

ISSUE BRIEF

The Massachusetts Health Policy Forum

Massachusetts Healthy Aging Collaborative

Update and Vision

By Walter Leutz and Nicole Schneider
The Heller School, Brandeis University

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Healthy Aging in Massachusetts: Where Do We Go From Here?

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Executive Summary

This Issue Brief describes the model of healthy aging for the Commonwealth that has been developed by the “Massachusetts Collaborative for Healthy Aging,” a yet-to-be formalized group of community service organizations, health and wellness providers, state agencies, advocates, researchers, funders, and others across the state. Over the last three years the many and diverse members of the collaborative have been holding healthy aging forums, meeting in committees and subcommittees, developing plans, brainstorming ideas, and seeking and providing funding - all to promote the cause of healthy aging.

The model of healthy aging that the collaborative is using was laid out in the Issue Brief that was prepared for the first Forum in December 2009. It says that healthy aging is much more than “health,” as defined by presence or absence of disease and disability. Rather, health is a multi-dimensional construct that recognizes that even people with chronic illnesses and disabilities can feel and be seen by others as “healthy” if they are able to be resilient in the face of their medical and functional issues and stay involved with friends and family and community, have a purpose and find meaning in life, feel safe and secure, eat and drink healthily, stay physically active, and be proactive about their health. This model of healthy aging also posits that communities can and should support residents to achieve this vision of healthy aging and also that older adults can be part of the effort. Another part of the model is that older adults have easy access to needed services and supports.

To develop this Issue Brief, we reviewed materials and interviewed leaders to assess what the collaborative and others working on healthy aging have accomplished. We found a two-part model of programming to support this vision of healthy aging, and we learned that important elements of it are already in place in parts of the state. One part of the model is a statewide network of evidence-based health promotion and empowerment programs, the biggest being the Stanford Chronic Disease Self-Management Program, which help older adults who have chronic illnesses to better understand their conditions and also to advocate for themselves with care providers.

The other part of the model is to create healthy communities, which have policies and programs that help older adults to participate and contribute in their communities, to keep physically active, to have access to support and medical care services, etc. This part of the model puts much of the onus for conceiving and creating healthy communities on local providers, public servants, businesses, and residents. The state can provide key pieces of supportive policy and programming, but each locality has the opportunity to use and build on the pieces consistent with its interests and energies.

There have been key actors in this effort. They include:

- The Tufts Health Plan Foundation, which in 2009 made healthy aging a priority and which has supported the three forums, regular meetings of the collaborative, and made grants to many providers of services and supports that foster healthy aging.
- The Massachusetts Executive Office of Elder Affairs and Massachusetts Department of Public Health, which have worked together to create policies and programs supporting healthy aging. Through federal funding secured by EOEA, a statewide network of evidence-based healthy aging programs is in place. Nearly 2,800 people participated in CDSMP classes in the first round of funding, and new funding promises to support thousands more by 2015. Through private and federal funding secured by DPH, the Mass in Motion program is now in 52 cities and towns, implementing a model that promotes environmental changes to make it easier for people to make healthy choices. Many other activities and policies are described in the Issue Brief.
- The Healthy Living Center of Excellence, a partnership of Hebrew Senior Life and Elder Services of Merrimack Valley, which operates the network of evidence-based programs across the state. The HLCE system includes training for group leaders, marketing to and contracting with health care providers and systems, and centralized systems for posting and enrollment into classes.
- The Massachusetts Health Policy Forum, housed at the Heller School at Brandeis University, which has helped organize the committees and subcommittees, conduct research for Issue Briefs, and develop the healthy aging conferences hosted by the Tufts Health Plan Foundation.
- The other members of the key committees and subcommittees of the collaborative, who provide services, policy support, advocacy, and more, and who have given their time and insights in numerous meetings and other committee work over the last three years. The members of the original steering committee, the subcommittees, and the current collaborative Executive Committee and membership are listed in Attachments 1-3.

The collaborative started out thinking that it would develop a statewide plan and then get it funded and implemented. That's not quite the way it has worked. Instead, members of the collaborative -- individually and working together -- have brought different pieces of the healthy aging model to the table as they have been able in the form of ideas, programming, joint work on proposals, and sharing of information. The collaborative has come to represent a commitment to work together to continue to promote healthy aging using the models, policies, energy, and resources that have evolved.

Besides the growing network of evidence-based programs and numerous healthy communities initiatives, other future directions deserve mention. Backed by Tufts Health Plan Foundation funding, there will soon be a Healthy Aging Status Report Card for tracking health status and program availability by community and region. The foundation also intends to continue to support meetings of the collaborative and the executive committee, and it is looking toward sponsoring regional meetings that will be more accessible and supportive of regional cooperation. Perhaps in the future there will be a collaborative website. And hopefully the collaborative will find ways to get a share of the new \$15 million per year for the next four years from the Commonwealth's Prevention Trust Fund. In short, the collaborative for healthy aging in Massachusetts has accomplished a great deal already, and it appears to have a promising future.

I. Background

A. Forum 1: A Vision for Healthy Aging

On December 14, 2009, the Tufts Health Plan Foundation (THPF¹) sponsored a Massachusetts Health Policy Forum on Healthy Aging in the Commonwealth. More than 300 people attended to hear up-to-date information on the meaning of healthy aging, the most promising approaches for achieving it, and the status of healthy aging programs and initiatives in Massachusetts. The material was summarized in Issue Brief 1: *Healthy Aging in the Commonwealth: Pathways to Lifelong Wellness* (Leutz 2009).

The vision of healthy aging laid out in the Issue Brief was multidimensional and dynamic. Experts and older adults agree that "health" means much more than absence of disease and disability. One study distills older adults' visions of being healthy as "going and doing," which is dependent on not only the ability to go and do things, but also having something meaningful to do. For many older adults, being healthy is also dependent on having a positive attitude, adjusting expectations with changed situations, and getting necessary support from family, friends, and the environment (Bryant, Corbett et al. 2001).

In that vein, the Brief argued for a socio-ecological view of keeping healthy,

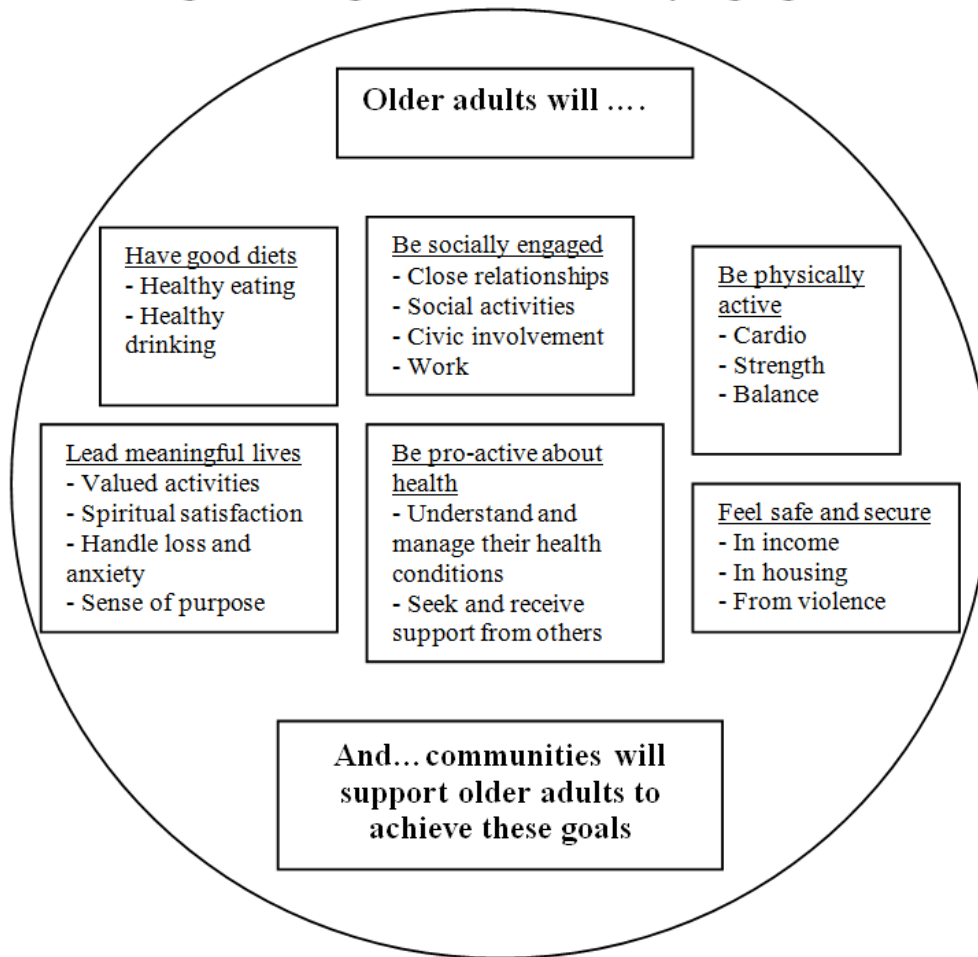
¹ See Attachment 7 for a list of acronyms.

which says that we all are shaped by our environments, while we act simultaneously to shape our environments. To promote healthy aging, at one level older adults (as well as adults of all ages) will ideally live as healthy as possible by having good diets, being physically active, being proactive about health, being socially engaged, leading meaningful and purposeful lives, and feeling safe and secure. At the same time, communities will support older adults to achieve these goals (See Figure 1). Of course individuals and communities differ widely in their capacities to achieve and promote healthy aging, e.g., by class, race, health status. Recognizing those differences and then doing what we can to move toward that broader vision of health is central to the mission.

