

Journal of AGING (i)fe CARE™

VOLUME 32
ISSUE 2
WINTER 2022

3275 West Ina Road,
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Arizona 85741
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The Age-Friendly Movement in Communities, Health Care, and Higher Education

A Special Issue of the Journal of Aging Life Care™

Lenard W. Kaye, DSW, PhD, Special Issue Editor

Momentum is Building Toward Achieving an Age Inclusive Society

Lenard W. Kaye, DSW, PhD, Center on Aging, University of Maine

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EDITOR'S MESSAGE

Kaaren Boothroyd, Editor

We are extremely fortunate to have Lenard W. Kaye, DSW, PhD, from the Center on Aging, University of Maine, to be the Special Issue Editor of the *Journal of Aging Life Care*.

His introduction, "Momentum is Building Toward Achieving an Age-Inclusive Society," gives you an overview of the timely topics being addressed. We believe the content will be of great interest and value to Aging Life Care Managers®* as well as all professionals working in the field of aging.

We extend heartfelt thanks to Len and all the authors contributing to this stellar issue.

**Only members of the Aging Life Care Association can call themselves Aging Life Care Managers®, Aging Life Care Professionals® or Aging Life Care Experts®.*

Journal of AGING (ife CARE™)

Published by the Aging Life Care Association®

3275 W. Ina Road, Suite 130, Tucson, Arizona, 85741

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Momentum is Building Toward Achieving an Age-Inclusive Society

Lenard W. Kaye, DSW, PhD, Special Issue Editor

This special issue of the *Journal of Aging Life Care* is dedicated to the age-friendly movement, broadly conceived, that is expanding at a very rapid pace in communities, in primary care practices, and on college campuses throughout the nation. That movement is alive and well and has powerful implications for both the advance of less ageist practice in various sectors of society and more person-centered policies leading to the improved health, safety, and overall well-being of older adults. Additionally, it represents a significant and increasingly robust set of resources to turn to for those we serve, and a potential avenue for greater voice and participation by those who provide services to older adults and their caregivers (including, of course, Aging Life Care Managers®).

It is very important to understand that the age-friendly movement is broader and more multifaceted than many likely realize. Increasingly, it has come to permeate all facets of our daily lives, both professionally and personally. In addition to the age-friendly community movement, which is most widespread and likely more familiar to readers, the principles and philosophy of being age friendly now extend to health systems operations and the delivery of health care. It also is spreading to the campuses of higher education across the country and beyond. All three dimensions of the movement will be addressed in this issue.

It is worth recognizing that, in some circles, the term “age friendly” has received some pushback by those who believe it encourages a perspective that focuses solely on the needs and wants of a single segment of the population – namely older adults –

It is worth recognizing that, in some circles, the term “age friendly” has received some pushback by those who believe it encourages a perspective that focuses solely on the needs and wants of a single segment of the population – namely older adults – and downplays the benefits of the age-friendly movement that are realized by other age groups.

and downplays the benefits of the age-friendly movement that are realized by other age groups. The fact is, the age-friendly movement advocates for principles that will necessarily benefit young, mid-life, and old alike (e.g., personalized health care, accessible public spaces, walkable streets, access to key services, safe parks and walking trails, opportunities for learning across the lifespan, affordable housing, and transportation options, etc.). Even so, other terms have also been incorporated in descriptions of age-friendly initiatives to characterize what is occurring,

including “age inclusive” campuses and “livable” communities. Regardless of the terms adopted, all such initiatives seek, as their central intent, to enhance personal independence, enabling persons to remain in their homes and communities as they age, and maximizing opportunities for residents of all ages, ability levels, and backgrounds to engage fully in the civic, economic, and social dimensions of community life.

By definition, age-friendly health systems adhere to an essential set of evidence-based, high-quality care practices known as the “4Ms” (What Matters, Medication, Mentation, and Mobility) that are dedicated to causing no harm and are aligned with what matters most to the older adult and their family caregivers (<https://www.ihl.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx>).

Age-friendly or livable communities have walkable streets, housing and transportation options, access to key services, and opportunities for residents at all life stages to participate in community life (<https://www.aarp.org/livable-communities/about/>). And, age-friendly universities are higher education institutions that have endorsed the 10 age-friendly university principles and committed themselves to becoming more age-inclusive in their programs and policies (<https://www.geron.org/programs-services/education-center/age-friendly-university-afu-global-network>).

While the age-friendly model is expanding rapidly across the nation in distinct and separate ways across the sectors of community life, health care, and higher education, it is important to

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note that those efforts have rarely reflected an explicit philosophy and set of strategies that aim to integrate those efforts in complementary, cross-sector fashion. It is very possible that coordinating those efforts within the same city or region would have a synergistic effect and yield relatively greater benefits that accrue across those communities in terms of the quality of community living, health care provision, and the life-long learning experience. It is hoped that such tripartite age-friendly alliances emerge more commonly in the not-so-distant future and that allied health and human service professionals serving the older adult population have a significant voice in those efforts.

In this special issue, Carrie Henning-Smith, Megan Lahr, Hannah MacDougall, and Lacey Loomer at the University of Minnesota's School of Public Health and Rural Health Research Center remind us that, even though rural communities are aging faster than their urban counterparts, they remain underrepresented in the age-friendly movement. They appeal to Aging Life Care Managers in rural regions not only to advocate for older residents to take advantage of the resources that an age-friendly community has to offer, but also to advance the establishment of age-friendly commu-

nities in small towns and communities. Patricia Oh and Lisa White emphasize the influence age-friendly communities can have in ensuring easy and convenient access to community and health services, including advance care and end-of-life planning. It appears that the COVID-19 pandemic as a public health emergency has escalated interest in and need for the promotion and delivery of community and health services

With the goal of eliminating the physical and social barriers of engagement by older adults in all facets of life, the age-friendly movement is increasingly visible and apparently here to stay.

within the age-friendly movement, but that response has not necessarily extended to furthering the availability of advance care and end-of-life planning services. The discussion moves on to the age-friendly movement in higher education presented by Joann Montepare and Lenard Kaye. They note that the challenge for institutions of higher education to reconsider how their programs, practices, and partnerships can be more age-inclusive to better serve age-diverse learners has now been responded to by over 100 universities across the world. They make it clear that such efforts will realize greater

success if they extend their reach beyond the halls of academia to off-campus communities and stakeholders, broadly speaking, including establishing genuine partnerships with the specialized health and human services workforce that serves older adults. Finally, Jennifer Crittenden, Susan Wehry, and Judith Metcalf describe the principles and practices of age-friendly health care. Once again, Aging Life Care Managers and others who help older

patients navigate the myriad barriers to accessing and utilizing even the best that health care systems have to offer remains crucial. The authors discuss the tenets of age-friendly health-care and the barriers often encountered in achieving it and provide critical approaches that Aging Life Care Managers can adopt to promote access,

including, perhaps most importantly, addressing their own implicit bias.

With the goal of eliminating the physical and social barriers of engagement by older adults in all facets of life, the age-friendly movement is increasingly visible and apparently here to stay. In fact, it is already extending its reach beyond communities, higher education, and healthcare into the business sector, government, at the state level, and more. Aging Life Care Managers have the opportunity, and perhaps the obligation, to step up and represent an active and positive force as the age-friendly movement continues to evolve.



Advancing the Age-Friendly Movement in Rural Communities

Carrie Henning-Smith, PhD, MPH, MSW; Megan Lahr, MPH; Lacey Loomer, PhD, MSPH; Hannah MacDougall, PhD, MSW

ABSTRACT

The majority of rural older adults would prefer to age in place and most experience strong social relationships and cohesion within their communities. However, rural older adults also have poorer underlying health status, more limited access to financial resources, and more limited access to care compared to urban older adults. Advancing the age-friendly movement in rural areas requires taking all of these factors into account, and doing so is urgently important as rural areas are aging faster than urban areas, yet are underrepresented in the age-friendly movement. Aging Life Care Managers® can help to support the age-friendly movement in rural areas by advocating for the needs and interests of their clients, as well as for the broader involvement of rural communities in the age-friendly movement. Further, in order to support older adults in aging in place, thereby increasing the age-friendliness of their communities, Aging Life Care Managers can play an important role in helping their clients access care, services, and supports in rural areas where those are otherwise less available.

Introduction

The concept of “age-friendly” is increasingly common in communities, health care, and policy. Across sectors, advancing an age-friendly agenda entails fostering inclusion for all, regardless of age or ability status. This requires accessibility and inclusion within a wide range of factors, including physical environment, housing, infrastructure, civic processes, language, transportation, and health care. Ideally, age-friendly practices will make it easier for adults to live and grow older in their own homes and communities, or wherever they prefer. Aging Life Care Managers, sometimes referred to as geriatric care managers, can be partners with older adults and their families in navigating the changes and decision-making that accompany the aging process. And increasing age-friendliness will ideally make that role easier, while also including the perspectives and insights of Aging Life Care Managers in the age-friendly process.

Rural communities and residents are unique in myriad ways, each of

which presents unique barriers and opportunities to becoming age friendly. Rural areas have distinct challenges and strengths, and rural older adults differ in meaningful ways from urban older adults, across socio-economic status, demographics, health, and functional status (Tuttle et al., 2020). Rural environments also differ from urban ones in terms of infrastructure, access to resources, and the built environment. This means that efforts to advance the age-friendly movement must take geographic context into account and that solutions that work in urban areas may not necessarily translate to rural areas.

