e.g., medication diaries, color-coding, special packaging, large print and braille, pictographs, coordinated and consolidated dose forms, innovative delivery systems, easy-to-open packages, and messages adopted to social and cultural differences.
5. in the area of pharmacoepidemiological (postmarketing) research, we recommend:
   - post approval epidemiological research on elderly populations focusing on large automated linked data bases to study efficacy, risk, compliance, cost and new users rather than inefficient methods of ad hoc postmarketing surveillance, which require significant professional time;
   - current potential data sets be explored, particularly those relating to the elderly, e.g., Medicare, AARP, VA, and TRIMIS; the VAMP (England) automated medical practice model be examined as a possible model for use in the U.S.
   - development of better drug utilization denominators to understand risks from adverse reaction signalling systems; FDA should publish their data for general use;
   - targeted studies on nonlethal side effects to enhance patient acceptance and compliance and prevent secondary effects, e.g., dizziness, sexual dysfunction, nausea, incontinence, etc.; and
   - in epidemiological research, greater clarity in definitions and measurement of outcomes and exposure.

In the area of policy, we recommend that:

1. the standard of practice for pharmacists which includes use of up-to-date patient profiles and their application at the time of dispensing be endorsed.
2. consideration of medication provisions is vital in the Catastrophic Health Coverage Act (Medicare) (H.R. 2470) as follows:
   - Medicare should cover pharmaceutical benefits (prescribed items) including prescription and over-the-counter medication, biologicals, devices and appliances on an outpatient basis.
   - State windfalls from Medicare assumption of coverage should be required to be redirected to the health benefits, including drug benefits, of the non-Medicaid poor and near poor elderly.
   - States should be permitted Federal matching funds for Medicaid programs providing medication services to elderly persons at 200% of poverty.
   - so-called cost saving mechanisms in Medicare and Medicaid which control numbers or types of prescriptions or require co-payment for the poor and near poor for medicines are potentially hazardous and ineffective and should be abandoned.
   - correction of problems detected by drug utilization programs should emphasize education of professionals and not sanctions. Such efforts should be based upon current credible scientific

indicators of medical practice and should focus upon direct professional and collegial contact.
   - a new national mechanism is needed constituted by representatives of the gerontologic medication community for overseeing and evaluating this effort.
3. pharmacological tools currently available need broader application to attack the major causes of illness, disability, and preventable death in the older American. The Federal Government should vigorously pursue and support research for the use of medications in National prevention strategies based upon the considerable success in hypertension. Fruitful current areas include: arteriosclerotic cardiovascular disease, congestive heart failure, diabetic complications, and osteoporosis.
   - there is also promise in the longer term:
     —protection of renal function;
     —brain function and dementias;
     —protection of connective tissues;
     —preservation of immune function; and
     —benign prostate hypertrophy.
   - priority areas for treatment should also be directed to:
     —chronic obstructive pulmonary disease (COPD);
     —circulatory disturbances; and
     —cognition restoration.
4. official governmental health agencies explore and expose fraud and quackery.
5. vitamins, certain food stuffs, and nutritional supplements which are being used as drugs be reviewed by appropriate regulatory agencies; regulatory changes be made.
6. new drug labeling include, where appropriate, directions for use in the elderly or other subgroups at risk. If no data are available, the labeling should state that data are not available.
7. for existing products, label statements regarding use in the elderly be added incrementally as the label is revised. A schedule for such reviews needs to be developed.
8. the use of official drug labeling as a patient teaching tool should be enhanced.
9. the FDA proceed with the final development and implementation of proposed guidelines for development of drugs for use in the elderly, especially elderly subgroups at risk; in particular, persons should not be excluded from clinical trials on the basis of age alone (ASCPT Workshop, December, 1986).
10. the Federal Government be a more active partner in the drug development process, both in establishing the basic science foundation and in other stages of evaluating drugs of importance for the elderly.
11. the Federal Government should restore the extramural programs of core support for population pharmacoepidemiologic resources.

12. emphasis should be placed on the development of cost effective strategies for incremental improvement of health status and maintenance of highest possible function through the use of medications for symptomatic relief of pain, sleeplessness, anxiety, depression, and problems of the preterminal state.
13. public exploration is needed of current policy, e.g., the orphan drug act, to stimulate the development of drugs, especially those without adequate profit incentive or with excessive liability concerns, e.g., non-patentable compounds, drugs off patent, vaccines, and orphan indication which could address unresolved problems in the elderly.
14. Post approval studies focusing on the aging population at risk.

MENTAL HEALTH WORKING GROUP

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Misperceptions and a lack of information about mental health problems in later life are common among the public and health care practitioners alike. Many clinically significant changes are dismissed as representing inevitable mental or behavioral manifestations of normal aging. The early recognition of these problems, however, can often prevent excess patient disability, promote a higher level of health and social functioning, and reduce family stress among close caregiving relatives.

There is growing recognition of risk factors that have the potential of influencing the onset, clinical course, and response to treatment of mental health problems in elderly individuals. Such risk factors include: major losses, especially of a sudden or unexpected nature, as with loss of physical health, loss of a loved one, or loss of self-esteem; medication side

effects; social isolation; relocation trauma; and forced transitions, e.g., involuntary retirement.

The adverse influence of mental health problems on the course of physical illness in older adults is significantly underappreciated; similarly, the potential contribution of mental health interventions toward promoting more rapid recovery from major medical problems and surgical procedures in later life is greatly overlooked.

The capacity of an individual with mental or behavioral problems to respond to mental health interventions knows no end point in the life cycle. Even chronic mental disorders in later life can respond to clinical interventions and rehabilitation strategies aimed at preventing excess disability in affected individuals.

Older persons with mental health, alcohol, and other drug problems typically have physical health problems as well, bringing them into contact with multiple services and a range of health care providers. As a result, strategies to promote mental health and to prevent the exacerbation of mental disorder in an older person must take into consideration multidisciplinary and service coordination issues.

The consideration of mentally retarded older adults should be included in deliberations on research, training, service, and policy recommendations pertaining to mental health promotion and the prevention of mental illness in later life.

The promotion of mental health among older adults occurs in an environment which includes, and is influenced by, family members, friends, and various natural support groups.

In the area of education, we recommend that:

1. in order to assure the existence of a cadre of mental health teachers to effectively transmit state-of-the-art knowledge in clinical and research training and education for the range of health care providers who can contribute to promoting mental health and preventing mental illness in elderly persons, a national program, multidisciplinary in focus, should be assured and adequately funded.

   The diversity of health care providers who encounter older adults with (or at risk for) mental health problems, together with the diversity of service settings utilized by these elderly individuals, requires a multifocal training program. Given this:

2. mental health training models should be researched and developed, focused on:
   - mental health professionals in general training;
   - continuing education for mental health professionals who have completed their formal training;
   - primary health care providers;
   - paraprofessionals;
   - in-service training areas, e.g., senior citizen centers, older adult nutrition sites, senior housing projects, nursing homes, and board and care homes;
   - service systems serving the elderly, e.g., community health and mental health centers, area agencies on aging, home health care agencies, etc.;

- informal support system care providers, including older adults themselves and families;
- volunteers; and
- special training areas, such as for minorities (Asian Americans, blacks, Hispanics, and Native Americans), elderly individuals, and other special older population groups (mentally retarded, developmentally and physically disabled), team approaches to the provision of care, etc.