The Massachusetts healthy aging initiative, like others nationally and internationally, therefore targets change at two levels: at older adults to encourage and help them to be healthy on these dimensions, and on community environments to provide that encouragement and help. Using interviews with state agencies, providers, advocates, academics and others related to healthy aging, the first Issue Brief assessed the status of healthy aging initiatives in the state.

We found that there was a strong network offering one or more of a family of evidence-based programs to empower people with chronic illnesses to better manage their conditions, e.g., the chronic disease self-management program (CDSMP). Many agencies deliver supportive services, e.g.,

Figure 1: Ingredients of Healthy Aging



transportation, or supporting health in other ways by providing volunteer opportunities or organizing walking clubs. Others support environmental changes such as safer crosswalks and access to healthier food.

But there were crucial weaknesses. First, most of the funds supporting programs were short-term federal or foundation grants, e.g., one-time federal stimulus funds supported the CDSMP expansion to 2,000 participants in 2010, but the funds ran out in 2012. Second, the systems that could benefit from evidence-based programs –

medical care providers and payers – have not historically paid for CDSMP classes, in part due to inconsistent research regarding whether evidence-based programs deliver on their promise to reduce net health care spending.² Third, the many initiatives that could be said to be part of healthy aging were not part of a coordinated healthy aging plan for the Commonwealth. Rather, like so much of the rest of health care and long-term supportive services in the community,

² This will be discussed further in section IIIC below.

they were planning and operating largely independently.

the benefits of active, healthy living among older adults.

B. Forum 2: Applying the Healthy Aging Vision to Massachusetts

1. Background and Organization

On September 27, 2010, there was a second forum and issue brief, which presented *A Strategy for Healthy Aging in Massachusetts* (Leutz and Driscoll 2010). The presentations synthesized the work of a steering committee that was formed after the initial forum (see Attachment 1 for members). Consistent with the multidimensional and dynamic socio-ecological framework, the committee identified three priority program elements and four crosscutting elements for the healthy aging initiative. The three priority elements and related goals were:

- **Healthy Aging Communities:** Launch model projects in select cities or towns that build healthy aging into the fabric of communities by addressing environmental factors and coordinating with government as well as other community resources and organizations.
- **Healthy Aging Programs:** Build and maintain a statewide infrastructure of evidence-based healthy aging programming for older adults.
- **Public Awareness:** Improve public images of older adults in society and raise awareness of

Four crosscutting elements were posed as essential components of each of the above:

- **Older Adult Engagement:** Engage older adults in all aspects of the healthy aging strategy.
- **Evaluation:** Build a research and evaluation infrastructure that demonstrates the value of healthy aging efforts.
- **Leadership:** Create a structure to lead a broad, ongoing movement for healthy aging.
- **Systems Linkages:** Build bridges to companion services, e.g., health care, home care, long-term care, transportation, congregate housing, social and cultural groups.

After the second forum, the steering committee formed subcommittees in each of the three priority areas: healthy aging programs, healthy communities, and public awareness (Subcommittee members are in Attachment 2). Over the next year the sub-committees met regularly to discuss and develop approaches in their areas, interspersed with steering committee meetings to share progress and coordinate.

2. Subcommittee Activities

The Healthy Aging Communities subcommittee developed a proposal for a Center for Healthy Aging Communities. No funding has been obtained to date. Key components of

the Center vision include:

- An adult learning center where elders and community members of all ages can acquire the skills, connections, and inspiration they need to transform their communities.
- Central and regional workshops on community organizing, community assessments, community-based participatory action research methods, strategic planning, fundraising, and more.
- Seed grants to help communities get started.
- A resource library with written and digital information as well as healthy aging community materials.
- Evaluation services to communities conducting healthy aging communities programs.

The Healthy Aging Programs subcommittee began by assimilating and reviewing statewide data from evidence-based programs serving older adults. The committee's focus then turned to examine the challenges and opportunities for building and sustaining the evidence-based programs statewide, including the basic needs for trainers and funding, as well as opportunities for integrating healthy aging programs into the health system. Based on these data and input from committee members, the subcommittee emphasized:

- The need for increased coordination of healthy aging programs, including leadership

at both the state and regional levels.

- The need for better linkages with health care providers and other potential referral sources.
- What to do about disparities in access to programs, e.g., urban/rural differences and weak versus strong regions.
- Alternative sources of funding for programming and infrastructure when grants from the Administration on Aging and the American Recovery and Reinvestment Act (ARRA) expired in early 2012.

The subcommittee did not issue a report or create a specific funding proposal, but planning related to these issues was continued by the work on a business plan for statewide dissemination of CDSMP led by consultants from Root Cause (see below).

The Healthy Aging Public Awareness subcommittee decided that it was premature to develop a public awareness strategy before there were clearer plans and recommendations from the other two subcommittees.

3. Goals, Status, Membership, and Process of the Collaborative for Healthy Aging

In December 2011, the steering committee decided to accept the work of the subcommittees and to continue to meet on a regular basis as the Massachusetts Healthy Aging Collaborative, led by a 12-member

Executive Committee. The executive committee met in February, June, and September of 2012, and 31 members of the entire collaborative met in April 2012. Lists of steering committee members and collaborative members attending the April meeting are in Attachment 3.

Collaborative members agreed during these meetings that the collaborative serves several important purposes to its members, including:

- Providing updates on developments in the state such as new programs.
- Providing a place where members can decide how to respond to new funding and program opportunities.
- Providing a place to identify opportunities to leverage each other's work.
- Providing a place to discuss and shape goals, strategies and messages.
- Providing a base for expanding membership.

At the same time, members pointed to ways the collaborative could be strengthened, including:

- Coordination and leadership: The collaborative needs an even stronger coordinating group that provides direction to this effort. If this is going to turn into a movement, the collaborative will need more capabilities.
- Communications: The collaborative needs a better communication strategy to

connect people beyond the meetings and to get information out to the public. Suggestions included a collaborative website where members could go to post information about their programs and to learn what others are doing. Other suggestions included organizing a poster session at the next forum and creating a column about the collaborative to go in Senior Center newsletters.

- Dual model of healthy aging: The collaborative should emphasize the dual model of healthy aging, i.e., communities that support the actions of empowered older adults and vice versa.
- Research and evaluation: The collaborative needs to document the scope of healthy aging activities, further develop evidence of their effectiveness, and use the learning collectively to further healthy aging efforts.
- Elder empowerment: The collaborative needs more paths to engage older adults in its activities. The website could provide tools for older adult activists and a place for organizations to learn about best practices.
- Momentum: The collaborative has a broad-based membership, but there are other people who could be allies, e.g., employers and health care providers. The collaborative also needs catalysts to start chain reactions to get the "movement" going.
- Collaboration: The members of the collaborative will continue to

meet and communicate to move these concepts forward.

II. Progress on Innovations in the Commonwealth

This section of the issue brief presents selected highlights of healthy aging activities in Massachusetts over the last year. It is based on a review of reports, policy literature and websites; minutes from the healthy aging collaborative meetings; and guidance from 14 interviews of key informants working on healthy aging issues in the state. The interviews took place between August 15 and October 1 of 2012 and were conducted over the telephone. The interviews followed a semi-structured interview guide, found in Attachment 4. Two interviewers recorded the content of each. Information from both interviewers was consolidated and subsequent information presented here. A list of respondents appears in Attachment 5.

Certainly, these highlights do not represent all of the important developments in healthy aging in the Commonwealth. The collaborative would welcome new members and program descriptions or accomplishments from others working on healthy aging in the state.