Most efforts to increase age-friendliness, and the corresponding research to document those efforts, have been focused on urban areas (Keating, Eales, and Phillips, 2013; Menec et al., 2015). Some researchers have noted that state-level initiatives to support successful aging are valuable (Rehkopf et al., 2021), in that they are inclusive of rural areas. However, while many states have developed statewide initiatives to

increase age-friendliness, very few of those focus on the unique needs of rural older adults (Tanem, Henning-Smith, and Lahr, 2021). Even fewer focus on the role of Aging Life Care Managers in the advancement of age-friendliness in rural areas, although Cress (2021) discusses the financial challenges associated with locating such a business solely within rural areas. This paper builds on that work, addressing an important gap in the literature by focusing on rural-specific challenges and opportunities to increase age-friendliness and by discussing the potential role of Aging Life Care Managers in that work.

Demographics of Rural Older Adults

The population of rural areas is older than urban areas (Cromartie, 2018), partly owing to outmigration of younger adults to urban areas, coupled with the tendency of many older adults in rural areas to remain in their homes and communities as they age. Rural older adults tend to be in poorer health and

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have more chronic conditions than urban older adults (Tuttle et al., 2020). Rural older adults also have lower socio-economic status than urban older adults, including lower educational attainment and lower household incomes (Tuttle et al., 2020). Altogether, this means that any age-friendly efforts in rural communities must contend with the fact that rural older adults will have greater needs for care, including long-term services and supports, but fewer financial resources with which to afford that care.

Despite those challenges, rural older adults have particular strengths related to social connectedness and social cohesion within their communities. Rural older adults report larger family and friend networks (Henning-Smith, Moscovice, and Kozhimannil, 2019), as well as greater social cohesion within their communities, as measured by greater sense of trust among their neighbors (Henning-Smith, Lahr, MacDougall, and Mulcahy, 2022). This strong sense of social cohesion presents a solid foundation on which age-friendly initiatives can build and sustain themselves (McCrillis, Skinner, and Colibaba, 2021). Rural social cohesion should also be considered relevant for the work of Aging Life Care Managers; they would be wise to build on the social fabric already in place in rural communities and, ideally, would be embedded within that fabric themselves in the work that they do.

It is also important to note that rural places and the older adults who live within them are not monolithic. Instead, there is considerable diversity across rural people and places in terms of race, ethnicity (Henning-Smith, Hernandez, Hardeman, Ramirez, and Kozhimannil, 2019; Zahnd et al., 2021), socio-economic status (Glasgow and Brown, 2012), and access to resources. Recognizing the heterogeneity of rural people and places, age-friendly movements should not treat rural and urban older adults as one homogenous group, nor should they assume that all rural older adults have the same needs and preferences.

The Rural Environment

Just as rural older adults differ from urban older adults, so do the environments in which they live. Fundamentally, rural areas are geographically large and disparate, covering the vast majority of the land mass in the United States. To get from one rural place to another often requires traveling long distances; sometimes this is true even within the same rural community. Rural areas can be fragmented in terms of municipalities and governmental jurisdiction, falling under village, town, city, county, state, and federal regulations. This fragmentation can pose challenges for the development and long-term sustainability of age-friendly initiatives (McCrillis et al., 2021).

Rural areas also face unique challenges related to infrastructure. For example, the housing stock in rural areas tends to be older and of poorer quality than the housing stock in urban areas (Levitt, 2017; White, 2015). Rural older adults are also more likely than their urban counterparts to own their homes rather than rent (Tuttle et al., 2020), which may be beneficial for financial security, but which also means that rural older adults are more likely to be responsible for the maintenance and upkeep of their homes, as well as for finding resources for any modifications or accessibility features needed to be able to age in place (Levitt, 2017). Further, older adults in non-metropolitan (rural) counties are more likely to live alone than older adults in metropolitan (urban) counties (Henning-Smith, Schroeder, and Tuttle, 2020), which is a compounding factor in home maintenance and upkeep, despite having fewer financial resources.

Age-friendly initiatives in rural areas need to take the housing environment into account and might consider including specific programs to maintain and renovate older housing stock to ensure that it is accessible for people of all functional abilities. Such programs exist currently, but are not widespread or well-funded enough to meet the current need (Keglovits and Stark, 2020; Pynoos, 2019). Aging Life Care Managers helping rural older

Age-friendly initiatives in rural areas need to take the housing environment into account and might consider including specific programs to maintain and renovate older housing stock to ensure that it is accessible for people of all functional abilities.

adults age in place should become familiar with such programs and help their clients navigate them. However, the same professionals will also need to assist with finding creative solutions for housing needs in the absence of formal programs. In finding such solutions and in advocating for longer-term, more equitable housing solutions, rural-based Aging Life Care Managers can help to increase the age-friendliness of their communities.

Similarly, rural areas face persistent transportation challenges, including limited access to public transportation, greater distances, and poorer road conditions (Henning-Smith, Evenson, Corbett, Kozhimannil, and Moscovice, 2018). Rural residents who develop health conditions that make it difficult to drive are less likely than urban residents with the same conditions to stop driving (Henning-Smith, Evenson, Kozhimannil, and Moscovice, 2017), usually because of a paucity of other options. Further, rural areas have more limited access to broadband internet and cellular connectivity (Perrin, 2019), mak-

ing it more difficult for rural residents to access services, resources, and social connections remotely (Henning-Smith, 2020).

Altogether, rural age-friendly movements need to address infrastructure challenges in order to ensure that communities are inclusive of all, regardless of age. Broader, state-wide age-friendly initiatives that do not address these rural-specific issues will be ineffective at advancing the age-friendly movement for rural older adults. Aging Life Care Managers working in rural areas should be aware of these infrastructure concerns and can be an important voice in advocating for rural-specific policy solutions to better serve their clients.

Rural Health Care and Long-Term Care

Access to health care in rural communities can be difficult for many reasons, particularly for rural older adults. The number of health care facilities, including hospitals and nursing homes, has dramatically decreased over time. Since 2005, more than 180 rural hospitals have closed (University of North Carolina Sheps Center for Health Services Research, 2022), and between 2008 and 2018, nearly 475 nursing homes in rural communities have also closed (Healy, 2019; Sharma, Bin Abdul Baten, Ullrich, Clinton MacKinney, and Mueller, 2021). These closures have left rural residents without key health care facilities that allow older adults to remain in their communities as they age. Due to the diminishing supply of health care infrastructure in rural areas, Aging Life Care Managers may play a key role in navigating the remaining resources and identifying creative solutions in the absence of formal health care resources.

Beyond availability of facilities, there are several other barriers to accessing health care services that are specifically relevant to rural Medicare beneficiaries, most of whom are older adults. Issues with transportation, distance, lack of available telehealth and/or broadband Internet can all impact an older adult's ability to access care, as well as their ability to age in place (Henning-Smith, Hernandez,

and Lahr, 2019; Lahr, Henning-Smith, Hernandez, and Neprash, 2019). Rural Medicare beneficiaries are also more likely to have delayed care due to cost compared to urban counterparts and to have collection agency contact for unpaid medical bills (Henning-Smith, C., Hernandez, A., and Lahr, M., 2019; Henning-Smith, Lahr, and Hernandez, 2022), illustrating the additional financial concerns for rural older adults, despite having Medicare insurance coverage.

Access to health care providers, especially specialists, is another common difficulty in rural communities, as illustrated by the thousands of Health Professional Shortage Areas (HPSAs) in rural areas designated by the federal government (Bureau of Healthcare Workforce, 2021). Studies have shown that specialty care is particularly difficult for rural older adults to access due to lack of availability in rural communities, and that barriers to accessing general health care (e.g., transportation, lack of telehealth) impact access to specialty care as well (Lahr, Neprash, Henning-Smith, Tuttle, and Hernandez, 2019).

Inclusion of Rural Areas in the Age-Friendly Movement

Rural communities are currently underrepresented in the current age-friendly movement. For example, of the 621 communities that have entered the AARP age-friendly network, 158, or 25%, are in non-metropolitan counties according to Rural Urban Continuum Codes, but 63% of all U.S. counties are non-metropolitan (AARP Livable Communities, 2022b). This is significant, as AARP is one of the largest promoters of the age-friendly movement, and participation in their network is a signal of commitment by the community. In addition to local municipalities, states also vary in their efforts to support rural age-friendliness (Tanem et al., 2021), and financial and administrative support from a state is another important signal of a commitment to increasing age-friendliness. Rural Aging Life Care Managers can play an important role in advocating for and informing such age-friendly initiatives at the state and local levels.

Despite the current relatively low participation rates, rural communities that have entered the AARP age-friendly network are creative in their strategies for overcoming barriers due to low population density. One strategy involves rural towns grouping together to form a larger coalition of age-friendly communities. For instance, in Maine, the Age-Friendly Bethel community joined together Bethel with Gilead, Greenwood, Hanover, Newry, and Woodstock, towns with populations ranging from fewer than 200 to 2,500 (AARP Livable Communities, 2022a). On the other hand, some rural counties are joining regional collaborations along with their urban neighbors. For example, in Georgia, the River Valley Regional Commission is an age-friendly community of 16 counties, 12 of which are rural (AARP Livable Communities, 2022b; River Valley Regional Commission, 2022).

In addition to the emerging leaders in the age-friendly movement in the United States, Canada has been leading efforts to create specific rural-focused strategies for age-friendly communities. In 2007, the Canadian Ministers Responsible for Seniors released the Age-Friendly Rural and Remote Communities Initiative (Federal/Provincial/Territorial Ministers Responsible for Seniors, 2011). As part of that work, they created an age-friendly rural and remote communities guide using community-based research. Community members identified themes – including access to outdoor spaces, transportation, housing, social inclusion and participation, communication, civic participation, and community support – that indicated whether their community was or was not age-friendly.

