

GOVERNOR'S COMMISSION ON SUCCESSFUL AGING

Health Reform Subcommittee Interim Report

Adopted by the Governor's Commission on Successful Aging December 2, 2014

Executive Summary

The Health Reform Subcommittee of the Governor's Commission on Successful Aging was charged with studying issues of health access and unmet need among older Vermonters. The vast majority of people over age 65 have Medicare, so they are insured for most costs related to acute and ambulatory care. Because of this, the committee focused its work on understanding health care services that are not covered adequately or at all by Medicare, Medicaid or supplemental insurances, and that older adults are more likely to need than younger adults. This report focuses on three specific areas of health needs: oral health, falls prevention and mental health. The goals of each are:

- ❖ **Improve the oral health of older Vermonters by improving access to dental care.**
- ❖ **Improve the safety, quality of life and independence of older Vermonters.**
- ❖ **Improve the mental health status of older adults.**

In many cases, the Subcommittee's work builds on previous research and studies by other experts on health reform. The report presents a brief overview of each of these issues followed by findings and recommendations for presentation to Governor Peter Shumlin in late 2014. The Subcommittee's work will continue for two years and will culminate in a final report in late 2016.

Introduction

Through its Triple Aim¹ of improving health and the experience, quality and affordability of care, health reform has made unprecedented strides both nationally and in Vermont. Because the initial emphasis of health reform has been enrolling people in health insurance via health care exchanges, the population of concern has been those individuals and families who were uninsured or significantly underinsured. Most efforts have addressed the daunting task of enrolling people in insurance and developing financing schemes to subsidize insurance for low-income people. People over the age of 65, and many people with permanent disabilities and end-stage renal disease, are insured through Medicare. Considered to be insured, this population was not the target beneficiary of most reform initiatives. The 2010 Affordable Care Act did make some improvements in Medicare by adding preventive health as a covered service and closing the prescription drug coverage gap known as the donut hole. Nevertheless, Medicare, created in 1965 primarily as insurance for acute care illnesses, has many service and coverage shortcomings. People who can afford supplemental Medicare insurance are relieved of co-payments and deductibles, but supplemental policies rarely pay for anything not covered by Medicare. This has resulted in a population of Medicare-recipients who are underinsured for many services and products necessary for health, independence, community engagement and dignity.

¹ <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx> The Triple Aim, is a framework for understanding the goals of health care reform. It was first posited by the Institute for Healthcare Improvement.

The Commission's Health Reform Subcommittee (SC) began meeting in 2013 to study health needs of older Vermonters. Because there were 117,393 Vermonters enrolled in Medicare in 2012,² the SC chose to focus its work on health service needs and gaps for this population. The SC selected several key areas of focus, invited presentations by key experts and informants and identified and studied unmet health needs. The following presents a summary of the group's findings and recommendations for the three of content areas studied: Oral Health, Falls Prevention and Mental Health. These will be presented to Governor Shumlin during early 2015. The committee will continue its work of exploring areas of unmet health needs and write a final report in 2016.

Oral Health

Meeting the oral health needs of older Vermonters is a priority for the SC. The Vermont Department of Health's recently published 2014 *Vermont Oral Health Plan* discusses the importance of oral health for Vermonters of all ages. The Plan presents data about the oral health status of the population, and identifies goals and objectives for the state to improve this essential area of health. The report's section on *The Burden of Oral Disease in Vermont* begins with:

Oral health is an essential and integral component of overall health. Good oral health reflects freedom from tooth decay and gum disease, conditions associated with chronic oral pain, oral cancer and other conditions that affect the mouth and throat. Good oral health also includes the ability to carry on basic human functions such as chewing, swallowing and speaking. Oral health is related to the health of the rest of the body, and poor oral health can significantly diminish quality of life and overall health status.³

Older adults have some unique dental health needs. The dental health status of this population has improved, with a decline in the percentage of Vermonters ages 65-74 who have lost all of their natural teeth from 22% in 1999 to 15% in 2010. This is better than the national average, but implies that a larger percentage of older adults have natural teeth that need care and attention. For this report, the SC identified the oral health of older adults as a key area for its focus. It met several times with the former State Dental Director Dr. J. Steve Arthur to understand the oral health issues of older people. Dr. Arthur emphasized the interconnected nature of geriatric oral and systemic health and summarized the health risks as follows:

- Poor oral hygiene is associated with increased incidence of pneumonias.
- Many medications cause dry mouth, reducing the protective factor of saliva and increasing the risk of dental disease.
- Diabetic glucose control is worse in the presence of periodontal disease and periodontal disease is worse in diabetic patients, especially those with poor glycemic control.
- Poor oral health is a common cause of poor nutrition, weight loss and failure to thrive.
- Untreated dental decay can lead to painful dental emergencies requiring costly emergency room visits and interventions.

² The Kaiser Family Foundation <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/>

³ Vermont Oral Health Plan 2014, Vermont Department of Health, http://www.healthvermont.gov/family/dental/documents/oral_health_plan.pdf

In addition, many of the risk factors for poor oral health for any population, such as low socioeconomic status, are common among older adults. And, people who reside in residential settings such as nursing homes face greater challenges due to their lack of access to either preventive or restorative care.