The section uses text boxes to highlight 10 programs, activities and developments. They are organized into four categories:

A. State Agencies

Box 1: Executive Office of Elder Affairs: Report on ARRA results

Box 2: Department of Public Health: Reorganization

B. Healthy Communities

Box 3: Brookline Community Aging Network

Box 4: Boston Moves for Health

Box 5: Mass in Motion

C. Evidence-based Programs

Box 6: Healthy Living Center of Excellence: A statewide network for CDSM Programs

Box 7: Root Cause Report: A business plan for CDSM Programs

Box 8: Medical/Evidence-Based Programs Linkages: in Senior Care Organizations, Innovations Proposal, & 3026 Grant

Box 9: National Council on Aging: The Self-Management Alliance

D. Foundation Support

Box 10: Tufts Health Plan Foundation (THPF): Supporting the infrastructure and more

A. State Agencies

The Massachusetts Executive Office of Elder Affairs (EOEA) continues to work closely with the Massachusetts Department of Public Health (DPH) as the Commonwealth's lead agencies supporting healthy aging activities in the state. The activities of these two state units are embedded within broad priorities of the Executive Office of Health and Human Services (the umbrella agency in which each is housed) that include health care access, quality and affordability, safe communities, self-sufficiency, and community first. The priorities in the 2012-2014 EOEA strategic plan include:

- Expand income & financial support opportunities for elders.
- Expand capacity & availability of & enhance the quality of community-based long-term services and supports (LTSS).
- Increase supports available to informal caregivers.
- Protect & promote the well-being & quality of life of elders.
- Strengthen housing-with-supports options.
- Attain & sustain the best possible physical, cognitive, and mental health.
- Develop operational improvements that provide better service, quality and efficiency.

Overall these plans and activities follow from the Aging Agenda Principles announced by Governor Patrick in January 2010 (Attachment 6), which - much like the ingredients of healthy aging in Figure 1 - encompass issues such as caregiver support, economic security, affordable and accessible housing, community engagement, access to services, and affordable LTSS.

Several years ago EOEA and DPH brought in the federal funds that were central to building the infrastructure for evidence-based programs in the state, including a grant for \$875,000 from the Administration on Aging (AoA) and a \$1.4 million grant from American Recovery and Reinvestment Act (ARRA). The ARRA grant was vital to building the state's network of evidence-based programs, which have allowed thousands of older adults to attend classes (See Box 1).

By early 2012 both of these grants ended, but AoA (now a sub-unit of the Administration on Community Living - ACL) showed its continued federal leadership in promoting healthy aging. First, AoA introduced new guidelines that require Area Agencies on Aging (AAAs) to spend their Title IIID health promotion and prevention funds on evidence-based programs. Second, AoA issued a request for proposals to demonstrate advanced CDSMP systems, and in September 2012 the Massachusetts

EOEA was one of 22 states selected to receive a three-year \$1,750,000 grant to maintain and strengthen the state's CDSM programming.

The Massachusetts DPH has a strong focus on healthy communities and healthy living for residents of all ages. For example, in September 2011 DPH was awarded a total of \$15 million over five years for two grants from the Centers for Disease Control (CDC) to expand the Mass in Motion campaign, which was launched in 2009 in 11 municipalities through a public/private funding partnership. The CDC grant brings Mass in Motion to a total of 52 communities (discussed further below). Also, DPH is reorganizing its chronic disease programs into a structure that is consistent with the socio-ecological model of healthy aging that the collaborative endorses (Box 2). This reorganization provides a long-term framework of public health efforts to help create communities that support residents to live healthier lives, as well as to create better linkages between community systems and health care providers. A final resource that will be available next year through DPH is the first \$15 million of the four-year \$60 million Prevention Trust Fund, which is financed in the State's health care cost control bill. The collaborative's healthy aging vision is certainly consistent with prevention, so this may prove to be a source of funding for healthy aging initiatives.

Box 1: Accomplishments from the ARRA Grant

In 2010 The Executive Office of Elder Affairs, the Department of Public Health, the Healthy Living Center of Excellence (see Box 6 below), and the University of Massachusetts Boston Donahue Institute combined to provide and evaluate an expansion of CDSM programs funded by a grant from the U.S. Administration on Aging through the American Recovery and Reinvestment Act of 2009.

The grant's aims were to expand access to CDSMP, develop a quality improvement process, and evaluate the program's efforts. During the grant period, 249 group leaders were trained and 2,784 adults participated in 258 chronic disease management workshops. The programs reported a combined completion rate (completing at least 4 of the 6 sessions) of 78%.

Offered in both English and Spanish, the program was provided in a number of settings, including residential facilities and community gathering spaces. Participation in the evaluation was optional for both participants and organizations.

Pre-workshop questionnaires were paired with six-month follow-up services. Results indicated that completers had a slight reduction in health care utilization compared to the period before taking the class, as well as improvement in self-reported health status. Because there was no comparison group, these findings need to be interpreted with caution.

Box 2: Department of Public Health: Healthy Aging in the DPH Reorganization

Capturing nationwide attention, the Massachusetts Department of Public Health recently announced an innovative organizational redesign, which reflects a move toward a population health model and away from disease-specific offices. The former Division of Health Promotion and Disease Prevention was comprised of seven categorical disease programs, whereas the reorganized Division of Prevention and Wellness will be comprised of three integrated offices:

- The Office of Community Health will address social determinants of health, develop community-level measures of health, and facilitate health promotion and wellness across the lifespan.
- The Office of Clinical Preventive Services will address health screening, disease detection, early intervention and population health management.
- The Office of Integrated Policy, Planning and Management is in the planning stage. In addition to policy and planning activities, this office will facilitate the linkages between the health care systems and community systems found in the other two offices.

In a related effort, DPH is working with the health professions licensure board to further develop the role of the community health worker as a cost-effective extension of the clinical team and as a link with community services. Community health workers can make home visits, coach individuals and families on engaging in healthy behaviors, and assess and address risks in the home. Community health workers can also provide ongoing support and care management and be the crucial link navigating between individuals and clinical health care providers.

Lastly, DPH is focused on capacity building to create information sharing systems between health care providers and community programs such as quit smoking lines and CDSM programs.

B. Healthy Communities

At the core of the socio-ecological model of healthy aging is the idea that communities can promote or inhibit the health of their residents through the social and physical environments they create. Healthy environments will support individuals to be as healthy as they can, and individuals in turn can act to change their environments. The three text boxes in this section highlight three community-based programs in this area.

One of the most important aspects of these programs is to promote what might be

called "purposeful engagement," i.e., ways for older adults as well as others to become involved and collaborate to reach individual and community goals. Continuing to be involved socially and also having a purpose in life have been associated with long life by *Blue Zones* author Dan Buettner (Buettner 2010). Brookline CAN (Box 3) embodies this kind of engagement. Boston Moves for Health and Mass in Motion (Boxes 4 and 5) are examples of mobilizing communities to become more physically active.

Box 3: Brookline Community Aging Network (BrooklineCAN)

BrooklineCAN is a member organization based somewhat on the Beacon Hill Village model. Like other Village programs, BrooklineCAN helps members arrange services and encourages participation in community activities. BrooklineCAN is distinctive in its attempt to be highly inclusive by setting annual dues at just \$25, which allows it to enroll members without regard to income or ability to pay. BrooklineCAN has succeeded in creating an affordable Village model by heavy use of volunteers as well as a close partnership with the Brookline Senior Center for a variety of care coordination and support services. In its two years of operation, BrooklineCAN has attracted 350 members and aspires to attract a majority of older residents and many other concerned residents.

BrooklineCAN emphasizes use of support services already provided by Brookline's strong Senior Center, including the H.E.L.P. program, which provides individualized assistance to older people in identifying needed service resources and then connects them to its roster of service providers to fill these needs. The homemakers, housekeepers, escorts, and chore workers available through H.E.L.P. have been screened and agree to work at rates slightly below market rates. Members contract directly with workers recommended by the program. Other member services include educational programs, discounts provided by many Brookline merchants, and referrals to vetted services such as plumbers, electricians, and computer technicians.

Another distinctive feature is BrooklineCAN's Livable Community Advocacy Committee (LCAC). Based on the national livable community movement, LCAC calls attention to Brookline's age-friendly features and advocates for improvements. LCAC's concerns include affordable housing options, pedestrian safety, parking options for seniors and caregivers, park features of interest to older adults, and property tax exemptions for low-income older residents. LCAC has developed partnership relationships with most Town departments. Among LCAC's accomplishments are a database of restrooms available to the public and an inventory of all 20+-unit local residential buildings with elevators. The residential guide includes rich information about each of the buildings and is important for those who are seeking one-floor living. Both databases are available on a map on the BrooklineCAN website.

BrooklineCAN has also established an organization of professionals who serve older residents of Brookline. The aim of this group is to improve coordination among service

providers.