The Role of Aging Life Care Managers®

In light of the many strengths and challenges inherent in aging in rural communities, Aging Life Care Managers can play an important role in ensuring that rural communities are age friendly. This may include advocating for the interests of the older adults and families they serve to increase the

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age-friendliness of their communities and/or to connect their community with a formal age-friendly network or movement. Further, in rural communities with fewer formal health care resources and limited access to long-term services and supports, Aging Life Care Managers may help to fill in the gaps for older adults and their families in order to help them remain in their homes and communities. However, Aging Life Care Managers will also need to grapple with the fact that rural older adults have greater needs for care and fewer financial resources with which to afford care management, all within a context of more limited infrastructure (Cress, 2021). True age-friendliness in rural communities would include access to care management for older adults and their families that is affordable, accessible, appealing, and localized. Aging Life Care Managers can play an especially important role as a trusted community member within rural areas.

Aging Life Care Managers can prioritize needed services by listening to older adults and other key stakeholders in rural communities. By addressing priorities determined by the community, these professionals build trust and ensure the resources they have are being used most effectively. Moreover, the identification of community-specific priorities ensures Aging Life Care Managers do not treat rural communities as homogenous; rather, they can nimbly adapt to the unique concerns of the community they are working within. By working alongside rural older adults and their families, Aging Life Care Managers can help build on existing strengths to creatively tackle rural-specific issues while also advocating for greater resources to address challenges. Given the relative lack of evidence on Aging Life Care Managers in rural areas, an important next step would be to conduct additional research on the role they can – and do – play in advancing age-friendliness in rural areas. This might take the form of a pilot study or data collection focused on the current and potential use of Aging Life Care Managers in rural areas specifically.

Such age-friendly efforts face unique challenges and opportunities in rural communities, where the population is older, has poorer health outcomes, and has fewer financial resources.

Conclusion

The majority of older adults, including rural older adults, would prefer to age in place (Henning-Smith, Mulcahy, Lahr, & Tanem, 2021). That is, they would prefer to remain in their homes and communities as they get older. Supporting them in doing so is not only important for their quality of life but is also important for the social cohesion and vitality of the communities where they live. However, ensuring good quality of life, health, and well-being requires ongoing efforts to increase age-friendliness in communities in order to make them inclusive, accessible, and supportive.

Such age-friendly efforts face unique challenges and opportunities in rural communities, where the population is older, has poorer health outcomes, and has fewer financial resources. Rural older adults also experience especially strong social cohesion and should be recognized and appreciated as essential members of their communities. Aging Life Care Managers in rural areas have an important role to play

in lifting up the voices and preferences of rural older adults and accompanying their communities on the journey to becoming more age-friendly for all.

Funding Acknowledgement:

Funding for this work came from the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under PHS Grant #5U1CRH03717. The information, conclusions and opinions expressed are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred. This research was also supported by the University of Minnesota Fesler-Lampert Chair in Aging Studies and Center for Healthy Aging and Innovation.

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Approaches to Community Supports and Health Services in U.S. Age-Friendly Communities: Focus on Advance Care and End-of-Life Planning

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ABSTRACT

Background. The majority of older people plan to age in their communities. To strengthen local environments for aging, more than 700 U.S. municipalities have joined the AARP Network of Age-Friendly States and Communities (NAFSC). With the growth in network membership, there is increasing interest in understanding how localities contribute to the promotion and delivery of health and community services, including advance care and end-of-life planning (ACELP).

Methods. Based on the structure developed to guide municipal participation in NAFSC, this qualitative study uses directed content analysis to explore 187 action plans and 18 progress reports submitted to AARP by network members to fulfill membership requirements.

Findings. The majority (93%, n=174) of plans considered changes in health and community services, but few (14%, n=27) focused specifically on ACELP. Progress reports showed a similar pattern, with the majority (94%, n=17) reporting implementation of changes to enhance community and health services but a minority (33%, n=6) targeting ACELP. Generally, involvement by aging, health care, and community service providers in an age-friendly community was associated with more activities to increase access to community and health services but not to ACELP.

Implications. While this study shows that age-friendly communities are planning and implementing change in community support and health services and suggests an important role for Aging Life Care Managers® (ALCMs) and other health care providers, additional research is needed to understand why some communities include ACELP while others do not.

Age Friendly Communities and Advance Care Planning

Since AARP launched the Network of Age-Friendly States and Communities (NAFSC) as an organizational affiliate of the WHO Global Network of Age-Friendly States and Communities (GNAFCC), more than 700 U.S. municipalities have enrolled in the network to foster community engagement and maximize the health and well-being of residents by developing age-friendly approaches to housing; transportation; public spaces and buildings; communication and information; social participation; civic engagement and employment; and community supports and health services (AARP, 2022). A significant

literature describes the age-friendly process (e.g., Jacobs & Pestine-Stevens, 2021) and explores the effect of age-friendly implementation in the built and social environments (e.g., Cao, Dabelko-Schoeny, White, and Choi, 2020). However, despite program emphasis on the importance of adapting the service environment to the diversity of resident needs (WHO, 2018), there is limited understanding of how age-friendly communities (AFCs) approach the community support and health services domain (Lee, Cho, Cho, and Park, 2019). Barriers to access to community supports and health services, including quality advance care and end-of-life planning (ACELP), have gained increased attention during the COVID-19 pandemic (Morrow-Howell,

Galucia, and Swinford, 2020).

This study addresses the gap in knowledge about age-friendly approaches to the community support and health services domain, with a special focus on ACELP, by exploring documents submitted to AARP by network members as a condition of membership in NAFSC. First, the study explores age-friendly plans to increase access to community supports and health services and ACELP, and then examines progress reports submitted to AARP by network communities to categorize the types and extent of work in the community supports and health services domain and, particularly, ACELP activities reported by AFCs.

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Framing Age-Friendly Communities and Community Supports and Health Services

Age-friendly communities are broad, purposeful, geographically defined approaches to community change that engage municipal decision makers, residents, and formal and informal organizations representing multiple sectors in the community (Black & Oh, 2022; Pestine-Stevens & Greenfield, 2022), including ALCMs and other aging and health service providers (Jacobs & Pestine-Stevens, 2021). As an organizational affiliate of the WHO-GNAFCC in the U.S., AARP has spearheaded the age-friendly movement through membership in NAFSC. Members commit to a five-year cycle of continuous improvement (see Figure 1) to structure their work in the eight domains of livability (AARP, 2020).

In planning and implementing change within and across domains, AARP guidelines recommend involving older residents and professionals with expertise and an interest in promoting healthy aging as change makers to ensure that the needs, preferences, and desires of older residents are paramount (AARP, 2022). ALCMs are

familiar with a spectrum of needs among people growing older in the community, including isolated people and residents living with chronic illness or frailty and, so, are uniquely qualified to represent the experience of aging in the community. The community supports and health services domain is characterized by a broad mix of formal and informal services (Lowen, Davern, Mavoa, and Brasher, 2015), such as food security, emergency preparedness, elder abuse prevention, supports for people living with dementia and care partners, wellness promotion, and tele-health. AFCs approach the community supports and health services domain through advocacy, raising awareness of or expanding existing programs, and developing new services (AARP, 2020). ALCM expertise in the services and programs available and in forming collaborations among formal and informal services can contribute to planning and implementation in the community supports and health services domain.

The WHO GNAFCC includes focus on the needs that can accompany advanced old age and people at the end of life (WHO, 2018). However, programmatic emphasis in the U.S. and elsewhere has been on advancing local policy, services, programs, and

activities that promote active, healthy, and engaged aging (e.g., AARP, 2018b). Studies have noted the key role of community supports and health services to the perception of municipal age-friendliness (e.g., Choi, 2022) and to improve the health and well-being of people aging with a disability or chronic illness (Miskimmin et al., 2019; Zamora, Kloseck, Fitzsimmons, Zecevic, and Fleming, 2020), but few have included ACELP. Those that have included mention of end of life have focused on developing a broad culture of health that includes ACELP (DiGioia & Black, 2021) and not on ACELP activities planned and implemented by age-friendly communities.