3. educational materials and dissemination of information efforts should be further developed to (a) address stigma issues relating to mental health care of older adults and (b) provide information aiding in the recognition of mental health problems and the awareness of mental health interventions relevant to older patients. Such educational materials should focus on a diversity of target groups including:
   - older persons and their families;
   - the range of health care providers;
   - other service providers who come into contact with, and assume direct responsibility for, mentally ill older adults, including those serving as gatekeepers and those involved in the disposition of care, e.g., clergy, guardians;
   - the diversity of individuals and service settings utilized by older adults;
   - State and local level health, mental health, and aging departments and other specialized assistance programs, e.g., State pharmaceutical assistance programs;
   - foundations, corporations, and other grant makers.
4. a directory should be developed, compiling a list of higher education programs with an emphasis on training and research opportunities in mental health and aging. Such a directory should be developed by a multidisciplinary group such as the Association for Gerontology in Higher Education.

In the area of service, we recommend that:

1. there be continued development of service systems for treatment/rehabilitation programs for mentally ill older adults, aimed at preventing unnecessary institutionalization of the elderly.
2. there be an expansion of service systems providing interventions to address the overlooked opportunities to promote mental health and prevent excess disability among nursing home residents and other older adults living in various institutional settings.
3. there should be continued development of service systems focused on self-help and the use of older persons as mental health service providers, e.g., through the use of an older volunteer program receiving funding and technical assistance through the collaboration of NIMH, ACTION, and HRSA.
4. given the access problems experienced by the frail elderly with mental health problems, mobile mental health outreach efforts, including assessment and treatment, and other mental health outreach services should be fostered at the local level.

5. since increased risk of mental health symptoms is associated with various problems, disorders, and treatments in the elderly, and prevention/intervention strategies can reduce the frequency of adverse mental health consequences (analogous to the impact of treating hypertension to prevent stroke), practitioners should pay particular attention to those high-risk situations which include:
   - untreated depression associated with increased risk of suicide (greatest frequency in the elderly);
   - medication misuse and unintended side effects (drug use and polypharmacy are greatest in the elderly) causing mental health symptoms (high frequency of depression, dementia, and delirium);
   - Alzheimer's disease leading to high frequency (25+ percent) of depression in close caregiving family members;
   - compounding mental health problems, e.g., delirium, depression, or delusion, causing excess disability in dementia;
   - hearing loss in later life (approximately 30 percent of older adults) associated with increased onset of delusional ideation (sensory deprivation phenomenon) and depression consequent to communication difficulties;
6. in light of the frequent use by the elderly of multiple drugs prescribed by multiple health care providers, services must be developed to protect against potential mental health morbidity, e.g., drug-induced dementia and altered mental status due to unanticipated drug interactions/adverse reactions (active coordination among the prescribers and pharmacists is needed in administering patient drug regimens);
7. communities need to assure the coordination of formal linkages among medical, social service, and family service agencies with mental health practitioners and the mental health service system.

In the area of research, we recommend that:

1. at the national level, research support should be strengthened for studies aimed at identifying risk factors which can influence the (a) onset, (b) clinical course, and (c) response to treatment of mental disorders (especially delirium, depression, dementia, paraphrenia and anxiety) in older adults.
2. further studies should be carried out on how mental problems influence the onset, clinical course, and response to treatment for general health and medical disorders.
3. further studies should be conducted on the potential for, and frequency of, mental health symptomatology resulting from side effects of medications (over-the-counter and prescription) used for the treatment of general health and medical disorders; similar studies should be conducted on psychotropic medications relevant to the onset of somatic symptomatology.
4. further studies on suicide (most frequent in the elderly) should be conducted with the goal of advancing our understanding of risk factors and the development of strategies for its prevention.

5. further studies should be conducted to identify strategies that foster positive adaptation to later life stresses; coping strategies that could be developed in earlier adulthood in anticipation of such possible stresses should also be further researched.
6. further studies should be conducted to determine mental health promotion strategies and risk factors influencing the onset of mental illness in mentally retarded older adults.
7. further studies should be undertaken to improve our ability to achieve early and accurate diagnosis of mental health problems, with attention to the development of necessary diagnostic tools, to foster early intervention and more rapid return to higher levels of functioning.
8. further studies should attempt to establish the optimal use of behavioral, psychosocial, and somatic interventions in prevention and mental health promotion approaches.
9. further studies should be conducted which focus on the range of existing services (home-based, community-based, and institution-based) utilized by older adults, to establish efficacious and cost-effective model approaches for addressing the mental health needs of elderly individuals and their families in those service settings that they more frequently utilize. Such studies should include attention to preventing unnecessary institutionalization.
10. studies should be expanded on mental health promotion efforts for special aging subgroups, such as minority and rural elderly, older widows, those over 85, etc. Research should focus on intergenerational approaches to mental health enhancement in later life.
11. further studies should be conducted to determine when and for which groups of older adults mental health services should be age homogeneous or age heterogeneous in design; similarly, studies should be conducted to improve our understanding of the impact on the mental health of older adults living in, or being treated in, age-homogeneous and age-heterogeneous settings.
12. further studies should explore effective models of using older volunteers in mental health promotion efforts focused on elderly individuals.
13. further studies should focus on alternative residential settings (other than home and nursing home), with attention to promoting mental health and preventing excess mental disability in the elderly.

In the area of policy, we recommend that:

1. treatment, diagnosis, and care of mental disorders should be reimbursed by all insurance providers at comparable levels to general medical disorders in order to assure adequate access to mental health services by older patients and their families, in order to prevent mental disability.
2. to promote mental health and encourage maximum independence, the provision and reimbursement of mental health services in specific community settings, e.g., housing programs, health centers, nutrition settings, and outreach to in-home family providers, should be mandated.