In a challenging time of shrinking government dollars, BrooklineCAN is focusing on what can be done now with the programs and volunteer resources available, not what they could do with more funding.

More information can be found at the BrooklineCAN website, <http://www.brooklinecan.org/>

Box 4: Boston Moves For Health

In April 2012 Boston Mayor Thomas Menino announced an ambitious challenge for Boston residents: Lose 1 million pounds and move 10 million miles. The City launched a free web portal where Bostonians can learn about the initiative and then set and track their own fitness goals, find nutrition information, and join walking groups and running clubs. A community calendar allows residents to easily find fitness events, including yoga, zumba and a "bootcamp" held on City Hall Plaza. The website has other helpful information such as skin care, gardening tips, and locations of farmers markets. (<http://www.bphc.org/programs/cib/chronicdisease/bostonmovesforhealth/Pages/Home.aspx>)

The City has made an extensive effort to connect Boston Moves with existing Healthy Aging programs, including including the Senior Games, and Celebrate your Health Day, which corresponds with Medicare open enrollment.

Box 5: Mass in Motion Expanded through CDC Grant

In September 2011 the DPH received \$15 million, over five years, for two Community Transformation grants from the Centers for Disease Control (CDC) to expand Mass in Motion to 52 communities. Mass in Motion began in 2009 in 11 communities through funding from the state's leading health foundations and Blue Cross and Blue Shield. The model focuses on Healthy Eating and Active Living through policy, systems and environmental changes that make it easier for people to make healthy choices. For example, increasing access to fresh fruits and vegetables and creating safe and accessible places for physical activity both support this goal. The CDC grants expand the scope of the program to include reducing use of tobacco and decreasing heart attacks by promoting better management of blood pressure and cholesterol.

In addition, DPH received a coordinated chronic disease grant from CDC. Its staff are developing a chronic disease statewide partnership to work on chronic disease

prevention and control in an integrated model of care coordination that links clinical care to community services and support. This chronic disease statewide partnership has more than 100 stakeholders that represent different sectors both within state government and external partners from the private sector. They will work collaboratively to support Communities of Practice and implement evidence-based interventions to prevent and control chronic diseases while focusing on policy and system-level changes. There was a kick-off meeting in June 2012 to present plans for how to work together, discuss communities of practice, and identify areas of priority. There is a comprehensive evaluation plan that includes conducting random phone surveying about health and wellness and how much residents know about these efforts and their self-reported health status. Website: <http://www.mass.gov/eohhs/consumer/wellness/healthy-living/mass-in-motion-english>.

C. Evidence-Based Programs

Evidence-based healthy aging programs include a series of interventions that seek to change participants' health maintenance behaviors, sense of self-efficacy regarding managing their health conditions, and also to reduce health care utilization and costs. There are programs that focus on particular issues, e.g., falls and healthy diets; conditions, e.g., diabetes; as well as the CDSMP approach, which deals with chronic illnesses in general. Specifically, the family of CDSM programs includes the following:

- Chronic Disease Self-Management (English CDSM) - called "MY Life, MY Health" in Massachusetts
- Tomando Control de su Salud (Spanish CDSM)
- Diabetes Self-Management Program
- Manejo Personal de la Diabetes (Spanish Diabetes Self-Management Program)
- Arthritis Self-Management (ASM)
- Chronic Pain Self-Management
- Positive Self-Management (workshop for people with HIV)

There are also on-line versions of CDSM in English and Spanish and Diabetes Self-Management in English and Spanish.

The Commonwealth has been fortunate to have both an enthusiastic and expert network of providers and community agencies not only interested in delivering evidence-based programs but also successful in obtaining funds to support the effort (see Section 1). At the center of the delivery network is the Healthy Living Center of Excellence (Box 6), which has created and maintained a network that covers large parts of the state. Local partners in this network include Area Agencies on Aging (AAAs), Aging Services Access Points (ASAPs), Councils on Aging, and other providers and

community agencies.

Over the last year the National Council on Aging grant and the Tufts Health Plan Foundation supported a planning process led by Root Cause to develop a business plan for sustaining the CDSMP network (Box 7). Several initiatives in the state have also been trying to address the need to better tie the delivery of evidence-based programs to medical care systems in order to better coordinate care and obtain health care payment for programs and services (Box 8). Finally, the Tufts Health Plan Foundation is one of three foundations helping NCOA to develop the national Self Care Alliance, whose vision is to make self-management programs a part of the health care system by 2020 (Box 9).

An ongoing question about CDSMP and other empowerment programs is how effective they are at achieving desired participant outcomes. Programs are called evidence-based because initial clinical trials showed positive results, but consistent replication of results has been elusive. For example, a recent meta-analysis of both controlled trials and pre-post longitudinal studies of CDSMP showed that the program produces small to moderate improvement in participants' sense of self efficacy, self-reported health status (especially psychological), and health behaviors (e.g., exercising). Benefits are most often evident at 4-6 months after the program, but some also tend to continue at 12 months (Brady, Murphy et al. Forthcoming). Reductions in health care utilization have not been consistent or statistically significant, with the exception of small reductions in the number of self-reported hospital days in the short term.

More definitive assessments of the impacts of CDSMP and related programs require longitudinal studies that measure outcomes and utilization over a period greater than 18 months, something that has not been done, and qualitative research providing a greater understanding of the relationship between self-efficacy and health status. Studies should also move away from self-reported measures on both health status and utilization. A proposal for a new evaluation of CDSMP has been developed by members of the collaborative (See Box 8).

Box 6: Healthy Living Center of Excellence

Hebrew SeniorLife and Elder Services of Merrimack Valley, with help in part to support infrastructure from the recent EOEA grant from the federal Administration on Community Living, created the Healthy Living Center of Excellence (HLCE) to provide an array of programming for seniors. The mission of the HLCE is to promote the integration of evidence-based self-management programs within the health care delivery system through collaboratives which include the community-based organizations, health care providers and plans, government, foundations, and for-profit partners. In addition to functioning as a centralized, statewide body to promote and sustain programs, the HLCE and partners will operate as a "learning collaborative," offering motivation, inspiration, support, and technical assistance to organizations seeking paths to program

sustainability (e.g., accreditation to offer Diabetes Self Management for Medicare reimbursement). To perform these functions, the HLCE requires an infrastructure consisting of staffing and expertise in the arenas of capacity building, quality assurance, and business development. HLCE infrastructure also consists of six part-time “regional coordinators” to convene local collaboratives to implement, grow and sustain programs. HLCE infrastructure is further enhanced by an “Advisory Board” consisting of key stakeholders. Some of the available programs are aimed at caregivers while others, such as CDSMP, Healthy Eating and A Matter of Balance, engage seniors in living well and learning to manage their health.

Several programs offered by the HLCE are innovative, addressing issues identified in national reform efforts. One such program is Care Transitions, where medically complex patients are educated on self-management strategies and supported in their transition home by a Care Coordinator. Another program, Healthy Ideas, assists in depression screening and management. This program empowers participants to manage their condition through behavioral strategies and social connectivity.

<http://www.healthyliving4me.org/ideas.html>

Box 7: Root Cause Business Plan for CDSMP

In late 2011, the EOEA and DPH engaged consultants from Root Cause to develop a business plan for maintaining a network of CDSMP in the Commonwealth. In September 2012, a draft report was circulated to the executive committee of the collaborative. The draft plan envisions a system that is coordinated by the HLCE (see Box 6) working with regional lead agencies and affiliated local groups that offer group sessions. The plan includes goals for reaching diverse populations, addressing geographic and workforce gaps, and creating an infrastructure at HLCE for training and technical assistance, fidelity and quality assurance, marketing, referral and enrollment, and billing and payments. For long-term financial feasibility, the plan recommends moving from grant funding to making alliances with health care systems that are willing to pay for proven benefits.

Box 8: Medical Sector Linkages

There are several examples in the Commonwealth of closer linkages between evidence-based programs and medical care providers, including referrals of patients/clients to evidence-based programs, payment by medical systems for those services, and a proposal for research on cost-effectiveness.

- Elder Services of Merrimack Valley’s 3026 demonstration: In 2011 ESMV won a CMS grant under section 3026 of the Accountable Care Act which provides post-

acute patients referred by hospitals with a range of community supports and evidence-based programs, including diabetes self-management, pain management, and CDSM. The intervention extends the usual post-acute intervention from 30 days to 180 days. ESMV bills and gets paid for the evidence-based programs.