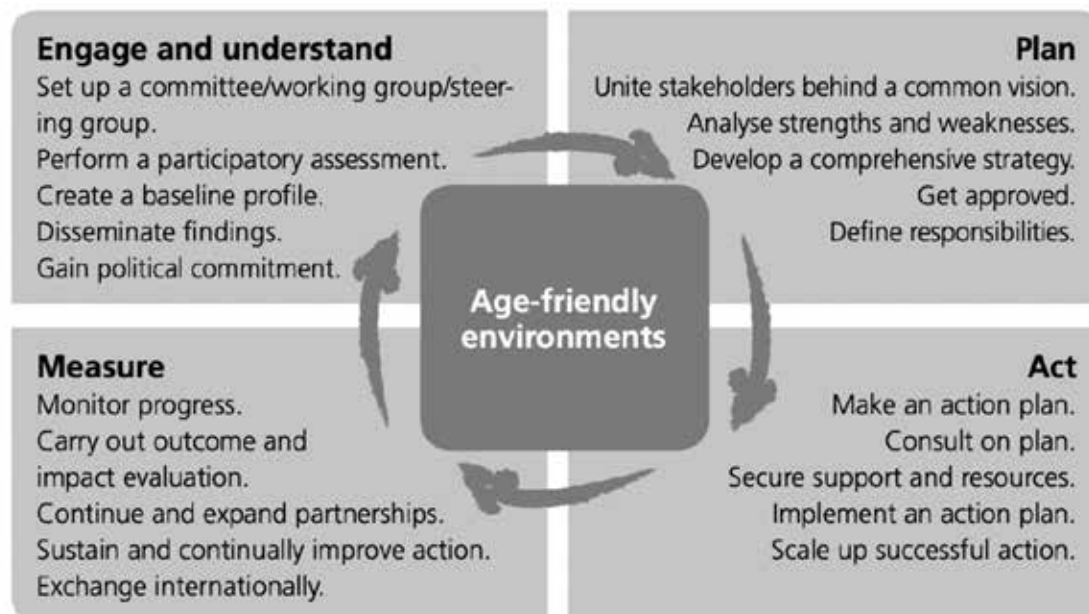
Community Approaches to Advance Care and End-of-Life Planning

The public health gains of the last century have allowed people to live longer even with chronic disease (Sallnow et al., 2022), which has increased the need for ACELP, processes that support individuals of all ages and health conditions in understanding and sharing their personal values, life goals, and preferences regarding future medical and non-medical care (Sudore et al., 2017). While most people planning for

end of life want to die at home (Cruz-Oliver, 2017), barriers in health care policy and local services often prevent the desired death (Committee on Approaching Death, 2015), especially for people who are traditionally marginalized in the community (Stajduhar, et al., 2019). Public health advocates are increasingly asking health care providers and communities to reconsider societal attitudes about end of life and to address social determinants of health that impact a person's ability to attain a desired death (Sallnow et al., 2022). Studies suggest that collabo-

Figure 1

Cycle of Continuous Improvement for Age-Friendly Cities and Communities (WHO, 2018)



ration between the health care sector and community results in improved health outcomes, mitigates avoidable suffering, and strengthens community capacity for care and support (Vanderschelen et al., 2022).

Prior to the COVID-19 pandemic, facilitated ACELP conversations and outreach were shown to enhance end-of-life discussions (Eneslätt, Helgeson, and Tishelman, 2021). During the COVID-19 pandemic ACELP activities expanded to include telehealth facilitated conversations (Bender, Huang, and Raetz, 2021; Gupta et al., 2021). During the pandemic, local age-friendly community initiatives successfully advocated for expansion of telehealth to increase access to community supports and health services (Delange Martinez, Nkayama, and Young, 2020), but it is not known if communities advocated for telehealth services to expand access to ACELP.

This study examined evidence of planning and implementing changes in the community supports and health services domain with a focus on ACELP as it was reported by NAFSC members. Specifically, the study assessed the scope of age-friendly community involvement in the community support and health services domain and the extent, range, and type of participation in ACELP across AFCs. Results were then synthesized for enhanced understanding of age-friendly community engagement in the community support and health services domain, with a focus on ACELP.

METHODS

Research Design and Analysis

To conduct this study, the authors employed directed content analysis of 187 action plans and 18 progress reports submitted by NAFSC members to AARP as a requirement of membership in the network and made publicly available on the AARP NAFSC member website (<https://www.aarp.org/livable-communities/network-age-friendly-communities/>). The authors analyzed action plans as an indicator of intention to engage in activities to enhance community supports and health services and examined progress report data to explore how communities implement-

ed change in community supports and health services and, in particular, ACELP. Analysis of the action plans and progress reports was done using a priori codes based on the WHO (2015, p. 49) core indicators of the community supports and health services domain and the AARP Age-Friendly Community survey (2018a), which adapted the WHO GNAFCC framework to the United States context.

Sample and Data Collection

NAFSC requires members to submit an action plan within two years of joining the network. A progress report must be submitted three years later, at the conclusion of the five-year cycle of continuous improvement. Of the 587 active members of NAFSC on November 15, 2021, 417 had been members for more than two years, and therefore were at or beyond the date when their action plan was due, and 121 were en-

rolled in the network for five or more years and, if program milestones were met, should have submitted their progress report. Of these, 187 action plans, representing 262 communities (25 plans reported the aspirations of regional approaches that included multiple communities) in 37 states, and 18 progress reports, representing 29 communities (4 progress reports described regional initiatives) in 14 states, were publicly available on the AARP member website. Age-friendly communities that had not submitted an action plan or progress report to AARP were excluded from this analysis.

RESULTS

Action Plans

Of the 187 action plans submitted to AARP, nearly all (93%, n=174)

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TABLE 1

Summary of Activities in the Community Supports and Health Services Domain Planned and Implemented

Community Supports and Health Services Activity	% Action plans address issue area (n=187)	% Progress reports address issues areas (n=18)
Policy change	13.4	16.7
Address economic security	23.5	38.9
Promote health knowledge and skills	50.8	77.8
Increase access to community services	54.5	83.3
Increase access to and promote telehealth/telemedicine	4.3	5.6
Dementia-related activity, service, education	36.9	50.0
Activity, program or service for people with dementia	24.1	38.9
Education about dementia friendly practices	27.8	33.3
Formally joins Dementia Friendly America®	13.9	5.6
Activities, programs, or services for informal caregivers	48.1	50.0
Promote and advocate for caregiver-friendly policies	7.5	22.2
Programs or services for informal caregivers	43.9	44.4
Funding for services	3.2	16.7
Address food security	34.8	50.0
Elder mistreatment initiative	26.7	33.3
Public Service initiative	47.1	83.3
Crime prevention and awareness	13.4	44.4
Fire prevention and home safety	11.2	50.0
Emergency preparedness	34.2	61.1
Improve health and public health outcomes	65.8	83.3
Advocate or promote age-friendly health care	3.2	16.7
Program or service to reduce readmission	5.3	22.2
Recruit health care workers	11.8	27.8
Increase access to primary or specialty care	19.8	38.9
Wellness initiative	56.1	66.7
ACELP	14.4	33.3

TABLE 2

Summary of ACELP Activities Planned and Implemented

ACELP Issue Area	% Action plans address issue area (n=187)	% Progress reports address issues areas (n=18)
Advance directives	7.5	11.1
Conversations about wishes and goals for ACELP	4.3	22.2
Aging transitions/long life planning/ long-term care	3.2	11.1
Financial planning	3.2	11.1
Powers of attorney	3.2	0.0
Promote hospice & palliative care	2.7	22.2
Grief support/loss	2.1	0.0
Hospice house	1.6	0.0
End-of-Life planning	1.1	0.0
Last will and testament	1.1	0.0
End-of-life counseling	0.5	0.0
Guardianship	0.5	5.6
Funeral planning	0.0	0.0
Advocate for legislature (proxies)	0.0	5.6

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planned activities, programs, services, or advocacy as part of their approach to increase the availability of and access to community supports and health services, and 25 (13%) indicated plans to engage in some type of ACELP activity.

Community Support and Health Services

The most common area in the community supports and health services domain targeted by age-friendly communities was the improvement of health and public health outcomes by implementing or expanding access to a wide variety of wellness initiatives (e.g., evidence-based health promotion programs; wellness checks; sand bucket or snow shoveling to keep private walkways safe). Age-friendly communities frequently planned to increase access to services and programs (e.g., transportation to services; developing or expanding a community navigator program); promote health knowledge and skills (e.g., community health talk series; health and wellness fair); and, develop, advocate, or promote caregiver supports. Less commonly, age-friendly communities planned dementia-related activities, emergency prepared-

ness initiatives, and food security activities (see Table 1). A minority of communities planned ACELP activities.

Advance Care and End-of-Life Planning

Communities that planned ACELP activities were more likely to describe a domain planning team to lead the work in community supports and health services than other communities; 24% of the 55 communities with a domain planning team targeted increasing access and availability of ACELP as part of their action plan, compared with 9% of the 132 communities that did not have a community supports and health services planning team. Most often, community supports and health services domain teams included at least one aging service or health care provider (e.g., ALCM, area agency on aging). Plans to address ACELP were more likely to be aligned with the Community Health Improvement Plan (CHIP) than other submitted action plans; 30% of plans that included ACELP had goals that overlapped with their CHIP, compared with 2% of plans that did not include ACELP. When ACELP activities were noted in action plans, age-friendly communities generally described one or two activities. However, a few communities planned a comprehensive

approach to ACELP, with as many as six activities. Planned ACELP activities most commonly included promoting conversations about end-of-life planning, completing advance directives, financial planning, powers of attorney, and promoting hospice and palliative care (see Table 2). Less common activities included guardianship and last will and testament. No communities included funeral planning as an ACELP activity in their action plan.

Progress Reports

Eighteen progress reports were submitted to AARP by communities in 14 states with nearly all (94%, n=17) reporting work to make the community supports and health services domain more age-friendly and a significant minority (33%, n=6) describing ACELP activities.

Community Support and Health Services

Overall, more communities reported successful initiatives in community supports and health services than had planned them (see Table 1). Nearly all the age-friendly communities reported success improving health and public health outcomes through increasing access to: (1) wellness programming (e.g., health or medication screenings, falls prevention initiatives); (2) health care or community services (e.g., translating and distributing a resource guide in Spanish; mobile health clinics); (3) health knowledge and skills (e.g., resource fair; public access media program). Communities also frequently reported public service initiatives, which included crime and fire prevention activities as well as emergency preparedness (see Table 1). Less commonly, age-friendly communities implemented caregiver supports or engaged in dementia-related activities. Reported successes in the community supports and health services domain were often complex and multi-faceted, requiring collaboration between two or more partners. For example, an emergency preparedness initiative required intersectoral cooperation between multiple municipal departments (e.g., public health; emergency services) as well as

engagement by multiple sectors (e.g., long-term care services; Red Cross).