3. since homebound persons at risk for mental health problems have limited access to mental health diagnostic and treatment services by mental health professionals and primary care physicians, third-party payers (public and private sector) should be encouraged to remove the financial disincentives to mental health home visits to the elderly aimed at preventing excess disability.
4. nursing homes should be mandated at legislative and regulatory levels as sites of mental health services and should be evaluated for the quality of their services designed to promote mental health and prevent excess disability.
5. State licensing agencies should develop policies that promote the role of the nursing home medical director in preventing excess mental disability in nursing home residents.
6. all Federal, State, and local public agencies that serve older persons should develop policies relevant to the promotion and coordination of mental health—such should be reflected in the development of national, State, and local plans.
7. State mental health agencies should be mandated to specifically target mental health services for the elderly.
8. there should be a legislative commitment to protect the mental health of the spouses, family, and other lay caregivers of the elderly. Specific funding for mental health care for caregivers could be incorporated into the upcoming rural health bill, long-term care bills, and/or catastrophic health benefits and/or existing Medicaid programs.
9. third-party coverage (Medicare and private insurance) should be available for hearing aids and other assistive devices to prevent mental health morbidity.
10. reimbursement under the PPS/RUG should have an allowance for psychosocial care in institutional and community settings.
11. drug utilization review to prevent psychotropic drug misuse among the elderly should be required in all Federal or State programs that provide access to pharmaceuticals for the elderly.
12. the Food and Drug Administration should require inclusion of elderly subjects during new psychotropic drug trials to assure that risk potential will be understood in medication management of older patients. Postmarketing surveillance of such drugs should similarly include a focus on older patients.

NUTRITION WORKING GROUP

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Members of the working group on nutrition stated that the overriding goals basic to their recommendations are:

1. improved quality of life for older Americans and the promotion of continued autonomy; not cost containment.
2. good nutritional status is essential for a high quality of life, and food contributes to the quality of life through psychological and social, as well as physical, mechanisms.

In addition, the following assumptions are basic to their recommendations:

1. older people vary greatly in their social, economic, and life-style situations; functional capacity; and physical conditions.
2. nutrition policy should be crafted from a multidisciplinary framework.
3. a critical shortage of knowledgeable personnel in the areas of nutrition education, research, and service now exists (see "Health Personnel for the 1990's").
4. the research base for nutrition of older Americans is evolving; therefore, specific recommendations must be periodically updated.

In the area of education, we recommend that:

1. in all aspects of training for dieticians and other health care professionals (e.g., physicians, nurses, and pharmacists) and para-professionals (e.g., nursing assistants), basics of geriatric nutrition should be required in core curriculum, in-service training, and continuing education.
2. Federal agencies (e.g., NIA, USDA, and FDA), professional societies (e.g., ADA, SNE, AIN, and ASCN), and private health organizations (e.g., the American Heart Association and the American Diabetes Association) should develop new or adapt existing health promotion nutrition messages to the special concerns of the elderly,

e.g., multiple use of drugs, low energy intakes, and existing chronic diseases. These groups should coordinate efforts to assure wide dissemination of nutrition education materials and messages to older persons.

3. Federal agencies supporting nutrition research should provide health care professionals with criteria for the evaluation of diets of older adults and information on efficacy and safety of commonly used nutrient supplements for use in counseling on their proper use as a supplement to, but not as a replacement for, adequate diet.
4. all DHHS agencies that have responsibilities for provision of services for older persons must provide ongoing formal geriatric nutrition training for staff with nutrition responsibilities in their service networks.
5. Health promotion messages from the public and private sectors should utilize advanced communication techniques:
   - recognizing different life-styles;
   - adapting to different sensory capacities;
   - adjusting to different cultural experiences; and
   - recognizing different learning styles.
6. Data bases should be developed by the Public Health Service for use by pharmacists and dieticians in counseling older persons on drug-nutrient interactions.
7. Primary and secondary school districts can have a positive influence on health status of parents and grandparents of students by providing nutritional information to students, promoting a better understanding of the relationship of good nutrition to health status in old age.

In the area of service, we recommend that:

1. assessment be done at admission or enrollment in all institutional or community-based health services for older adults, e.g., acute and long-term care inpatient services, hospital-based outpatient services, alcohol and drug treatment programs, community health services, and home delivered meals programs.
2. nutrition counseling by a credentialed nutrition professional/registered dietician be a part of all institutional or community-based programs providing health services to older adults.
3. hospital discharge planners assess the need for in-home nutrition services for patients and refer patients to the appropriate area agencies on aging to link older persons with services in the community.
4. in providing outpatient nutrition services to older adults, program models should minimize the burden placed on patients, e.g., encourage health professionals to coordinate services and function as patient advocates.
5. any evaluation of institutional or community-based nutrition services providing meals or nutritional supplements for older adults should include an assessment of the various nutrition-related characteristics against criteria such as the RDA, dietary guidelines, therapeutic considerations, and cost and food preferences.

6. nutritional data bases that include dietary or nutrition data on older adults, e.g., NHANES, NHIS, and the Nationwide Food Consumption Survey, should be linked with data bases that have outcome variables, e.g., the National Death Index and the National Hospital Discharge Survey.
7. national nutrition data collection for older adults, i.e., NHANES, USDA, and the Nationwide Food Consumption Survey, should be based on samples sufficiently large and representative to support analysis within age-sex-income-race/ethnic categories.

In the area of research, we recommend that:

1. funding agencies, e.g., NIH and USDA, establish permanent study sections composed of experts in aging and nutrition.
2. Federal agencies provide adequate, additional funds to support the research efforts described below:
   - definition of nutrient and energy requirements of older adults, now extrapolated from younger age groups, and establishment of recommended dietary allowances;
   - studies on the interactions between nutritional status and activities of daily living and other aspects of life-style and behavior;
   - research on the effects of nutrition on age-related impairment of organ system functions, e.g., cardiovascular, gastrointestinal/oral cavity, immune, musculoskeletal, nervous, and other systems;
   - studies on the efficacy and cost-effectiveness of dietary assessments and interventions for reducing the risk of age-associated diseases among populations over 65 years of age;
   - research on interactions among nutrients and between nutrients and drugs in older adults;
   - development of age-specific methods to assess the nutrient, nutritional status, and body composition of older adults;
   - studies directed toward comprehensive dietary recommendations relevant to common morbidity patterns among older adults.

In the area of policy, we recommend that:

1. credentialed nutritionists/registered dieticians be employed as staff at all levels of the Federal and State Government in all agencies involved in policy, planning, administration, and evaluation of aging programs. Examples of agencies at the Federal level within DHHS include NIH's Nursing Institute, other NIH Institutes, HRSA, AOA, HCFA, CDC, NCHS, and FDA. Other relevant agencies include both the Federal and State offices of the VA, and AID, USDA, and DOD.
2. State and local agencies on aging use the expertise of credentialed nutritionists/registered dieticians and encourage other appropriate agencies to use such expertise.
3. Federal, State, and local legislators and agency administrators give high priority to nutrition services, education, and research on the aging when they allocate FTE's and target both existing funds and future increases.