- Senior Care Options health plans and new Integrated Care Organizations: These two models pool capitated Medicare and Medicaid payments in a managed care model. These programs are able to (and in the case of SCOs have) use funds to refer members to evidence-based programs and to pay for those services.
- Innovations Grant Proposal: In January 2012 HSL, ESMV, and Brandeis University submitted a proposal to the CMS Innovations Center to test better linkages of CDSM programs. The multi-million dollar three-year proposal, which was not funded, would have created six regional coalitions and implemented two healthy aging programs: Chronic disease self-management and diabetes self-management. It included regional coordinators, a stronger workforce (cross-training CDSMP group leaders and community health workers), coordination with health care systems, and an evaluation of effectiveness. The evaluation included a randomized trial of effectiveness of offering CDSMP to Tufts Health Plan Medicare Advantage members.

Box 9: NCOA Self-Management Alliance

This is a national, tri-sector coalition that includes government, private business, universities, foundations, and non-profits. Through THPF funding, Massachusetts is one of the three original states participating. The goal of SMA is to create approaches and support to integrate self-management programs into the health system by 2020. Members of the collaborative attended meetings in January, May, and October 2012 in Washington, DC. (<http://www.ncoa.org/improve-health/center-for-healthy-aging/national-self-management.html>)

D. Foundations

The primary funding for the collaborative's meetings and communications, as well as a supporter of many of the organizations in the collaborative, is the Tufts Health Plan Foundation (Box 10), which has made healthy aging its priority. In addition, other foundations are also important to regional and local programming related to evidence-based programming and healthy communities initiatives. An important regional

supporter is the Metrowest Health Foundation, which serves 25 cities and towns in the Framingham area west of Boston. Supporting healthy aging on a local level is the Watertown Community Foundation, which is a member of the collaborative.

Box 10: Tufts Health Plan Foundation

In 2009, the Tufts Health Plan Foundation (THPF) decided to focus its grant-making on promoting healthy aging initiatives in Massachusetts and Rhode Island, and it reaffirmed the focus in 2012 into the future. The foundation has supported not only some key components of the collaborative, e.g., the Massachusetts Health Policy Forum and this issue brief, but also a report card on community health measures and perhaps in the future a collaborative website. The THPF also supports direct service providers, volunteering programs and other CDSM and evidence-based programs. The foundation hopes the collaborative will develop data supporting the positive impact these programs have on health. This type of data is crucial to secure long-term funding for these programs.

Through new efforts, the foundation will develop capacity to enhance the sustainability of organizations and the breadth and quality of healthy aging programs. Tufts Health Plan Foundation President David Abelman says, “The goal should be better health and quality services, not just more and more health care.”

The 2011 THPF Annual Report shows more than 80 grants totaling nearly \$2.8 million in four areas:

- Caregiver Support: The foundation funds skill-building and educational programs for caregivers as well as several workshops focused on coping strategies such as yoga and relaxation techniques.
- Fall Prevention: Grantees in this area provide wellness and healthy aging through fall prevention workshops, which include both exercise and awareness. The work is focused on balance and endurance.
- Intergenerational Collaboration: Intergenerational collaboration programs focus on providing meaningful ways for seniors to engage with younger generations. Examples of activities include mentoring, tutoring, fitness and interest based activities such as knitting.
- Vibrant Lifestyles: This area is by far the largest, with 40 grants totaling more than \$1.6 million. Many programs with an emphasis on providing vibrant lifestyles offer CDSMP, case management and an introduction to new or second careers as well as comprehensive exercise and wellness programs.

III. A Model to Promote Healthy Aging in Massachusetts

In this section we propose a three-part plan for promoting healthy aging in the Commonwealth that encompasses evidence-based programs, healthy communities, and public awareness. The proposal draws from the experience of the collaborative to date as well as from what we learned from our interviews with stakeholders and our review of materials. The plan is realistic, feasible and worthwhile, but this is going to be a work in progress. With hard work on the parts of many people and organizations, and with targeted and timely funding of central components, the plan for the basic model can be implemented and maintained. If future key program and funding milestones are reached, the plan can be substantially expanded and enriched.

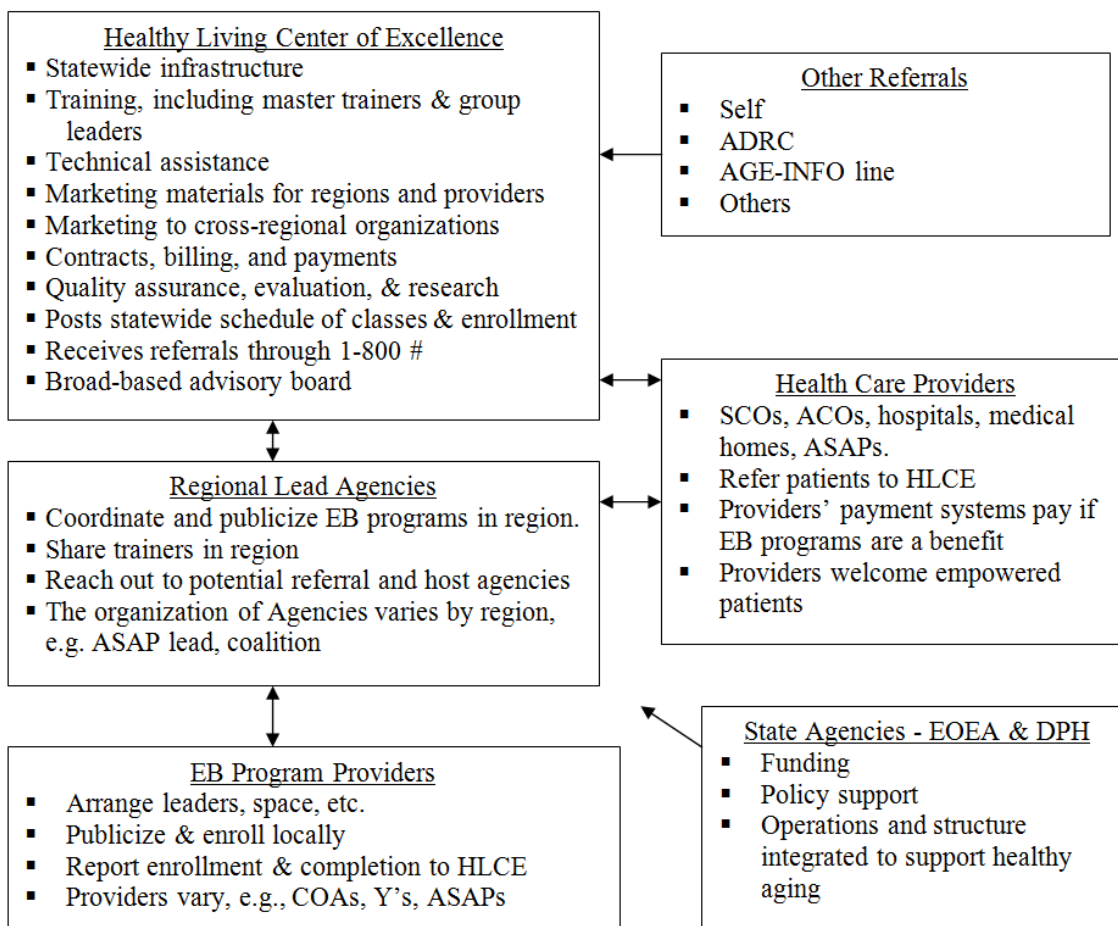
A. Evidence-Based Programs

The first part of the plan is to establish and maintain a network of evidence-based healthy aging programs across the state. Thanks to prior grants from AoA and ARRA, and to the work of the HLCE and its affiliates, this network has been established; and through new (2012) ACL/AoA funding of \$575,000 per year the core operations of the network are funded for another three years. The challenges going forward include

expanding the network to include more communities and more evidence-based programs, showing the value of the programs through evaluation, maintaining and ensuring fidelity, expanding referral relationships, and finding permanent funding. A comprehensive analysis of these challenges and description of how the network could work to deliver CDSMP is found in the Root Cause Business Plan, which will be available to the collaborative in early 2013.

The network model, which is illustrated in Figure 2, shows the lead agency for this initiative as the HLCE, which is a joint venture between the Elder Services of Merrimack Valley AAA/ASAP (ESMV) and HSL. Consistent with its recent work on becoming a place for "one-stop shopping" for a state-wide system of evidence-based programs (Box 6), the model has HLCE leading the overall effort, working with regional lead agencies and a wide array of local providers of evidence-based programs. The HLCE also leads the training of master trainers and group leaders, ensures quality of services, provides technical assistance, creates marketing materials for all to use, markets directly to large entities such as managed care organizations, and manages contracts, billing and payments. It also maintains and posts a statewide schedule of evidence-based classes, takes referrals for those classes, and manages enrollment. Finally, the HLCE takes the lead in research and evaluation on its

Figure 2: Model for a System of Evidence-Based Healthy Aging Programs



programs. The venture is overseen by a broad-based advisory board that includes representatives of state agencies and regional and local partners.