Advance Care and End-of-Life Planning

Age-friendly communities that implemented ACELP activities reported active engagement with the aging and/or health services sectors, with a range of 2 to 79 partners. Typically, partners included the Area Agency on Aging, home care services, senior center, senior housing, and long-term care facilities. Among the six communities that described ACELP activities, only one had included it in its action plan. Frequently reported activities were engaging community members during workshops and health fairs, distributing materials in languages other than English, educating care providers, and advocating for the expansion of hospice and/or palliative care services. Less commonly, communities facilitated ACELP workshops that promoted advance care directives, educated residents about financial and long-term care planning, and advocated for legislation (see Table 2).

CONCLUSION

Ensuring that a broad range of programs in the community supports and health services domain are available, affordable, convenient, and accessible to all residents in a community is central to developing an age-friendly community environment and is core to ALCM support for healthy, engaged aging in the community. Results from this study suggest that age-friendly communities provide and promote a wide variety of activities in community supports and health services, especially when health and social service providers are engaged with age-friendly community planning and implementation, but that few include ACELP as part of their approach. Though not without limitations, this study's findings have implications for ALCM practice.

Communities often accomplished more changes in the community supports and health services domain than were planned. In line with prior studies on the impact of multisector engagement in age-friendly communities (Black & Oh, 2022; Pestine-Stevens

& Greenfield, 2022), this study found that involvement by ALCMs or other aging and health care service providers was associated with greater activity in the community supports and health services domain. While this study is unable to further contextualize the factors that contributed to an age-friendly community's decision to address one or more aspects of the community supports and health services domain, research suggests that more committed efforts by formal organizations and professionals with an interest in aging may be necessary to advance age-friendly progress, especially in rural areas (McCrillis, Skinner, and Colibaba., 2021). This study suggests that the involvement of professionals, such as ALCMs, who were familiar with the services available in the community and the needs of residents, provided knowledge, resources, and experience that were deployed to enhance the scope of activities planned in the community supports and health services domain.

The majority of communities that described ACELP activities in their progress reports had not planned to include end of life, which suggests that age-friendly communities had limited awareness of resources during planning. The results of this study point to the importance of raising awareness of ACELP during age-friendly planning. Advocacy for inclusion of ACELP in age-friendly planning is a potential role for ALCMs and other health care professionals who are able to connect the age-friendly team to information about ACELP and local resources to support end-of-life planning. Age-friendly teams consist of people and organizations representing multiple sectors in the community, and so may not be aware of the importance of ACELP or the community supports and health services available. ALCMs have experience with difficult conversations about decline, chronic illness, incapacity, and end of life, and are able to educate the age-friendly team about the importance of these conversations to help people live their lives to the fullest. When ACELP activities were described, the most common approach was conversation-based projects, which is consistent with a growing literature

that emphasizes the effectiveness of community conversations about these issues (Eneslätt et al., 2021). The information pertaining to ACELP gained through this study is minimal, and therefore, further research is needed to identify the mechanisms behind an age-friendly community's decision to prioritize ACELP among a host of other community needs.

Limitations

Although this study provides evidence that age-friendly communities are planning and implementing changes to increase the availability of and access to community supports and health services, which includes ACELP activities, there are a few caveats. This study is an exploratory, qualitative analysis of publicly available documents submitted by age-friendly communities as part of their participation in NAFSC, and so does not capture the extent of involvement by ALCMs in age-friendly communities or how involvement impacted plans to produce and promote community supports and health services or the extent of change implemented. ALCMs have the potential to expand the scope and reach of age-friendly community work in the community supports and health services domain, additional methodologies, such as case studies, could deepen understanding of ALCM engagement in AFCs and how and why age-friendly communities approach the community supports and health services domain, and, in particular, ACELP. Despite its many limitations, this study provides preliminary empirical data to stimulate additional research into ALCM engagement with age-friendly communities and how that involvement affects age-friendly communities' approach to the community supports and health services domain and promotion of ACELP activities.

Implication for Aging Life Care Managers®

With their broad focus on community development, age-friendly community initiatives are natural part-

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ners to ALCMs seeking to make the environment where older people are aging more conducive to longer lives. ALCMs are experts in connecting older people to the services, programs, and activities that support healthy, engaged aging. As ALCMs navigate the environment for aging with their clients, they develop an appreciation for what is working well in the community and the gaps in services that impact the ability of older people to thrive. ALCMs are crucial advocates for changes that reflect the needs and preferences of people with diverse aging experiences. Age-friendly community leadership teams benefit from the deep understanding of aging in the community and established networks for connecting clients to health care and other forms of community support that ALCMs bring to the table. Involvement by ALCMs in age-friendly community initiatives has the potential to increase awareness of the services and programs offered by ALCMs and lead to changes in the environment for aging that will benefit residents beyond the direct service provided by ALCMs.

To find out if your community is part of the AARP NAFSC, go to the NAFSC page, <https://www.aarp.org/livable-communities/network-age-friendly-communities/>. The member list and map will tell you if the municipalities that you serve are part of the network. If your city or town is not a member, the page also includes information about developing a team and working with your municipality to join NAFSC.

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Age-Friendly Universities (AFU): Expanding Opportunities for Older Community Members and Aging Service Providers

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SUMMARY

Populations are aging at a historic pace locally, nationally, and globally, with demographic age transitions impacting almost all aspects of society. Building on the last decade of their Sustainable Development Goals, the United Nations' Decade of Healthy Ageing (2021-2030) collaboration has called for governments, communities, and others to work to adapt environments, policies, services, and products to enhance the well-being of individuals as they age. In response, pioneering initiatives have emerged to help shape responses to aging populations. The Age-Friendly University (AFU) initiative is one such effort that has challenged institutions of higher education to reconsider how their programs, practices, and partnerships can be more age-inclusive to better serve older adult community residents as well as partner more deliberately with the specialized health care and human services workforce that serves them.

The Principles and Pillars of Age-Friendly Universities (AFU)

The AFU initiative reflects the work of an international, interdisciplinary team of educators, researchers, administrators, and community partners convened by Dublin City University (Ireland) to identify how institutions of higher education can meet the needs and interests of aging populations. The AFU team identified ten principles to guide the development of age-friendly practices that were built on the six pillars of institutional activity: 1) teaching and learning; 2) research and innovation; 3) lifelong learning; 4) intergenerational learning; 5) encore careers and enterprise; and 6) civic engagement (see Table 1). These guiding principles articulate specific ways colleges and universities can be more age-inclusive by extending institutional practices in distinct ways (Andreoletti, Montepare, & Silverstein, 2019; Montepare, Farah,

Bloom, & Tauriac, 2020; O'Kelly, 2015).

The AFU framework advocates that older adults be enabled to participate in core education, research, and cultural and wellness activities in higher education for personal and professional development. It also calls for institutions to disrupt age-segregation by extending aging education to younger students and bringing younger and older learners together in intergenerational exchanges that facilitate reciprocal learning. Age-friendly institutions also offer extended educational opportunities to support an age-diverse workforce and encourage aging research by developing agendas informed by older adults' diverse needs. As well, they look to develop partnerships beyond their campuses (e.g., with older adult-serving health and human service providers) to address the needs of local aging communities, and to cultivate an appreciation for the richness that

aging brings to society. Considering extensive research in gerontology and geriatrics education, the AFU principles offer an evidence-based approach that institutions of higher education can use to assess existing programs and practices, identify challenges and gaps, and implement new efforts to support aging populations.

Growth of the AFU Global Network

In the last several years, the AFU network has grown from a few institutions to a worldwide network of over 100 colleges and universities in Europe, the United States, Canada, Australia, and beyond. Momentum to extend the network continues, with the endorsement of several prominent professional organizations such as the Gerontological Society of the America (GSA) and its Academy for Gerontology in Higher Education (AGHE) and Division 20 (Adult Development and Aging) of the

American Psychological Association (APA). As well, conferences, workgroups, newsletters, and other network collaborations have been launched to expand AFU efforts, along with the creation of resources such as GSA's Tools for Advancing Age Inclusivity in Higher Education (Gerontological Society of the America, 2022). In addition, the AFU initiative joins other age-friendly initiatives that share the common goal of moving toward a global age-friendly ecosystem (Fulmer et al., 2020), as described below.

The Role of AFUs in Advancing Specialized Training in Gerontology and Geriatrics

In addition to providing new educational opportunities for older, age-diverse learners, advocates of more age-inclusive higher education have called attention to the value of AFU efforts for aging services providers and age-friendly community organizers working with older adults. AFUs repre-

sent a relatively untapped resource for such professionals to consider when looking for educational, cultural, social, and recreational resources to recommend to their older clients to enable them to remain active, connected, and engaged in their communities. The continuing high demand for professionals with expertise in gerontology and geriatrics (such as Aging Life Care Managers and allied health care professionals) represents an additional point of focus to which AFUs can and should respond by offering specialized gerontological and geriatrics professional training opportunities. Moye et al. (2019) have made the case that the looming crisis in the geriatric behavioral health workforce predicted for decades (Jeste et al., 1999) is now upon us and will continue to grow if educational institutions do not intervene. According to estimates made by the American Psychological Association, the U.S. demand for psychologists who provide services to older adults was expected to increase by 5,970 full-time equivalents (FTEs) from 2015 to 2030

(American Psychological Association, 2018). Moreover, this demand will continue to increase by approximately 375 FTEs per year given shifting age demographics. Surely, mounting more age-friendly health professions and related education programs, along with career support incentives, at the undergraduate, graduate, and postgraduate levels, would help to address this demand by building stronger professional pipelines (Gugliucci & O'Neil, 2019).