4. HCFA require that staffing in long-term care and skilled nursing facilities include credentialed nutritionists/registered dieticians.
5. third-party payers (Federal and private insurance entities) pay for nutrition counseling services provided by credentialed nutritionists/ registered dieticians for older persons at nutritional risk.
6. State and Federal agencies encourage development and implementation of innovative public-private sector models for health promotion and education including nutrition for older adults.
7. *successful* public-private sector models for nutrition, health promotion, and education for older adults, e.g., Healthy Older People, Age Well, and OASIS (Older Adult Service and Information System), be widely disseminated by Federal and State agencies.
8. by 1990, an NIH Consensus Conference be held and information disseminated on dietary recommendations for older adults, both well and ill.
9. funding be provided from third parties and other sources, e.g., Medicare, Medicaid, OAA, and private insurance, for outpatient and in-home nutrition and other services that permit older Americans who are ill to remain in their own homes with an optimal quality of life and function.
10. existing guidelines for categorical funding of nutrition services for older adults should be evaluated to determine if they permit sufficient feasibility for overcoming specific situational barriers and accommodating preferences of individuals and cultural subgroups.
11. the Interagency Committee on Human Nutrition Research:
    - assign responsibilities for interagency coordination in aging to a nutrition researcher at the Secretary's office in each department and agency;
    - continue to give aging research priority; and
    - continue to coordinate aging research efforts at NIH, CDC, and elsewhere in DHHS, USDA, DOD, AID, etc.
12. all research, service, and education programs should be periodically reviewed to keep pace with a constantly changing knowledge base.
13. nutrition education and service programs should be designed to meet the diverse needs and living situations of older adults.

PREVENTIVE HEALTH SERVICES WORKING GROUP

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Working group members agreed that effective preventive care of the elderly requires an appreciation of problems outside the more traditional focus of primary and secondary prevention. Health in the elderly is often best measured in terms of functional status as well as the absence of disease.

Effective prevention strategies must recognize that informal caregivers are appropriate recipients of information about preventive services needed by the elderly. Preventive services should not be arbitrarily started at a specific age. Ideally, health promotion for the elderly would not begin in old age, but would be part of an ongoing program begun in childhood. Individuals of all ages need to be encouraged to take increased responsibility for their own wellness and health promotion.

The World Health Organization's model which underscores the transition from disease to impairment to disability and to handicap is a useful framework since interventions may be made at one or more of these stages. Preventive services for the elderly should foster the development of effective environmental and social support systems.

The recommendations that follow address these two goals:

- To prevent physical, psychological, and iatrogenic disorders.
- To prolong the period of independent living with particular attention to quality of life.

A significant inhibitory factor in the provision of preventive health services is lack of reimbursement. Preventive services should be reimbursed. While reimbursement will surely increase utilization, the working group agreed that only those preventive services that have been scientifically shown to have merit should be reimbursed. Several expert groups like the U.S. Preventive Services Task Force have systematically reviewed preventive services on the basis of rules of evidence and it seems reasonable to

reimburse those services for which there exists good evidence in favor of efficacy. For example, medicare coverage should be expanded to include yearly influenza immunization for the elderly. The working group felt strongly that curative or diagnostic services should also be reviewed with the same level of scrutiny.

It is important to emphasize that preventive services need to be individualized according to the following characteristics:

- active life expectancy;
- physical activity;
- cognitive capacity; and
- presence, nature and stage of disease(s) processes.

This individualization of preventive services should respect these principles:

- Minimize unnecessary disruption of life-style.
- Preserve the patient's autonomy.
- Minimize iatrogenic insults.
- Recognize that avoidance of death may not be the ultimate goal of preventive services.

In the area of education, we recommend that:

1. certifying organizations for health professional and allied health training programs should require inclusion of didactic and clinical training on health promotion and disease prevention in the elderly. Some areas which should be addressed include:
   - Awareness of the determinants of successful aging and development of positive attitudes about normal aging and the preservation of independent function.
   - Appreciation of the heterogeneity of elderly persons with respect to functional status, individual values and goals.
   - Knowledge of basic principles of preventive medicine, methods of assessing values of screening and intervention programs.
   - Development of professional learning practices which allow for incorporation of emerging information regarding the utility of specific preventive practices.
   - Training in identification of individuals "at risk" for decline in health status which may be preventable based on the model of progression from wellness to disease to disability.
   - Training in functional assessment methodologies.
   - Experience in multidisciplinary approaches to wellness and health promotion.
2. all primary care training programs emphasize geriatric wellness and disease prevention.
3. continuing education programs for practitioners focus on preventive medicine practices for the elderly.
4. all certification and licensure examinations include testing for knowledge of preventive medicine strategies in the elderly.
5. service agencies educate and train their staff to recognize elderly who are at high risk for preventable conditions.

6. service agencies develop educational programs for their staff in disease prevention and health promotion in the elderly.
7. service agencies develop training programs for informal caregivers about preventive strategies in the care of the elderly including knowledge of community resources.
8. service organizations develop well being and stress reduction programs directed at caregivers themselves.
9. private and government employers provide information to their older employees regarding normal aging, wellness and disease prevention.
10. programs be developed by the aging network and professional organizations that educate the elderly consumer to actively seek out preventive services as a part of their regular health care.
11. public and private funding sources provide faculty development programs designed to enhance knowledge and skills in the teaching of health promotion and disease prevention in the elderly.

In the area of service, we recommend that:

1. mass screening programs should be viewed with skepticism unless they adhere to standardized criteria (WHO), are targeted to a focused population, and are linked to the primary care system for follow-up. Freestanding screening programs are to be avoided, since they are often ineffective and potentially exploitive.
2. the provision of preventive services should take into account the heterogeneity of the elderly population.
3. preventive services for the elderly should address factors that prevent disease from producing disability and that prevent disability from becoming handicaps.
4. hospital/nursing home admissions and discharges should be viewed as opportunities to assess preventive services or special risk factors (iatrogenic disease, dependency).
5. preventive services should be targeted for the elderly living in nursing homes.
6. health promotion programs should emphasize self-responsibility for health and life-style modification.
7. recommendations for behavioral change, especially for the very old, should be balanced against life-style disruption.
8. prevention strategies should include families and informal caregivers.
9. secondary prevention (screening) services in the elderly should be addressed in primary care settings since the effective provision of these services depends on detection, response and follow-up of subtle changes in functional status.
10. primary health care providers should be encouraged and assisted to look for easily detected and treatable conditions, e.g., depression, incontinence and vision, hearing, foot and oral health problems.

11. primary health care providers should carefully evaluate physical, mental, functional status, and existing social support systems for each of their elderly patients.
12. primary health care providers should use checklists and other specific tools that facilitate and guide specific preventive services for the elderly.

In the area of research, we recommend that:

1. with regard to those preventive services for which effectiveness in the elderly has not been established, a vigorous, well funded, and well coordinated research program should be undertaken to investigate their applicability to the elderly.
2. specific research efforts should be devoted to strategies aimed at behavioral changes in the elderly. Such research should encompass a variety of life-style changes among elderly in different functional categories.
3. studies to measure and control adverse events secondary to medical intervention should be encouraged and funded.
4. studies of the determinants of behavioral change in the elderly and utilization of preventive services should be funded.
5. agencies funding health care training programs should develop incentives aimed at increasing researchers in health promotion and disease prevention.