The system also includes regional lead agencies that coordinate and publicize evidence-based programs in their regions and local partners that host the delivery of the programs. Regional agencies recruit local partners, which recruit group leaders, find space, and reach out to their constituencies. The lead agencies help local partners with logistics and encourage them to share trainers. They also recruit and educate

potential referral sources in their region. This regional structure is in place in three regions of the state (Northeast, Boston and Western Mass.).

This model has the capabilities to market evidence-based programs to a wide array of possible referral sources and make it easy for individuals to enroll in classes. All referrals will be steered to the HLCE website, where schedules of classes across the state can be found; enrollment can also take place through a toll-free number. Enrollment methods will be publicized to individuals and to information and referral services such as Aging/Disability Resource Centers

(ADRCs) and the State's AGE-INFO line. Special efforts are being made to expand referrals from health care providers, including some that may pay for program completers as part of their benefit packages, e.g., SCOs and ACOs. The HLCE has the capabilities to report on enrollment and completions and to bill insurers that are willing to pay. Part of the vision is to help providers to welcome back and work with newly empowered individuals. The creation of closer ties between evidence-based programs and health care providers is also part of the DPH reorganization (Box 2).

Ultimately the vision for this network is that a full range of evidence-based healthy aging programs (e.g. CDSMP, Matter of Balance, Diabetes Self Management, Healthy Eating, Healthy Ideas) will be available statewide through active regional lead agencies and local partners. Adults of all ages who have chronic illnesses will have easy access to these programs, and government and private payers and at-risk providers will help pay the costs. Participants in the healthy aging programs may choose to participate in other programs, become ambassadors for the programs and also become more active in their communities in civic action.

B. Healthy Communities

The second part of the plan is to help Massachusetts communities to create environments that support healthy aging for their residents. The socio-ecological model of healthy aging posits that healthy environments support

residents to act in healthy ways and that residents act in ways that reinforce healthy environments, e.g., through volunteering, civic action, and support networks. Given the nature of Massachusetts local government, as well as the diversity of communities in terms of resources, histories, needs and activation of individuals and groups, it is not reasonable or possible to promote a single model or path for a healthy aging community or to set standards that decide which communities are "healthier" than others. Rather, the plan for healthy aging communities is to recognize that each community will find its own way - with different actors in the lead, with different targets and priorities, and through different methods. The responsibility of the collaborative is to encourage action, to identify and promote models, and to help marshal outside resources as possible to stimulate and support local action. This approach of providing models, encouragement, and resources for healthy communities' initiatives is also supported by the newly reorganized DPH.

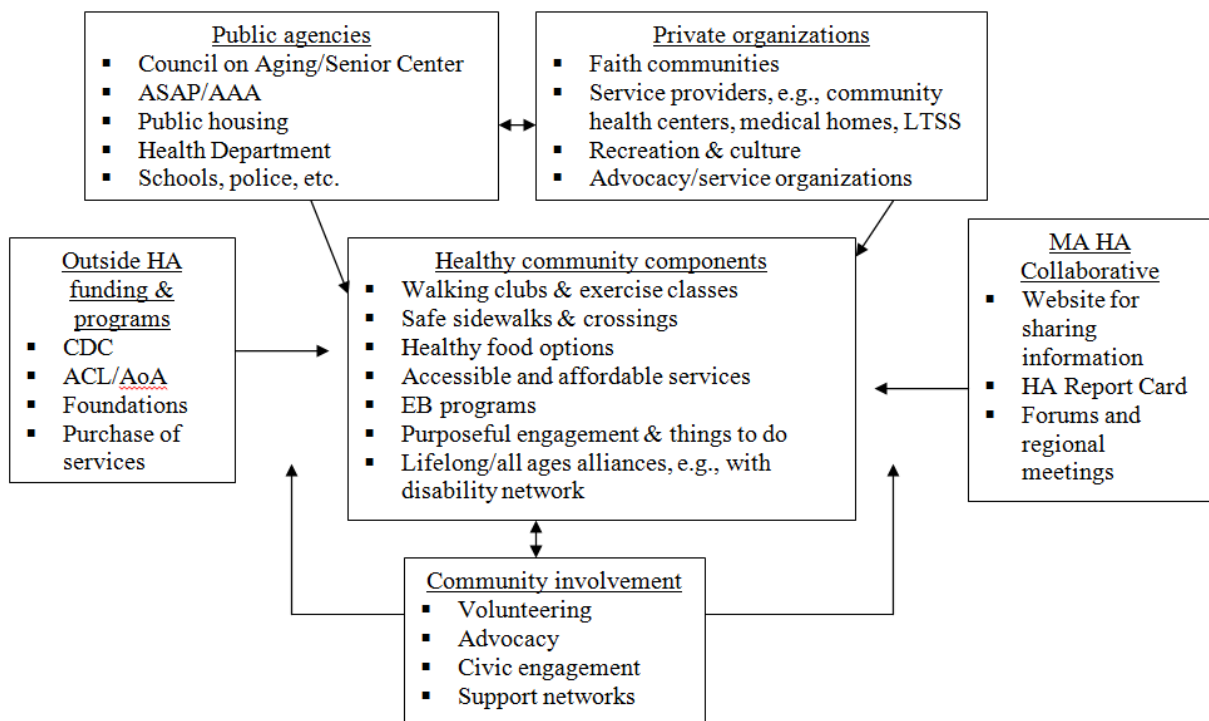
Given this, the model for creating healthy aging communities is shown in Figure 3. In the center are examples of things we find in healthy aging communities: encouragement to exercise and eat well, supportive services, evidence-based healthy aging programs, interesting things to do, opportunities for purposeful engagement, and alliances with healthy aging initiatives for residents of all ages. At the top we see that these components are supported by both public and private agencies and

community organizations. They act and collaborate in different ways in each community, but there are some common core elements that are the base from which to build: The Councils on Aging and its companion meals, transportation, and socialization programs; the ASAP/AAA and core home care and information and referral programs; faith-based organizations; and elder-focused service providers. At the bottom is the ingredient of actions from involved volunteers – both elders and others who find fulfillment and purpose in being a part of making their communities a better place to live. This can be in informal ways such as being part of support networks, as well as in more organized advocacy groups and in larger volunteer organizations like BrooklineCAN, where a volunteer-based village program is partnering with a senior center to be the engines for

change.

While the energy and direction for a healthy aging community is local, the figure shows two avenues for outside assistance. On the left we see funding from public and private sources such as the CDC (support for Mass in Motion), AoA/ACL (support for evidence-based programs), and foundations (e.g., THPF’s support for both service providers and capacity). Outside funding also comes into communities in the form of purchase of services. When aging network providers have reliable and adequate service funding, services are more available and agencies are stronger. Payment for evidence-based programs from government and private insurers and risk-based providers could strengthen the public and private organizations that currently offer the programs.

Figure 3:
A Model for Healthy Aging Communities



The other source of outside help is shown on the right side of Figure 3: the collaborative itself. With THPF support the collaborative will soon have a Healthy Aging Status Report Card for tracking health status and program availability by community and region. The foundation also intends to continue to support meetings of the collaborative and the steering committee, and is looking toward sponsoring regional meetings that will be more accessible and supportive of regional cooperation.

Overall, the collaborative provides a link between the evidence-based programs and healthy aging community activities – through the websites of the collaborative and the HLCE, which will have links to each other; collaborative meetings, which will have participants from both sectors; and the agencies and older adults that participate in both sectors – by referring and being referred, by being empowered and then being an empowered actor through purposeful engagement in their communities.

C. Public Awareness

Both the evidence-based programs and communities efforts are affecting public awareness, but they lack a larger framework and strategy for informing the public, policy makers, and other key audiences about healthy aging and the collaborative's work. The second issue brief charged the Public Awareness subcommittee with "developing a plan for improving public images of older adults in society and raising awareness of the benefits of active, healthy living

among older adults, thereby leading to (1) older adults being more physically, socially and civically active and (2) greater societal support for healthy aging programs and a more positive perception of older adults in general." The Brief asked for "a social marketing plan...to coordinate closely with state and local government, private and non-profit sector organizations to combine any public awareness campaign with programs, services and activities being offered."

In his presentation at the September 2010 forum, John Beilenson, president of Strategic Communications and Planning, advised that the healthy aging movement create the right frame, find the right messengers, provide concrete solutions, and have a "single brand" with "multiple platforms." Drawing on that presentation, and on the minutes of the one meeting of the subcommittee, these points can be elaborated and expanded.