Support for Advancing Age-Friendly Communities and Health Systems

AFUs are also well-positioned to support and sustain the work of Age-Friendly Communities (AFC) designated by the World Health Organization (Fitzgerald & Caro, 2014) to help shape more age-inclusive cities, states, and countries (Luz & Baldwin, 2019). The value of AFU-AFC partnerships can be seen in the case of age-friendly Portland, Oregon, where faculty and students from Portland State University played a central role in the assessment of aging-related community needs and contributed to strategic planning with community leaders (Neal, DeLaTorre, & Carder, 2014). Cannon, Kerwood, Ramon, Rowley, and Rubio (2021) further showed how AFUs can provide instructive insights about the barriers, facilitators, and opportunities for engaging with older members of AFCs. To this end, data collected from the neighboring community by an AFU research team revealed how the university could implement AFU principles and increase community age-friendliness by strengthening its senior center partnership, developing a lifelong learning center, and removing physical accessibility barriers.

AFUs may also establish valuable connections with the Age-Friendly Health System (AFHS) program (Fulmer et al., 2020) developed by The John A. Hartford Foundation, the Institute for Healthcare Improvement, the American Hospital Association, and the Catholic Health Association of the United States. The AFHS model uses four evidence-based elements, referred to as the 4Ms – What Matters, (continued on page 20)

TABLE 1
Age-Friendly University (AFU) Principles

1. To encourage the participation of older adults in all the core activities of the university, including educational and research programs.
2. To promote personal and career development in the second half of life and to support those who wish to pursue second careers.
3. To recognize the range of educational needs of older adults (from those who were early school-leavers through to those who wish to pursue Master's or PhD qualifications).
4. To promote intergenerational learning to facilitate the reciprocal sharing of expertise between learners of all ages.
5. To widen access to online educational opportunities for older adults to ensure a diversity of routes to participation.
6. To ensure that the university's research agenda is informed by the needs of an aging society and to promote public discourse on how higher education can better respond to the varied interests and needs of older adults.
7. To increase the understanding of students of the longevity dividend and the increasing complexity and richness that aging brings to our society.
8. To enhance access for older adults to the university's range of health and wellness programs and its arts and cultural activities.
9. To engage actively with the university's own retired community.
10. To ensure regular dialogue with organizations representing the interests of the aging population.

Source: Principles: Age-Friendly University

(continued from page 19)

Medication, Mentation, and Mobility – to guide the delivery of high-quality health care to older adults. If AFUs and AFHSs engaged in regular dialogue to support each other's endeavors, it would strengthen new and ongoing age-inclusive activities. For example, partnerships could develop around university research initiatives and clinical programs that encourage the participation of older adults in the development and evaluation of these ventures and that promote public dialogue on how higher education and medical systems can better address the diverse needs of older adults. In turn, these initiatives could inform the efforts of aging services providers and community organizers working to maximize the range of services and active aging resources (such as those on higher education campuses) made available to older community members and their families.

The University of Maine: An Illustrative Example

The University of Maine's (UMaine) acceptance as a member of the AFU Global Network was realized in April 2022. UMaine remains only one of two higher education institutions in the state to have attained that status (the University of New England is the other AFU) and represents the only public AFU in Maine. However, preparatory work began approximately two years earlier and included obtaining preliminary support from executive administration (the Office of the President). UMaine began by conducting a campus-wide inventory of existing age-friendly resources that exist across all campus departments and units through a survey that explored resources, benefits, and programming each unit has explicitly made available to older adults and their families, and the community organizations serving them. The survey also focused on opportunities that exist for collaboration between students and older adults and between the campus and the aging service providers and community organizations that serve older Mainers. It was ultimately discovered that older adults had a wide range of opportunities in no

fewer than 54 units and departments to be actively engaged in various facets of university life, including:

- Serving as role models, teachers, and mentors
- Participating in the UMaine research enterprise as citizen scientists, focus group members, steering and advisory committee members, clinical subjects, and in other participatory research roles
- Lending their expertise by serving on UMaine boards, advisory panels, and task forces
- Engaging in life-long learning through senior college classes and auditing courses
- Taking advantage of recreational and cultural opportunities
- Volunteering their time and expertise through civic engagement and community service offered through campus-based civic engagement placement programs
- Pursuing encore careers with the support of job preparation and career guidance programs.

The Importance of Collaborating with Gerontological Service Providers

Of particular relevance in terms of engaging Aging Life Care Managers and other health and human service professionals in the larger community is UMaine's intention to focus on expanding its community partnerships to help to connect the wider older adult community to the university. The assistance of community health and human service providers such as Aging Life Care Managers, who work on the front lines with older adults, would be especially beneficial in this regard. Aging service professionals are far more likely to know about individuals residing in small towns and rural communities who may be looking for ways to stay engaged and could benefit from the educational, social, recreational, and cultural resources offered at a higher education institution. Additionally, for UMaine to reach its full potential as an AFU, it is essential that community providers be well informed about the age-friendly opportunities and ben-

efits available on campus and to share that information with their older adult consumers. Furthermore, an additional dimension of UMaine's commitment to its standing as an AFU will be realized by engaging gerontological and geriatrics specialists in the larger community in UMaine's educational and research enterprise that focuses on advancing health promotion and quality of life for citizens of all ages in small towns and rural communities.

It will be incumbent on UMaine to develop marketing opportunities that encourage older adults' presence on the UMaine campus and expand ways in which the university engages directly with retirees that encourages their continued involvement in university life. Possible initiatives for consideration include establishing a standing retiree institute or center, an off-boarding process in which the educational, research, cultural, and recreational benefits are formally transmitted to employees at the point of retirement, as well as creating programs of older adult mentoring of younger students.

Expanding opportunities for community service professionals who work with older adults to contribute to educational programming at UMaine will also help to realize the vision of UMaine as an AFU. This includes having aging services specialists guest lecture and teach courses in the various health science professions, serve on advisory boards and committees for special aging-related research and education projects and programs, and partner with academic researchers and faculty in carrying out a wide range of health and human service translational and community-based research investigations.

For UMaine, becoming an AFU reinforces the explicit goal of the state of Maine to be age-inclusive (Maine became a designated age-friendly state in 2019) and the mission of a public university to serve the entire state and its citizenry. For Aging Life Care Managers and allied health and human service professionals, being well informed about UMaine's intentions is yet another resource in their toolkit of aging resources to be shared with their clients.

Obtaining final endorsement from UMaine's executive administration (including the President, Provost, and

other executive administrators as well as the Faculty Senate) put the on-campus “seal of approval” on its application for membership in the Age-Friendly Global Network. However, long-term success in fulfilling the principles of practice of an AFU will not be fully realized without the broad engagement of a diverse population of older adult Mainers. That is not likely to happen without genuine partnerships established with helping professionals in the larger community.

In summary, while a fully established relationship between AFUs and aging service professionals is somewhat aspirational (especially given the “newness” of the AFU approach), fully realizing the vision and mission of AFUs is, in our view, unambiguous. Ultimately, if institutions of higher education were more age-friendly, we argue that the result would be not only exciting new avenues for participation of older adults in the vibrancy of campus life, but, additionally, increased opportunities for individuals working in and aspiring to aging service careers to contribute their expertise and prepare for such specializations, respectively.

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Age-Friendly Healthcare: Opportunities for Aging Life Care Managers®

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ABSTRACT

As the number of older adults increases across the globe, innovative ways of conceptualizing and delivering healthcare and supportive services to this population are needed. Aging Life Care Managers serve a critical role in assisting older adults as they navigate the healthcare arena, one that is not often tailored to age-specific health needs and considerations and a system that is typically driven by a crisis mindset rather than prevention and health promotion. As an alternative to traditional models of healthcare, age-friendly healthcare recognizes the unique health needs of older adults and prioritizes care in the four domains of mobility, medication, what matters, and mentation. The cornerstone of becoming an age-friendly practitioner is to first examine and address ageism among clients, colleagues, and even within oneself. Additional foci of practice include placing an emphasis on screening and prevention, age-friendly care planning, and reconsidering prevailing notions about risk. The authors discuss the tenets of age-friendly healthcare, the barriers often encountered in achieving it, and provide approaches that Aging Life Care Managers can utilize including addressing one's own implicit bias, becoming familiar with and adopting the Institute for Healthcare Improvement's 4Ms of Age-Friendly Healthcare, and shifting toward a prevention mindset all while giving special attention to social determinants of health.

Vignette: Eva, a 79-year-old woman living in rural New England, recently saw her primary care provider for a blood pressure check. Not surprising to her, there was no improvement over her last visit. Eva thinks to herself why this might be the case: "if only I had the money to pay for my prescription, but Jeffery and I need to eat, keep warm, pay for gas, and there's only so much money to go around. Now I'm responsible for everything." Eva is proud, and hesitant to mention these challenges. She is preoccupied with her husband's recent dementia diagnosis; she's overwhelmed and doesn't know where to turn.

Introduction

Stories like Eva's are all too common within healthcare. Older patients and clients must navigate a maze of services and supports in the face of co-occurring conditions and difficult life circumstances within systems wedded to healthcare models that do not adequately consider aging-related changes or the specific needs of older adults. Factors like ageism, lack of training in geriatrics, and lack of experience with older patients can create negative experiences and outcomes for older adults and their families. In this article we will describe how Aging Life Care Managers (ALCMs) can provide age-friendly care and navigation to clients like Eva and her husband Jeffery.