In the area of policy, we recommend that:

1. medicine and other third-party payers should reimburse for those preventive services that have been found to be efficacious and effective for the elderly by independent panels such as the U.S. Preventive Services Task Force.
2. quality assurance standards promulgated by health care organizations should include standards for the provision of preventive services to the elderly.
3. both Federal and nonfederal research organizations should develop mechanisms for the prompt translation of prevention related research findings into guidance for health care providers, payers and the public.
4. a preventive geriatrics grant program analogous to the Preventive Cardiology Career Development Award should be established to provide the academic leadership essential to the further advancement of the field, and such a program should accept applications from researchers in a number of health care disciplines.
5. AoA, NIA, and other relevant PHS agencies, and the VA should develop a joint strategy for ongoing consumer education on preventive services.

SMOKING CESSATION WORKING GROUP

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The smoking cessation working group bases its recommendations on the following tenets:

1. Cigarette smoking produces serious disease in smokers.
2. Environmental tobacco smoke can cause disease, including lung cancer, in healthy nonsmokers. Furthermore, the simple separation of smokers and nonsmokers provides inadequate protection of the nonsmoker.
3. Older Americans have the right to protect their health from the toxic chemicals of tobacco smoke through a smoke free environment.
4. Older Americans should quit smoking. By doing so, they can realize immediate gains in their quality of life through substantial improvements in physiological, psychological, and functional status.
5. The addictive nature of nicotine creates a dependency on cigarettes which threatens the health of older smokers.
6. The dearth of smoking cessation initiatives for older Americans, in spite of the growing scientific evidence showing both short- and long-term health benefits, constitutes a serious public health need.
7. Smoking cessation initiatives aimed at older Americans should give special attention to the concerns and needs of minority and low income older people and should include in their planning the representation or involvement of these subgroups.
8. The decision to stop smoking—and the behavior that follows—is not the result of one or two exposures to smoking-related information but is a cumulative effect.

In the area of education and training, we recommend that the Surgeon General undertake the following:

1. emphasize, in his contact with opinion leaders and the media, the short- and long-term health benefits of smoking cessation for older smokers, and the effects of passive smoking on older people, particularly those with disease.
2. encourage health care educators to incorporate the importance of smoking cessation for older adults and effective interventions in curricula for health care professional students, including preventive medicine, nursing, social work, dentistry, gerontology, public health, and other allied health disciplines.
3. stimulate the training of professionals to incorporate a strong smoking cessation message into their encounters with older adults in emergency room and community and rural health center settings, in order to reach lower income older adults who lack access to the health care system.
4. encourage State and local professional societies and other organizations to include information on the importance of smoking cessation for older adults in continuing medical education programs for health professionals.
5. urge the development and adoption of smoking cessation messages and interventions as standards for primary health care delivered to older persons to include:
   - identification of the individual's risk factor (smoking);
   - identification of potential medical and pharmacologic complications of smoking;
   - delivery of strong cessation and educational messages to all smokers;
   - referral to or direct behavioral cessation therapy; consideration of pharmacologic therapies; and
   - monitoring of progress toward cessation and maintenance at each encounter between the patient and the health care provider.
6. work with the Administration on Aging to promote the establishment of "No Smoking" policies in all settings in which services are provided to older persons. The work site and service delivery areas of the aging network, as authorized under the Older American Act, should be models for older persons in the provision of smoke free environments to encourage smoking cessation for older persons.
7. convene the Interagency Committee on Smoking and Health to address the issues of smoking and older adults.
8. provide information to State and local governments on the health effects of smoking in public places, restaurants, workplaces, public transportation vehicles, and on airplanes. These deterrents would protect nonsmokers from the adverse health effects of passive smoking and eliminate the possibility of fires caused by smoking.
9. encourage long-term care providers to facilitate smoking cessation for older persons in long-term care facilities through:
   - providing access to cessation materials for residents and their families;

- educating staff to the benefits of cessation for themselves and older adults; and
- designating nonsmoking resident rooms and no smoking in all common areas.

10. recommend that pre-retirement programs currently conducted by public and private employers, private insurers, and labor unions contain a health promotion focus, including an emphasis on the positive health benefits of smoking cessation for older adults.
11. designate responsibility to a PHS working group to meet with relevant public and private sector agencies and organizations to coordinate the development of a public education initiative. The group would explore the feasibility of sharing resources and networks to stimulate community program development.
12. encourage public and private sector agencies/organizations actively engaged in anti-smoking education activities to examine existing educational materials and public service announcements on prevention, cessation, and maintenance for cultural, ethnic, racial, and gender relevance to the older audience.
13. insure that the Office on Smoking and Health include an overview of smoking and older adults in the 25th Anniversary Surgeon General's Report on Smoking and Health and biannual reports to Congress.

In the area of education and training, we recommend that:

1. State and local health departments, voluntary health agencies, advocacy groups, and coalitions be strongly urged to work with public and private organizations serving the social service needs of older Americans to support them in:

   - the development, implementation, and enforcement of restrictive smoking policies directed toward clients and staff;
   - the education of staff in such agencies to serve as credible and effective sources of smoking cessation support;
   - the provision of cessation materials (pamphlets, posters) to support clients and staff in their attempts to stop smoking.

Such organizations would include:

- churches;
- senior centers;
- veterans' groups;
- fraternal organizations;
- congregate meal sites;
- minority and ethnic clubs and centers;
- self-help groups; and
- area agencies on aging.

2. the organizations and agencies that serve older adults and the private, public, and voluntary agencies that focus on smoking control issues create a coalition to organize their resources in order to create

a smoke free environment that repeats and reinforces, through many and varied channels, smoking cessation messages specifically targeted to older adults, and that encourages participation in such national smoking cessation activities as the Great American Smokeout.
3. agencies, organizations, and medical facilities distributing information to older persons about smoking cessation methods refer, whenever possible, older persons to local self-help/mutual aid groups formed to encourage ex-smokers to stay nicotine free.
4. providers of direct services to the older population, including social workers, educational specialists, nutritionists, and other support personnel be targeted with smoking cessation messages which identify the benefits of quitting for older adults.
5. professional and accrediting organizations be encouraged to offer seminars and workshops on smoking cessation and that supplemental materials (e.g., posters, brochures) be made available.

An underlying assumption is that research on smoking cessation with older adults must address the difficulties inherent in reaching a population for whom smoking is likely to have been a lifelong habit. Associated with this lengthy duration is a history of nicotine addiction, unsuccessful quit attempts, and psychological and situational dependencies on smoking. By the very nature of the duration and cumulative exposure to smoking, older smokers may present the most significant challenges to smoking cessation efforts. Furthermore, because of decades of self-selection, the population of older people who still smoke are heavier smokers and are more likely to have low incomes and be members of minority groups.

Research on smoking and smoking cessation among older adults can benefit from advances in research design and methodology that occur with younger target groups. Moreover, as with other populations, research on smoking and aging should investigate smoking as it broadly affects the lives of older persons, not only its morbid and mortal outcomes.