- **Frame:** Beilenson suggested that healthy aging should be "about life not health." Public awareness efforts should have images of what older adults really do in their families and homes and communities. The model should avoid the extremes of the heroic elder athlete and the sad and frail elder isolate.
- **Messages:** There are two primary messages to address: (1) examples of how healthy older persons are living well and engaging in their communities,

- and (2) suggestions for what communities can do to influence health. Messages should provide concrete solutions with simple and doable actions, paths to access, and reasons why to act. Finally, messages should find ways to combat ageism.
- **Audiences:** There is not just one audience for messages about healthy aging; there are a number of audiences, each of which is also segmented. Audiences include older adults, family members, the general public, policy makers, professionals, and businesses. The collaborative has some ready-made audiences in the members of the collaborative and in the larger worlds of those who have attended the Massachusetts Healthy Policy Forum programs on healthy aging.
 - **Messengers:** Beilenson suggested using a range of messengers, including professionals, program alumni, families, and "boundary spanners," such as discharge planners and medical home coordinators. These and others are represented in the collaborative and forum participants. The challenge is how to take this diverse and comprehensive group of organizations and people and inspire and equip them with clear and unified messages to project.
 - **Strategy:** The prospect of finding the resources to organize and finance a statewide public awareness campaign is daunting. Another strategy is to focus on one or two communities and highlight the work they have done on healthy aging. This approach would focus on promoting model programs and testing these marketing strategies before trying broader initiatives.
 - **Marketing resources:** There is much information available on building public awareness, including campaigns about healthy aging and healthy communities. Resources include <http://www.healthypeople.gov>, the CDC's healthy aging site <http://www.cdc.gov/aging/>, and the AARP program to promote volunteering by older adults <http://createthegood.org>.

D. The Future of the Massachusetts Healthy Aging Collaborative

In the last three years the movement to promote healthy aging in Massachusetts has found a formula to create and maintain progress. The ingredients to the formula include the energy, commitment and expertise of many agencies and individuals across the state; leadership and collaboration by DPH and EOEA; success in obtaining federal funds for evidence-based programs and community initiatives; convening interested parties by the Massachusetts Health Policy Forum; and

funding for communications, meetings, and healthy aging programs from the Tufts Health Plan Foundation. The initial vision of the many who have worked on the healthy aging initiative was to come up with "the plan" and then to get funding for it, but this model has proven to be elusive. The collaborative has landed instead on a joint vision of healthy aging programs, healthy communities and public awareness, plus a joint commitment to keep working together and collaboratively with an informal but real infrastructure toward that vision. The members of the collaborative are excited about being part of a movement and its members welcome others to join in.

Attachment 1: Members of the Original Healthy Aging Steering Committee

David Abelman, Tufts Health Plan Foundation
Anita Albright, Massachusetts Department of Public Health
Deborah Banda, AARP Massachusetts
Valerie Bassett, MA Public Health Association
Ann Bookman, Brandeis University
Anne Marie Boursiquot King, Tufts Health Plan Foundation
Jessica Costantino, AARP Massachusetts
Mireille Coyle, Office of Representative Alice Wolf
Michael Doonan, Massachusetts Health Policy Forum
Abby Driscoll, Tufts Health Plan Foundation
Robert Dwyer, Central Massachusetts Agency on Aging
Sarah Ferguson, Massachusetts Health Policy Forum
Larry Gordon, Greater Boston Interfaith Organization
Vicki Halal, Office of Senator Patricia Jehlen
Chet Jakubiak, Massachusetts Association of Older Americans
Chuck Koplik, Greater Boston Interfaith Organization
Walter Leutz, Heller School, Brandeis University
Ruth Palombo, Massachusetts Executive Office of Elder Affairs
Rob Schreiber, Hebrew SeniorLife
Emily Shea, City of Boston Elderly Commission
David Stevens, Massachusetts Association of Councils on Aging
Carolyn Villers, Massachusetts Senior Action Council
Amy Whitcomb Slemmer, Health Care For All
Jan Yost, Health Care Foundation of Central Massachusetts

Attachment 2: Subcommittees and Members

Healthy Aging Communities Subcommittee

Co-Chairs

Ann Bookman, Brandeis University
Emily Shea, Commission on Affairs of the Elderly, City of Boston

Members

Kathleen Bitetti, Healthcare for Artists & Massachusetts Action Leaders Coalition
Kathy Burnes, Jewish Family & Children Services, Geriatric Institute
Molly Butler, State Office of Rural Health
Joanne Calista, UMASS Worcester, Central MA Area Health Education Center

Melissa Carlson, Boston Elderly Commission
Elaine Cawley Hill, MetroWest Community Healthcare Foundation
Megan Cheung, Greater Boston Chinese Golden Age Center
Reed Cochran, SCM Community Transportation
Linda Cragin, UMASS Worcester, Central MA Area Health Education Center
Michael Doonan, Massachusetts Health Policy Forum
Patricia Forts, Fallon Community Health Plan, Worcester
Carol Greenfield, Discovering What's Next
Vicki Halal, Office of Senator Pat Jehlen
Polly Hoppin, UMASS Lowell, Environmental Health Program
Pam Jones, Boston Public Health Commission
Dana Kern, Hebrew SeniorLife
Bridget Landers, MA Department of Public Health
Brenda Limone, My Way Village - Connected Living
Lisa McNeill, Cape Cod Volunteers
Dale Mitchell, Ethos
Maura Moxley, Baypath Elder Services
Lea Susan Ojamaa, Healthy Communities, Massachusetts Department of Public Health
Ned Rimer, Education Development Center
Sarah Ferguson Rudy, Massachusetts Health Policy Forum
Michael Schade, Watertown Community Foundation
Janet Seckel-Cerrotti, Friendship Works
Barbara Wales, Bristol Elder Services
Susann Wilkinson, Staying Put

Policy Lead

Walter Leutz, Brandeis University

Healthy Aging Programs Subcommittee

Co-Chairs

David P. Stevens, Executive Director, Massachusetts Association of Councils on Aging
Rosanne DiStefano, Executive Director, Elder Services of the Merrimack Valley
Joan Hatem-Roy, Assistant Executive Director, Elder Services of the Merrimack Valley, Inc.

Members

Anita Albright, Director, Director, Office of Healthy Aging and Disability, Massachusetts Department of Public Health
Mireille Coyle, Office of Representative Alice Wolf
Lauren Gray, Healthy Aging Program Coordinator, Elder Services of Merrimack Valley, Inc.
Ana Karchmer, MA Executive Office of Elder Affairs, Office of Program Planning and Management, Chronic Disease Self-Management Program
Lisa Krinsky, Executive Director, LGBT Aging Project

Jean Lussier, Self Management Education-Nutrition Education Director, Latino CEED:REACH
New England, Greater Lawrence Family Health Center
Roseann Martoccia, Executive Director, Franklin County Home Care Corporation
Linda Monteiro, Community Relations Director, Ethos
Jennifer Raymond, Director of Evidence-Based Programs, Hebrew SeniorLife
Robert Schreiber, Physician-in-Chief, Hebrew SeniorLife
Emily Stone, ABCD Elder Services Violet Suska, Health and Fitness Coordinator, Chicopee
Council on Aging
Amy Waters, Executive Director, Worcester Elder Affairs

Tufts Health Plan Foundation/Mass Health Policy Forum Liaison

Abby Driscoll, Tufts Health Plan Foundation

Healthy Aging Public Awareness Subcommittee

Co-Chairs

Deborah Banda, AARP
Chet Jakubiak, MA Association of Older Americans

Members

Diane Barry, Education Development Center
John Beilenson, Strategic Communications & Planning
Anne Marie Boursiquot King, Tufts Health Plan Foundation (Policy Lead)
Abby Driscoll, Tufts Health Plan Foundation (Policy Lead)
Carol Greenfield, Discovering What's Next
Joan Hatem-Roy, Elder Services of Merrimack Valley
Ana Karchmer, MA Executive Office of Elder Affairs, Office of Program Planning and
Management, Chronic Disease Self-Management Program
Jane Lane, Phillip Johnston Associates
Jan Latome-Stiller, SOAR 55 (RSVP Program)
Becky Lovendovski, Tufts Health Plan
Jennifer Raymond, Hebrew Senior Life
Maria Valenti, Greater Boston Physicians for Social Responsibility

Attachment 3: Current Membership in the Collaborative

Healthy Aging Collaborative Executive Committee

Cheryl Bartlett, Massachusetts Department of Public Health
David Abelman, Tufts Health Plan Foundation
Michael Doonan, Massachusetts Health Policy Forum
Vicki Halal, Office of Senator Pat Jehlen