Before disentangling the factors that impact the quality of care that

older adults receive, it is important to examine biases that we hold, both explicit and implicit, about old age. Moreover, whereas ALCMs frequently encounter conflict about care goals within and between family members who have their own biases, we also examine attitudes towards risk. Invariably, conflict arises when the goals of the older adult do not align with those of the family; typically, these conflicts center on issues of self-determination, autonomy and independence, and the relative value assigned to safety considerations. These conflicts are magnified when the older adult is experiencing, or is perceived to be experiencing, some degree of diminished capacity.

Examining Age-Related Bias

Bias is a tendency or inclination

to view, favorably or unfavorably, an individual or group based on stereotypes or pre-existing assumptions in a way that is seen as unfair toward the reference group. Implicit bias, a largely unconscious automatic reaction we have towards other people, can negatively impact our understanding, actions, and decision-making (National Institutes of Health, 2022). This tendency, when directed towards our future selves, is called ageism and was first used by Robert Butler (1969). Ageism, or negative bias and discrimination directed toward aging and older people, is an unfortunate fact of Western cultural life and its negative impact on health and well-being has been well documented (Chang et al., 2020). This impact is felt in access to resources, lack of health professionals choosing to work with older adults, and

in clinician attitudes. These attitudes are reflected in the oft-heard comment: “What do you expect? You’re fill-in-the-blank years old!”, which may lead to less inquiry or less effortful treatments. These attitudes also reflect a bias towards measuring health outcomes in terms of added years of life rather than quality of life.

Not surprisingly, older adults themselves are as likely as their younger counterparts to hold ageist views (Levy, 2001). When COVID-19 vaccines became available, some older adults themselves opined that others would be more deserving: “I’ve lived my life, let someone else have my dose.” This view was further reinforced by public stances and media messaging, during the early days of the pandemic, which suggested older adults were “expendable” (Schoenherr, 2020). Ageist attitudes and beliefs such as these have been directly linked not just to health impacts but economic impacts as well, with a recent study by Levy and colleagues (2018) putting the cost of ageism at \$63 billion dollars in annual healthcare expenditures. When older adults internalize negative beliefs about getting older such beliefs have a direct impact on the extent to which they seek help and actively self-manage their medical conditions (Levy et al., 2018).

Ageism is often deemed as one of the remaining socially appropriate forms of discrimination that needs to be addressed at its root. Examining one’s own implicit bias about what it means to grow old is a critical starting point for Aging Life Care Managers. Completing the on-line Harvard Implicit Bias Test is an activity that may prove interesting and further one’s professional development. As language is a powerful influencer, it is also incumbent on the ALCM to be mindful of the language used to describe the older people they serve. Neuroscientists since the 1990s have asserted that how we speak does not merely reflect what we think but shapes both the way we think and what we think (Boroditsky, 2012). Referring to older people as “seniors” or “the elderly” triggers strong and mostly negative images and the term “older adult” is a more favorable

and neutral term of reference (Ludenberg et. al, 2017).

Gerontologists typically use the term “older adults” to describe a population spanning chronological years from about 55+ to the oldest-old (100+). Social policies such as eligibility for Older American Act funds (60) and Social Security benefits, such as Medicare (65), required minimum distribution (RMD) of retirement funds (72), and milestones such as retirement or grandparenthood confer a status of older adult at any age. Who or what constitutes being an older adult is often context-dependent: for many healthcare professionals, including geriatrics specialists, older means frailer, despite efforts to add wellness, health promotion, and disease prevention to health system improvement efforts.

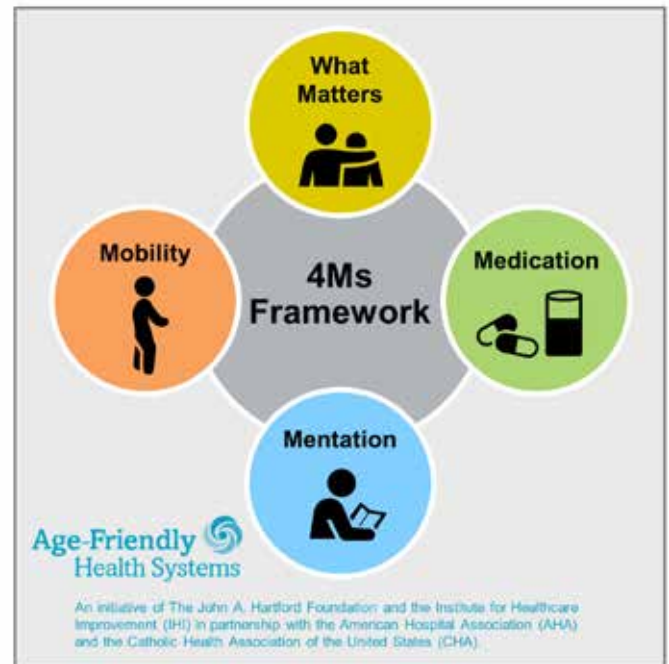
What is Age-Friendly Healthcare?

Fortunately, Eva is being seen by a health professional whose practice embraces the Institute for Healthcare Improvement (IHI) Age-Friendly 4Ms Framework of Care for Older Adults (IHI, 2020). While sitting in the waiting room, Eva noticed a bulletin board describing the 4Ms: what matters, medication, mentation, and mobility, along with a flyer describing strategies, programs, and resources to deal with the high cost of food. Eva noticed a brochure describing the Alzheimer’s Association Dementia Care Coordination Program (DCC), suggesting patients talk to their provider to find out more information.

In growing recognition of the unique healthcare needs of older adults in the U.S., the Institute for Healthcare Improvement (IHI) developed a model of age-friendly healthcare as a means of addressing the unique and often

FIGURE 2

Institute for Healthcare Improvement’s Age-Friendly Health Systems Components



complex health needs of older adults (Institute for Healthcare Improvement, 2020). As a specialized approach to care, age-friendly healthcare can be viewed as an antidote to ageism within the traditional healthcare delivery model, one that often focuses on cure rather than quality of life and a reactive rather than proactive approach to care.

The IHI model of care centers on four components, known as the 4Ms of age-friendly healthcare. These components include:

- 1) Medication: avoiding high-risk medications when possible and the use of medication in a way that does not interfere with what matters to the older patient, their brain health, and their mobility;
- 2) Mentation: supporting and managing brain health and mental health, including the 3Ds (delirium, dementia, and depression);
- 3) Mobility: supporting movement and physical function in the older patient;
- 4) What Matters: aligning care with patient goals including end-of-life care.

The 4Ms principles are designed to
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serve as a framework for care, rather than a prescriptive set of practices. Due to its flexibility, this model of care has been implemented in a variety of care settings and levels, including at the healthcare systems level, primary care, and nursing home level of care (Institute for Healthcare Improvement, 2020).

While the 4Ms provide a useful framework for the provision of care to older adults, they do not address the critical upstream factors that play a powerful role in health outcomes – social determinants of health (SDOH). As reported in the literature, as much as 80% of the variation in health outcomes experienced by patients is related to social determinants of health, such as health behaviors, socioeconomic factors, and physical environment, rather than access to healthcare services/medical intervention itself, making SDOH a key area of awareness and intervention for ALCMs (University of Wisconsin Population Health Institute, 2022).

Social Determinants of Health – The Missing Link

During Eva’s clinic visit, her provider inquired about access to food using the



TABLE 1
Strategies for engaging older adults in screening and referral

When?	Approach
Prior to Screening	<ul style="list-style-type: none"> Identify screening tools (including both health and SDOH screens) to be used and provide staff training Create an environment that is thoughtful, sincere, and cultivates a trusting relationship Assure privacy Communicate the universal nature and benefit of screening
During Screening	<ul style="list-style-type: none"> Assure privacy Check-in regularly with client about their comfort Use validated tools conveyed with plain language Provide assistance filling out forms and applications as needed
After Screening	<ul style="list-style-type: none"> Assure privacy Make referrals to other age-friendly providers Follow up to determine whether resources have been accessed

Table references: Anderman, 2016; Bloch & Rozmovits, 2021; Hsu et al., 2019; Wallace et al., 2021

Hunger Vital Sign™ screen, a validated two question tool to screen for food insecurity (Pooler et al., 2018). Eva felt the care, concern, and sincerity of her provider and knew that her privacy would be honored. That, coupled with the flyer about food insecurity resources, encouraged her to come forward with these concerns. During the conversation she also shared worry over her husband’s recent diagnosis and asked more about the Alzheimer’s Dementia Care Coordination Program (DCC). With Eva’s permission, a referral was made to the DCC, and she received local food library/food location resources and assistance in filling out applications for available federal food programs. A fol-

low-up appointment was scheduled to evaluate Eva’s ability to access resources and to determine if there were any other needs or questions.

As defined by the World Health Organization (n.d.), social determinants of health are “the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems” (para.1).

CDC Healthy People 2030 further defines these factors as “the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality of life outcomes and risks” (U.S Department of Health and Human Services, n.d., para.1). SDOH can be grouped into five domains (see Figure 2): economic stability; education access and quality; healthcare access and quality; social and community context; neighborhood and built environment

(U.S Department of Health and Human Services, n.d.).