In the area of research, we recommend that:

1. knowledge of smoking and older adults be improved and refined by studies that include but are not limited to:
   - the interaction of smoking status and smoking history with other risk factors of mortality, morbidity, and loss of functional health in older adults;
   - the association of smoking with older adults' status on other health-related practices;
   - the benefits of smoking cessation in improving the quality of life which extend beyond the biological, behavioral, and health aspects of smoking;
   - evaluation of age-related or intergenerational differences in the smoking cessation process, strategies used in quitting, and factors influencing relapse;
   - development of a research agenda that examines the value of self-help groups as a mechanism to help older people stop smoking and stay nicotine free; and

- investigation of the effects and consequences of nicotine withdrawal which are affected by aging, coexisting illness, and the duration and intensity of smoking.

2. the Centers for Disease Control (CDC) be encouraged to expand the National Health Interview Survey to include the smoking supplement annually, and that its sample be sufficient to report statistically significant results for subgroups of the older population (e.g., the young-old, blacks, Hispanics, and Native Americans).
3. the National Ambulatory Care Survey of Physicians in Private Practice, conducted by the National Center for Health Statistics, include questions on advice and assistance physicians provide to their patients, especially older patients, regarding the benefits of smoking cessation. Although U.S. physicians view smoking as a serious health risk, less than one-fourth offer any kind of structured assistance in helping patients quit, and physicians are less likely to give a strong cessation message to older adults.
4. CDC should encourage states to include smoking data on older adults in The Behavioral Risk Factor Surveillance System (BRFSS).
5. research focus on epidemiologic analyses to improve chronic disease risk estimates for continued smoking into the seventh and eighth decades of life, particularly for female smokers.
6. researchers incorporate questions about smoking status and smoking history into longitudinal epidemiologic studies of older populations.
7. major trials and other studies of smoking cessation be encouraged to include older persons in numbers sufficient to make separate analyses meaningful and useful.
8. academic researchers evaluate the application of smoking cessation techniques and materials for older adults.
9. academic researchers evaluate the delivery of smoking cessation messages by physicians, dentists, and other health care professionals to older adults.
10. the Surgeon General encourage the Food and Drug Administration to formally ask drug companies (holders) of already approved New Drug Applications (NDA's) to initiate pharmacokinetic studies on the interaction of nicotine on serum and tissue levels of the companies' drugs and to include such information in the physician's package insert.
11. foundations with health promotion and/or aging agendas be encouraged to fund demonstration and other research projects that focus on smoking cessation and to incorporate information on smoking cessation into new and existing health promotion programs.

In the area of policy, we recommend that:

1. the Social Security Administration be encouraged to include health promotion messages, including smoking cessation information, in beneficiary mailings.

2. private insurers be encouraged to charge differential rates to smokers in their Medicare supplemental and long-term care policies.
3. the Surgeon General encourage the United States Pharmacopeia, the American Society of Hospital Pharmacy, the American Pharmaceutical Association, and other organizations that disseminate patient package inserts to develop a section on "Effects of Smoking on Drug Serum and Tissue Levels" focused especially on the potential for such interactions in older persons.
4. the Surgeon General encourage the Food and Drug Administration to require drug companies to undertake pharmacokinetic studies on the interaction of nicotine on serum and tissue levels of the sponsor's drug, especially in older persons, as a condition for completion and approval of all forthcoming NDA's, and that such information be included in the physician's package insert.
5. the sale of all tobacco products be eliminated from all government health facilities.
6. the Surgeon General encourage the Administration on Aging to establish a priority in its discretionary grants funding for model State level smoking cessation campaigns for older persons and for dissemination of smoking cessation materials targeted for older persons.
7. the year 2000 health objectives should be set which measure:
   - reductions in smoking prevalence by sex and race for older adults;
   - increases in public awareness of cessation benefits at older ages; and
   - increases in the frequency of smoking cessation advice being given in primary care settings.
8. the Surgeon General urge the tobacco industry to manufacture only fire-safe products, in order to reduce the risk of morbidity and mortality in older persons from residential fires.

Response to Workshop Recommendations

Presented by C. Everett Koop, MD
Surgeon General, United States Public Health Service
Wednesday morning, March 23, 1988

This is the moment that I always look forward to at the close of a Surgeon General's workshop, but it also is a moment that I dread. You've all made my task today much simpler than is usually the case and for that I am grateful.

I would like to extend my congratulations to the chairpersons of the various working groups and my thanks to all of the participants. You have done an outstanding job.

As I told you in my charge, what you have presented to us as recommendations will not be edited as to substance. Grammatical and syntax changes will be kept to a minimum.

It is almost impossible to have a workshop such as this without having several participants who come with private agendas which supersede the work at hand, but to my knowledge that has not happened on this occasion and I am not only pleased but very grateful. You have indeed shown what a cooperative effort can be.

This has been the best organized Surgeon General's Workshop, and I ought to know. My thanks again to DSG Faye G. Abdellah, SR PHARM Steve Moore, and countless others for a job exceedingly well done. My thanks to Social and Scientific Systems, Inc. of Bethesda, Maryland. This was our contractor and people worked all night to type the recommendations you will receive at the end of this conference.

I didn't work *all* night, but almost. As I make my response, I will stumble, stutter, appear to loose my place but be assured none of these are the result of the short night, my age, or my eyesight. Rather, it is my penmanship which is at fault which is vintage physician. It is unreadable, even by the author.

When President Reagan nominated me to be his Surgeon General, back in 1981, I was just a youngster of 65. But, unfortunately that was the age at which—traditionally—Surgeons General were supposed to *leave* the Public Health Service—not enter it for the first time.

So a great hue and cry went up, alleging that I was too old for the job.

You can imagine that this did not sit very well with the man who nominated me. President Reagan had just celebrated his 70th birthday, when he sent my nomination to the United States Senate.

I don't recall that he took very kindly to the idea that someone who was 5 years *younger* than he would be considered *too old* to serve his country.

Senator Hatch spend many hours of many months convincing his senate colleagues to accept the idea that *chronological* age ought not to be the sole and final criterion of an individual's personal or professional worth.

Senator Hatch prevailed ... and I became your Surgeon General. I am indebted to him for the courage and foresight he demonstrated at that time. I also happen to think he was right.

And just as a footnote to all this history, I am pleased to say that, when the President re-nominated me for a second term, the whole process took less than 5 minutes and there were no "nay" votes.

Now, my personal story had a happy ending. I got the job. But that's not always the case for everyone, as I'm sure you all agreed at your work groups.

As so many of us know from personal experience, age prejudice is still far too common in America. Yet, that makes no sense at all, because the new scientific information coming to light ought to be pointing society in exactly the *opposite* direction.

We're now coming to understand that—medically speaking—there *is* such a thing as a *disease free aging process*. A process during which all systems in a person's body continue to function normally.

So let's get a few things straight:

- Gray or white hair is *not* a sign of disease. Never has been. Never will be.
- Dry skin is a natural phenomenon of aging. We don't know why it happens—but it's not the result of disease.
- Taking things a little easier is *not* a disease condition, either. It's more like a sign of maturity.
- And getting a stronger prescription for your eyeglasses or being fitted for a hearing aid is not evidence that you have one foot in the grave and another on a banana peel. It just isn't so.