Joan Hatem-Roy, Elder Services of the Merrimack Valley
Linda Fitzgerald, AARP MA State President
Walter Leutz, Brandeis University
Ruth Palombo, Mass. Executive Office of Elder Affairs
Jennifer Raymond, Hebrew SeniorLife
Rob Schreiber, Hebrew SeniorLife
Emily Shea, City of Boston Elderly Commission
David Stevens, Mass. Association of Councils on Aging

Healthy Aging Collaborative Members

David Abelman, Tufts Health Plan Foundation
Diane Barry, Education Development Center (Health Division)
Cheryl Bartlett, MA Department of Public Health
John Beilenson, Strategic Communication & Planning
Kathleen Bitetti, Healthcare for Artists & Massachusetts Action Leaders Coalition
Ann Bookman, Healthy Aging Communities Subcommittee, Chair; Brandeis University
Anne Marie Boursiquot King, Tufts Health Plan Foundation
Kathy Burnes, Jewish Family & Children Services - Geriatric Institute
Molly Butler, State Office of Rural Health
Joanne Calista, Central MA Area Health Education Center, Inc.
Melissa Carlson, City of Boston Elderly Commission
Elaine Cawley Hill, MetroWest Community Healthcare Foundation
Megan Cheung, Greater Boston Chinese Golden Age Center
Reed Cochran, SCM Community Transportation
Marty Cohen, Metrowest Health Foundation
Linda Cragin, UMASS Worcester, Central MA Area Health Educ Center
Rosanne DiStefano, Elder Services of Merrimack Valley
Michael Doonan, MA Health Policy Forum
Abby Driscoll, Tufts Health Plan Foundation
Beth Dugan, UMass Boston Gerontology Institute
Bob Dwyer, Elder Services of Merrimack Valley
Ari Fertig, Health Care For All
Linda Fitzgerald, AARP MA State President
Patricia Forts, FCHP Worcester
Larry Gordon, Greater Boston Interfaith Organization
Carol Greenfield, ReServe Greater Boston/Discovering What's Next
Vicki Halal, Office of Senator Pat Jehlen
Joan Hatem-Roy, Elder Services of Merrimack Valley
Polly Hoppin, UMASS Lowell, Environmental Health Program
Chet Jakubiak, MA Association of Older Americans
Pam Jones, Boston Public Health Commission
Sara Kanevsky Khan, Massachusetts Public Health Association
Ana Karchmer, MA Executive Office of Elder Affairs
Dana Kern, Hebrew Senior Life

Chuck Koplik, Greater Boston Interfaith Organization
Lisa Krinsky, LGBT Aging Project
Bridget Landers, Massachusetts Department of Public Health
Jane Lane, Philip Johnston Associates
Jan Latome-Stiller, SOAR 55 (RSVP Program)
Walter Leutz, Healthy Aging Communities Subcommittee, Policy Lead; Brandeis University
Brenda Limone, Connected Living, Inc.
Kelly Love, Office of Rep Alice Wolf
Jean Lussier, Greater Lawrence Family Health Center
Roseann Martoccia, Franklin County Home Care Corporation
Kristyn McCandless, Tufts Health Plan Foundation
Lisa McNeill, Cape Cod Volunteers
Dale Mitchell, Ethos
Linda Monteiro, Ethos
Lea Susan Ojamaa, Department of Public Health
Ruth Palombo, Executive Office of Elder Affairs
Frank Porell, UMass Boston Gerontology Institute
Jennifer Raymond, Hebrew SeniorLife
Ned Rimer, Education Development Center
Kayla Romanelli, Tufts Health Plan Foundation
Ray Santos, Ethos
Michael Schade, Watertown Community Foundation
Rob Schreiber, Hebrew SeniorLife
Janet Seckel-Cerrotti, Friendship Works
Emily Shea, City of Boston Elderly Commission
Nina Silverstein, UMass Boston Gerontology Institute
David Stevens, Healthy Aging Programs Subcommittee, Chair; Massachusetts Association of Councils on Aging
Emily Stone, ABCD Elder Services
Violet Suska, Chicopee Council on Aging
Kristina Turk, UMass Boston Gerontology Institute
Maria Valenti, Collaborative on Health and the Environment
Carolyn Villers, Massachusetts Senior Action Council
Barbara Wales, Bristol Elder Services
Jamie Walzer, Massachusetts Health Policy Forum
Amy Waters, Worcester Elder Affairs
Amy Whitcomb Slemmer, Health Care For All

Attachment 4: Interview Guide

Interview guide for Healthy Aging Issue Brief 3

1. What is the most important or promising thing you and your organization are doing now in healthy aging?
 - a. What programs or services are you most proud of?
 - b. Do you see gaps in services for the aging population in your area?
2. What has changed in your HA programs or initiatives in the last two years?
 - a. Additions? Losses? Changes?
(If there were changes: Why were the changes made? How did they impact your work? What types of challenges, if any, did the changes create?)
 - b. Can you send us any specifics, e.g., data, program descriptions; participation/completion rates?
 - c. Are there people in your sphere we should be talking to?
3. How do you see the MA HA Collaborative working? Helping? Hindering?
 - a. What does your organization (or what do you as an administrator) want from the MA HA Collaborative?
 - b. How can they help you?
 - c. What agencies or partnerships do you value the most?
 - d. Do you have any concerns about the collaborative?
4. Where should the State and the Collaborative be going?
5. Anything else to add?

Attachment 5: Interview Respondents

Vicki Halal, Committee Director, Office of Massachusetts Senator Patricia Jehlen
Deborah Banda, Massachusetts State Director, AARP
Dave Abelman, President, Tufts Health Plan Foundation
Cheryl Bartlett, RN, Director, Massachusetts Department of Public Health
Emily Shea, Director of Elder Services, City of Boston Elderly Commission
Rob Schreiber, MD, Physician in Chief, Hebrew Senior Life
Charlotte Yeh, MD, Chief Medical Officer, AARP Services Incorporated
Ruth Grabel, Program Specialist, Massachusetts Department of Public Health
Frank Caro, Brookline Community Aging Network, Journal of Aging and Social Policy
Jennifer Raymond, Director of Evidence Based Programs, Hebrew SeniorLife
Ruth Palombo, Assistant Secretary, EOE
Al Norman, Area Agencies on Aging
Joan Hatem-Roy, Associate Executive Director, Elder Services of Merrimack Valley
David Stevens, Executive Director, Massachusetts Councils on Aging and Senior Centers

Attachment 6: Aging Agenda Principles

Aging Agenda Principles Commonwealth of Massachusetts January 2010

Society cannot thrive or even survive without the continuous active participation of all people as they age. Each of us, both individually and collectively, has a stake in building an environment in which every person has an equal opportunity to participate in all aspects of civic life. We believe all adults, during each stage of the lifespan, should have the full and free enjoyment of these fundamental principles for aging well.

- To live in a society that understands the positive aspects of aging, recognizes the interdependence we rely upon to meet life's challenges, and values the intergenerational sharing of life, wealth, wisdom, caring and caregiving.
- To attain economic security through a combination of earning an adequate income, saving money over one's lifetime, and learning basic financial skills to avoid financial hazards and financial exploitation.
- To attain and sustain the best possible physical, cognitive, and mental health and have the opportunity to benefit from proven methods for maximizing and improving one's abilities, health and happiness.
- To reside in affordable housing suitably designed to accommodate the predictable changes in functional abilities we'll likely experience as we age.
- To exercise control over managing one's own life and participate in a wide range of civic, cultural, learning, spiritual and recreational opportunities for as long as possible.
- To have access to social assistance services, including protection against abuse and neglect, that can be readily provided in an efficient and appropriate manner for diverse populations.
- To have an adequate array of flexible, reliable transportation options.

- To have access to affordable long-term services and supports that can sustain individuals in the setting of their choice, including a consumer's full participation in managing services.
- To lend meaningful support to caregivers to preserve the beneficial impact caregiving has upon the caregiver, the person depending upon them and society at large.

Attachment 7: List of Acronyms

AAA - Area Agency on Aging
 ACL - Agency for Community Living
 ADRC - Aging and Disability Resource Center
 ARRA - American Recovery and Reinvestment Act
 ASAP - Aging Services Access Point
 ACO - Accountable Care Organization
 CDC - Centers for Disease Control
 CDSMP - Chronic Disease Self Management Program
 DPH - Department of Public Health
 EOEA - Executive Office of Elder Affairs
 ESMV - Elder Services of Merrimack Valley
 HLCE - Healthy Living Center of Excellence
 HSL - Hebrew Senior Life
 LTSS - long-term services and supports
 NCOA - National Council on Aging
 THPF - Tufts Health Plan Foundation

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