Eva's case illustrates the importance of developing routine screening of SDOH and referral processes to meet the identified needs. A client's willingness to disclose personal issues related to SDOH is often influenced by their perception of those administering the screening to be trusting, sincere, and offering assurance of privacy. Research from Wallace et.al (2021) demonstrates that issues such as stigma and privacy concerns serve as barriers to addressing social determinants of health. Prior to screening, it is recommended that healthcare professionals discuss the importance of universal screening. Practitioner approach and rapport building have been found to be key elements in establishing a trusting relationship for screening purposes.

All too often the screening and recognition of social determinants are not routinely addressed within healthcare. Results from the Health in Community Survey (HCS) found significant levels of food insecurity among adult primary care patients with nearly one in three individuals reporting that they did not have the necessary resources to meet their food, transportation, medical, and healthcare needs. Approximately four out of every ten reported their clinicians were relatively unaware of these resource needs (Lezzoni et al., 2015). As such, ALCMs should integrate screening into their practice and encourage their clients to discuss screening with their providers.

Many older adults are hesitant to be screened and engage with prevention activities until rapport and trust are established. Aging Life Care Managers are in a unique position to create a welcoming environment for screening. Table 1 provides some examples of how ALCMs can prepare and engage older adults within the screening process.

Principles of Practice and Age-Friendly Approaches

The work of Aging Life Care Managers intersects with the provision of age-friendly healthcare as ALCMs can serve as key frontline supporters and

Many older adults are hesitant to be screened and engage with prevention activities until rapport and trust are established. Aging Life Care Managers are in a unique position to create a welcoming environment for screening.

advocates for age-friendly practices. The common services provided by the ALCM, including healthcare coordination and advocacy, managing safety concerns, and supporting independence for older clients, are vehicles for supporting age-friendly care (Horne & Ortiz, 2017).

Shifting to Prevention Mindset

All too often healthcare is provided to older adults within the context of crisis rather than prevention.

An international study by Osborn and colleagues (2017), examining health promotion and prevention among older adults, found that, in the U.S., approximately half of all older adults have not had a conversation with their doctor about healthy diet, exercise, and physical activity within the last two years. Fewer still were the number of older adults reporting conversations about mental health and stress (Osborn et al., 2017). A national study carried out by Hung et al. (2007) found that, within the primary care setting, the critical prevention methods

of screening, health risk assessment, behavioral counseling, and referral were offered infrequently. Citing lack of time, heavy patient loads, and a lack of internal resources to support prevention, healthcare practitioners often prioritize more emergent issues over disease prevention (Hung et al., 2007).

ALCMs can serve as an extension of the healthcare team by supporting client health promotion and serving as champions of a prevention mindset.

“What Matters” – Being Person-Centered in Your Approach

The 4Ms can help to begin the conversation by recognizing that “What Matters Most” may indeed be one of the social challenges causing great personal concern, requiring further exploration, and requiring critical resources. Being person-centered and age-friendly entails putting the client or patient at the center of the care provided. Care planning that is client-centered can increase patient engagement in health promotion behaviors and ultimately adherence to healthcare protocols (Naik & McCullough, 2014). However, in order to align client wishes and care approaches, ALCMs must engage in critical conversations about what matters most to the older patient. Where does healthcare intersect with their goals and desires? What future do they envision for themselves, and how does health play into that vision? ALCMs should center their work on client-driven care plans that take into account personal goals and desires as well as end-of-life wishes. Placing these discussions at the forefront of the care planning process will allow ALCMs to coordinate care in a way that meets these personal goals and will ultimately increase engagement in health promotion strategies.

Examining Risk and The Dignity of Risk

For many older adults, what matters most is remaining in their homes and integrated in their communities, often referred to as “aging-in-place” (Rogers et al., 2020). For many families caring for an older adult, parent, grand-

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parent, or spouse, managing safety concerns and access to healthcare may matter most. Older adults also want to feel safe but may assign a different relative value to its importance in their own personal hierarchy of “what matters.” Unfortunately, while many social service systems for individuals with developmental and psychiatric disabilities have *evolved*—emphasizing recovery, community integration,

empowerment, and personal choice, systems related to older adults’ care have *devolved* to one in which the risks and safety concerns are emphasized, effectively denying older adults “the dignity of risk.”

This concept of dignity of risk, first introduced by Patricia Deegan (1996) in reference to her own experience with mental illness, may finally be taking hold in older adult care (Woolford, et al., 2020). Dr. Teel (2011)

author of *Alone and Invisible No More: How Grassroots Community Action and 21st Century Technologies Can Empower Elders to Stay in Their Homes and Lead Healthier, Happier Lives*, puts it like this:

We must get away from our risk-averse stance where older individuals are segregated from the rest of the community, and severely limited in their living arrangements in order to improve compliance with medication usage, and

TABLE 2

Strategies for integrating age-friendly practices into care planning

Age-Friendly Health Domain	Care Planning Examples
Medication	<p>Medication review and medication management.</p> <p>Patient education and support for medication adherence.</p> <p>Discussion of alternatives to high-risk medications, including those found on the Beers list.</p>
Mentation	<p>Regular cognitive screening at least once per year at wellness visits. Evidence-based screens include Mini-Cog, Saint Louis University Mental Status (SLUMS), and Montreal Cognitive Assessment (MoCA).</p> <p>Participation in activities that increase brain health including socialization, physical exercise, and novel pursuits and learning.</p> <p>Consultation with a medical provider and specialized resources when brain health concerns are noted.</p>
Mobility	<p>Regular screening for falls risk using an established tool such as the Timed Up and Go (TUG) or the Tinetti.</p> <p>Identify and discuss medications that increase falls risk with a healthcare provider.</p> <p>Develop a plan for regular movement (at least three times per week).</p> <p>Refer to community-based movement programs specifically designed for older adults through local area agencies on aging, YMCAs or health clubs.</p>
What Matters	<p>Explore with clients from the outset of care planning what matters to them, including quality-of-life considerations and preferences.</p> <p>Develop an Advance Care Plan – This discussion can be enhanced by materials from established programs such as the Five Wishes® or the Conversation Project.</p>
Social Determinants of Health (SDOH)	<p>Screen for SDOH to identify common needs in areas such as: food insecurity, healthcare access/ insurance, housing, social support, trauma history, health literacy, transportation access.</p> <p>Develop relationships and familiarity with community resources that can address SDOH needs including SNAP offices, transportation providers, area agencies on aging, community action programs, and community-based resources, such as faith communities and community centers.</p>

Table references: Browne et al., 2021; Mate et al., 2021; O’Brien, 2019

Traditional approaches to healthcare create critical gaps in prevention and referral for older adults. The integration of age-friendly healthcare practices is a key approach to supporting the health and well-being of older clients.

theoretically improve their safety. ... We do not have the option of saying we will only embrace a course of action if it is guaranteed to succeed. Like many challenges we faced raising our own children, this time of life requires making the best choice with the information you have at hand, and moving forward (p.131).

Managing risk is a discipline for dealing with uncertainty and supporting individual choice. It "involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimizing the harm caused" (Department of Health, National Risk Management Programme, 2007, p 5). The ALCM is in a unique position to help older adults and their families identify and evaluate potential positive and negative consequences of decisions and to help construct, implement, and monitor the healthcare plan that is put into place.

Integrating Age-Friendly Practices into Care Planning

The IHI model provides a conceptual framework from which to develop an age-friendly care plan. At a minimum, care planning should include interventions and supports within each of the four domains of age-friendly healthcare with an overlay of SDOH considerations that may impact one's ability to access and participate in care activities. Care planning examples are provided in Table 2.

Traditional approaches to health-

care create critical gaps in prevention and referral for older adults. The integration of age-friendly healthcare practices is a key approach to supporting the health and well-being of older clients. Through a focus on addressing ageism, use of the 4Ms of age-friendly healthcare, addressing SDOH, prioritizing prevention, and focusing on "what matters" to the client, ALCMs can ensure that older adults receive appropriate and holistic healthcare and connections to community-based resources needed to support health.

Additional Resources for Exploring and Implementing Age-Friendly Practices

Age-Friendly Health Systems Guide to Using the 4Ms in the Care of Older Adults

This guide, developed by the John A. Hartford Foundation and the Institute for Healthcare Improvement, provides guidance on developing age-friendly healthcare plans for older patients/clients: http://www.ihf.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI-Age-Friendly-Health-Systems_GuidetoUsing4MsCare.pdf

Harvard University Implicit Project

The Implicit Project offers a series of online implicit bias tests that one can take to begin to identify and address any implicit bias that may impact one's professional practice with individuals. There is an age-bias test

option, among others. <https://implicit.harvard.edu/implicit/takeatest.html>

Patient Priorities Care Conversation Guide for Patients and Caregivers for Identifying Their Health Priorities

A user-friendly guide designed to help patients consider and articulate care priorities to their healthcare team: <https://patientprioritiescare.org/wp-content/uploads/2018/11/Conversation-Guide-for-Patients-and-Caregivers-for-Identifying-their-Health-Priorities.pdf>

Reframing Aging Initiative

Using evidence-based communication tools and frameworks, this initiative aims to change how one views and communicates about aging and older people. The Quick Start Guide provides some tips on how to shift use of aging language and concepts in practice: <https://www.reframingaging.org>

Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities- Managing Risk in Community Integration

This framework, for increasing client presence and community integration, was initially developed for individuals with psychiatric disabilities. However, the framework has considerable relevance to professionals working with older adults. This resource can increase awareness and understanding of dignity of risk. <http://tucollaborative.org/wp-content/uploads/2017/05/Managing-Risk-in-Community-Integration-Promoting-the-Dignity-of-Risk-and-Supporting-Personal-Choice.pdf>

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