From this common-sensical, scientifically accurate perspective, you soon realize that a *great many* older Americans today enjoy a *disease free old age*, mentally and physically healthy.

And we'd better get used to the idea that that's the way it's going to be perhaps for *most* older people in the future, because *tomorrow's* elderly are today's bikers, joggers, and swimmers.

They're people who snack on salad and yogurt.

They're today's young and the middle-aged Americans who've given up cigarettes and hard liquor ... who wear seat belts and sensible shoes ... and who do more about managing stress than just to pop another valium.

We need to remember that the aging process is not just a *biophysiological* process. As the work groups have amply demonstrated, the aging process is also a *social* ... and *political* ... and an *economic* process as well.

Good health in one's senior years may be a result of good diet, regular exercise, and an overall healthy life-style.

But it is also the result of decent housing ... and public order ... and environmental safety.

It can be the result of a life spent in steady and safe employment, closing with one's senior years protected by financial security.

It is also the sum-total of a lifelong sense of personal and family well-being ... and of one's ability to continue to live an independent, private life ... a life that is not a burden to one's self, to one's loved ones, or to society at large.

In hearing these remarks, I'm sure some of you recognize how your recommendations triggered these thoughts as I was preparing them in the not so wee hours of the morning.

And now to the specific recommendations of the working groups:

There are a number of recommendations that are common to several work groups. For example, not exhaustively:

1. Adequate dissemination of the material to specific special interest groups.
   This will be done. More on that subject later.
2. Public-Private Partnerships and Coalitions.
   We intend to implement these relationships by education, by precept, and by arrangement.
3. Inclusion in core curricula of health and professional schools of the basic precepts peculiar to the unique needs of older people.
   Your recommendations will be circulated to those who can make a difference, to the best of our ability to do so.
4. The assistance of the Surgeon General when and where advantageous.
   I pledge to do this within time constraints, but you tend to win on this one because of my compulsive personality.
5. Access to care.
   This perennial problem is not easily addressed. We will try where we can.

Alcohol

I feel a little foolish addressing these issues in the presence of Dr. Gordis who understands so well those concerns expressed in the research agenda, such as the need to understand the differences between lifetime and late onset alcohol abuse.

I will transmit to the National Heart, Lung, and Blood Institute your concerns in reference to cardiovascular disease and premature aging and their relationship to alcohol.

Secretary Bowen has recently launched a very comprehensive initiative on alcohol abuse and alcoholism. He will be pleased with your educational comments and a special letter of transmittal will be sent by me to the group responsible for this initiative.

To HCFA and the private insurance carriers I will pass on your concerns about third party payment for detoxification and rehabilitation.

Finally, the Veterans Administration will be apprised of the specific concerns and recommendations made regarding veterans.

Oral Health

I was pleased that these recommendations recognized that the mouth contained more than teeth because that concept conforms to my life-long professional belief that the mouth was part of the body and that dentists belonged in the mainstream of caregivers.

The suggestions for a research agenda will be transmitted personally to Dr. Harold Loe, Director of the National Institute of Dental Research. Through the Chief Dental Officer, every private sector organization will also be notified about service recommendations.

The particular concerns about oral health in long-term facilities and the need for financing will be delivered to appropriate umbrella organizations involved with long-term care, with HCFA, and private insurance carriers.

Physical Fitness and Exercise

I am impressed by and endorse your concerns directed toward types and levels of physical activity in terms of intensity, frequency, and duration to achieve, safely, the potential benefits in health and functional capacity across a wide age span and range of abilities.

[Dr. Williams was asked to comment on this research agenda and spoke at this time.]

Dr. Williams:

I agree fully with the major emphases in the recommendations on physical fitness and exercise. In particular, the recommendations in the area of research are clearly germane to the mission of the National Institute on Aging (NIA); we are already involved in research related to a number of the recommendations and expect to increase our activities in the field.

Overall, I urge emphasis on *incorporating fitness into daily living*. We should encourage, and practice ourself, walking briskly up and down stairs and between sites in our work place, at home, in retirement activity, and should encourage fitness programs as a part of all employment and living settings.

We should emphasize maintenance of function. It is also important that we learn more about how to tailor fitness programs and daily exercise activities to the needs and capabilities of persons who have varying types of chronic disabilities or disorders, just as we tailor fitness programs to the needs and capabilities of generally healthy older people.

. . . .

The educational component is universal and complete. We will seek appropriate community endeavors to take on this responsibility.

My penultimate Surgeon General's Workshop was on Self-Help and Public Health. I will attempt a cross fertilization of appropriate groups to see that some of these excellent educational suggestions see practical application.

And now a personal note. There are, as you know, Presidential Awards for young people who pass rigorous fitness examinations. Some of us

believe others who do not get superlative ratings on these exams deserve some recognition. Therefore, we are working on a Surgeon General's Award for physical fitness for youngsters.

I don't know quite how, yet, but I will seek ways to provide senior citizens with a Surgeon General's Recognition for physical performance appropriate to age. Perhaps the best place to start is with Commissioner Carol Fraser Fisk, and I will do just that.

I will lend my own powers of moral suasion to this effort.

Injury Prevention

The preamble of this excellent summary calls for coordinated effort among the Centers for Disease Control, the National Institute on Aging, and the Administration on Aging. This already exists as CDC and NIA are components of the Public Health Service, and we already have a coalition with AoA. That's why you are here! But, we will seek to strengthen and refine it.

The suggestions about injury prevention are quite valid. I will seek to provide all participants with some pilot program information on this subject.

Many of the research recommendations are in line with surveillance and epidemiology studies now underway at CDC. I will be certain that the specific recommendations made here are transmitted to the CDC.

Some of the policy recommendations overlap with education but whatever the recommendations are, they will be passed on to the various agencies that establish and enforce safety standards.

Drugs

The detailed exposition of 33 recommendations is noted. The PHS is composed of 11 disciplines. One large group are the pharmacists. Our pharmacists function, in many instances, at an interactive level with patients somewhat higher than is the usual expectation. Experience with pharmacists in the Indian Health Service has proven the worth of this interactive relationship.

It is my intent to turn the recommendations and proposals over to the Chief Pharmacist of the Public Health Service and ask him and his Professional Advisory Committee to implement the service, policy, and education components in cooperation with the Administration on Aging with whom we have already an initiative on medications for the elderly.

The research proposals will be turned over to the NIA and FDA. Financial implications will be directed to HCFA and the private sector.

Mental Health

Many of the recommendations of this workgroup grew out of a recognition of risk factors that have the potential of influencing the onset, clinical course, and response to treatment of mental health problems in elderly individuals.

Many also recognized that older persons with mental health problems, alcoholism, or other drug problems have had physical health problems which bring them into multidisciplinary and service coordination settings. The recommendations of this group cross cut many of those for other work groups as you might imagine. Some will in a sense be covered as we seek to implement the recommendations of other groups.

Many of the suggested outcomes are being addressed by the AoA and I'd like Commissioner Fisk to speak to some of them after which I've asked Dr. Williams to address some of the research agenda items.

Commissioner Fisk:

Thank you Dr. Koop. I was impressed with the Workshop recommendations in this area, so many of which emphasized collaboration between the aging and mental health networks. The Administration on Aging has conducted a number of demonstration projects at the State level that have been targeted at coordination. Clearly, we need to do more in this area. Also, this seems to be a good area for State Coalitions on Health Promotion to get involved in.

My agency is currently funding six projects in the area of mental health promotion. Through these projects, we hope to address some of the concerns of the participants such as drugs and depression, access, problem recognition and identification.

I see mental health issues, and especially depression among the elderly, as a serious concern. You have my assurance that AoA will continue to address these issues and will involve other agencies in our efforts.

Dr. Williams:

In considering the recommendations and needs related to mental health it is important to note, as is done in these recommendations, the close interaction of mental health with physical and social health issues.

Among the recommendations for research, I would emphasize in particular the importance in identifying risk factors, attention to coping strategies, and again the need for further studies on the interactions of mental problems with other characteristics including medication.

. . . .

The specific policy issues that touch on reimbursement will be called to the attention of HCFA and the private sector. Others, where appropriate will find their way to the proper agency such as FDA.

Hearing problems were also addressed by this group. Some of you may have noted the announcement in MMWR that the National Institute of Occupational Safety and Health will be starting a prevention of hearing loss initiative for the present work force that will be the next generation of the elderly. I am starting an information program on what can be done for those already suffering from hearing loss.

Finally, copies of the final report of this Workshop will go to the members of the State and Territorial Health Officers Association carrying the strong recommendation to the state concerning their responsibility in mental health to the elderly.

Nutrition

As with the mental health recommendations, the nutrition recommendations overlap and intertwine with many others. I note with pleasure that one of the overriding goals is "improved quality of life for older Americans and the promotion of continued autonomy, not cost containment."

Many of the policy recommendations were specific in reference to Federal and state responsibility, as well as agency cooperation. We will endeavor to bring the concerns to those who can make a difference.

There is almost no agency in or out of government—at all levels—that is not involved in nutrition. We will attempt to build bridges and transmit specific recommendations not only to the individual groups mentioned, but also to others who will have an increasing role to play such as the JCAHO committee on accreditation of hospitals, interagency committees, etc.

The specific recommendations of computer data bases for use by pharmacists and dieticians on medication-nutrient interaction will be given serious consideration and I will seek a niche for it in the Public Health Service.

These promises of catalytic action apply to service, education, and research.

There is in preparation by the Office of Health Promotion and Disease Prevention a new—first time "Surgeon General's Report on Nutrition." I see the launching of this report—much of which deals with the specific concerns of the nutrition work group—as a mechanism of bringing attention to your recommendations above and beyond the reach of this Workshop..

Incidentally, the attention paid to the elderly in the Surgeon General's Report on Nutrition is considerable, including medication—nutrition incompatabilities.

Preventive Health Services

Preventive health services are inexpensive, not glamorous, very effective, and seldom reimbursed. Those are my words,—not those of the working group, but many of the recommendations recognize these four truths.

Many of the concerns of this group were addressed in my generic remarks early on this morning; especially in education as it affects the core curricula of health schools.

I was impressed with the working group's understanding of the relevance of their goals to primary care. Accordingly, I will take special care to direct this working group's concerns to those organizations which draw together and serve family practitioners as well as those umbrella organizations specifically concerned with preventive medicine.

Once again access and reimbursement are key issues and I will address them in appropriate circles with special attention to reimbursement for immunization against influenza, appropriate screening services, and attention to readily diagnosed and easily treatable conditions.

Policy matters will be delineated and referred to appropriate authorities where responsive action seems most likely.

Smoking

I will continue my personal efforts to convince elderly Americans of the benefits of kicking the habit as well as my constant pressure on physicians to acknowledge that it is never too late to quit, that preventive medicine does have an important role in the health care of elderly people, and that no means to quitting is as effective as a physician's personal advice to his patient to stop smoking.

These recommendations will be turned over to the revitalized Office of Smoking and Health and I will see that each recommendation gets the attention it deserves.

The Federal government buildings have a restricted smoking policy. All Health and Human Services buildings have had a total ban on smoking for the past month. We will get smoking off airlines, out of public buildings, including restaurants, and before the year 2000 smokers will ask for permission to smoke in the presence of nonsmokers—and that will fit my definition of a smoke-free society by the year 2000.

It is in the area of smoking and health that I probably have my greatest clout, and I promise my personal attention to each recommendation made.

I hope to be around long enough to convene the Interagency Committee on Smoking and Health to address smoking and the elderly.

And finally, I have already begun to work with the churches which have awakened to realize that smoking is the number one cause of disease, disability, and death.

There is one other area that I will address, if possible and when feasible, that can only enhance the outcome of many of the recommendations made here.

That area is cross generational relationships. Not only are the relationships of the elderly with children socially and emotionally beneficial to the elderly, but they can be a source of education, indeed, wisdom, and companionship, but they can also prepare the youngster for much that is to come in life.

Kids don't know enough about old people and about people of all ages with handicaps. This is one place and one way to began.

Only 9 percent of children in the United States live within walking distance of a grandparent. How tragic that seems as I recall my childhood! I reaped great benefits as a child from a relationship with my grandparents. But I truly believe my interest in and concern for the elderly is not because I am old, but because of the bond that existed with my grandparents. Every child lives within walking distance of an elderly person who might well serve inloco *grand* parentis if there is such a word.

What a great project for our next first lady—whoever she might be. We'll see!

When I addressed you on Monday, I told you that the recommendations would be given the widest possible circulation. Because the document I have before me is in such good form, I think it may be possible to have a printed copy off the press within 6 weeks. You will recall that I said we may be asking some of you for help in reference to distribution suggestions. But let me say now that if there are any of you here who just know that there are several obscure individuals or groups that you just *know* we will not think of, we would be happy to have your suggestions even before we ask for them. Just use your judgment.

One of the greatest satisfactions for me that comes from a Surgeon General's Workshop is to look back a year hence and see how much has been accomplished. With that in mind I would suggest that, as the year goes by, when you are able to do something that implements suggestions made at this workshop that you notify us. It is our intent to collate these and to report to you at 6 months and again at a year.

Walt Whitman was also a Brooklyn boy, like myself, and maybe that's why I like him. It was Walt Whitman who wrote these lines:

> *Youth, large, lusty, loving—youth full of grace, force, fascination,*
> *Do you know that old age may come after you with equal force, grace, fascination?*

Our answer to Walt Whitman ought to be ... Yes, we know. And we should really mean it.

I hope to see some you at the hearing for the Objectives of the Nation this afternoon.

Have a safe trip home.

Thank you.

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