Concerns about the oral health of Vermonters and access to care have emerged on many fronts in Vermont. In addition to the research and reports produced by the Department of Health's Office of Oral Health, a broad stakeholder group, the Oral Health Coalition, was formed in 2011 to raise concerns about oral health issues and to work on strategies for improving access to care. In addition, Vermont's Green Mountain Care Board, the state's planning and regulatory body charged with implementing health reform in Vermont, commissioned a report in 2014 intended to "report on policy considerations to improve access, quality and cost of oral health services through payment reform". The report, *Vermont Dental Landscape Study*, identified all the factors that contribute to access challenges for dental care. These include economic, workforce and system infrastructure factors.⁴

Given the sound research, data and reports that have been recently published in Vermont, the Subcommittee does not intend to recreate an analysis of barriers to dental care in the state. Rather, these official documents will be cited and the SC's findings and recommendations will be based on those findings and recommendations that address dental care needs and access to care for older Vermonters. The intent is to call attention to the factors that most affect the oral health of older people in an attempt to advance efforts to address them.

Goal: Improve the oral health of older Vermonters by improving access to preventive and restorative dental care

1. Key findings related to oral health status:

- 1.1 Sound oral health for older Vermonters is important for general health and because of the vulnerabilities that older age can bring.
- 1.2 Older individuals in assisted living and nursing homes are at risk for dental disease because of their lack of access to preventive and restorative dental care.

Recommendations:

- Include older Vermonters in any state efforts to create affordable dental insurance as part of health reform.
- Dental hygienists should be eligible to bill Medicaid and dental insurance independent of dentists to encourage them to provide preventive care in nursing homes and assisted living facilities.

⁴ http://gmcboard.vermont.gov/sites/gmcboard/files/Dental_Landscape_Report.pdf

2. Key findings related to financial barriers to dental care:

- 2.1 Older adults who do not have either Medicaid or dental insurance must pay for dental care out-of-pocket. Although this is true for Vermont's entire population, older people are more likely to have fixed incomes.
- 2.2 The reimbursement differential between private insurance, private pay and Medicaid is thought to create access barriers for Medicaid recipients. This is particularly true in geographic areas with a tight supply of dental providers.
- 2.3 The annual fixed-benefit cap of \$510. for Medicaid beneficiaries is inadequate to meet the needs of many low-income older Vermonters.

Recommendations:

- The State should increase the annual dental benefit for Medicaid recipients.
- The state should increase its Medicaid reimbursement rate for dentists to 75% of commercial rates to improve access to dental care. This was suggested in the JSI Vermont Dental Landscape Study to the Green Mountain Care Board.

3. Key findings related to dental care workforce:

- 3.1 Well documented concerns about the dental health workforce supply and distribution are valid and need to be addressed to ensure access to preventive and restorative dental care.
- 3.2 All data indicate a looming exacerbation of dental access issues caused by an aging supply and distribution of dentists in Vermont, competition for dentists by other states and a decline in dental schools nationally.

Recommendations:

- Increase state strategies such as loan repayment and scholarships in return for service commitments to recruit and retain dental providers.
- Vermont should implement an alternative dental provider model to expand the dental provider workforce. Models such as the Advanced Practice Dental Providers, Expanded Function Dental Assistants and Public Health Dental Hygienists are options for consideration and have been employed successfully in other states. These models are discussed at length in the GMCB *Vermont Dental Landscape Study*.⁵

⁵ Op. cit.

Falls Prevention and Awareness

More people 65 or older in Vermont are hospitalized or die from falls than from motor vehicle accidents⁶. Falls are the most common cause of traumatic brain injuries, which account for 50% of fatal falls. In 2012, a third of Vermont adults 65 and older said they had fallen at least once⁷. More recently, the 2014 Senior Report ranked Vermont 43rd out of 50 states for prevalence of falls⁸.

While the greatest numbers of fall-related hospitalizations occurred among Vermont residents between the ages of 66-84 years, those ages 85 years and older had the highest rate of fall-related hospitalizations (5,712 per 100,000 people) and fall related emergency department visits (7,157 per 100,000 people)⁹.

The Vermont Department of Health's (VDH) 2008 Injury Report states that due to falls 1,659 older adults were hospitalized and 5,445 emergency department visits were recorded at a cost of \$39,400,000. The cost to the individual and the devastating impact on quality of life and family members cannot be measured.

Another important factor to consider is that the largest numbers of people with fall-related injuries go undocumented, as many do not see a doctor, receive no medical care, or treat themselves¹⁰.

Evidence strongly suggests that falls result from multiple factors that can be both intrinsic to the individual and within the environment. In other words, most falls can be prevented with evidence-based interventions by addressing modifiable risk factors, such as physical mobility medication mis-management, uncorrected vision and hearing deficits, and home and environmental hazards.

Additionally, Vermont is seeing a significant increase in the number of older adults. In 2009, there were 128,974 Vermont residents age 60 and older, as compared to 101,827 in 2000. This is a 26% increase in the 60+ population. Although falls occur across the life span, the rate of fatal falls is approximately 50% higher for older adults than for the rest of Vermont's population¹¹. Subsequently, the 2010 Vermont Injury Prevention Plan identified elderly falls prevention as one of the top three priorities in Vermont.

One of the greatest financial challenges facing our nation is the rising cost of health care services required by older Americans. Significant progress can be made in decreasing these health costs if we can reduce falls among older Americans¹². Unless Vermont commits to effectively addressing this serious public health issue, the impact and cost of fall-related injuries and deaths will increase dramatically as the population ages.

⁶ Healthy Vermonters 2020, Behaviors, Environment & Health, issue date December 2012

⁷ April 2014, Vermont Behavioral Risk Survey, VDH

⁸ United Health Foundation: America's Health Ranking Senior Report 2014

⁹ VDH 2008 Injury Report

¹⁰ NCOA Falls Prevention data www.ncoa.org

¹¹ Census data, 2010

¹² NCOA Issue Brief: Funding for Elder Falls Prevention

Goal: Improve the safety, quality of life and independence of older Vermonters.

1. Key findings related to leadership:

- 1.1 The 2010 Vermont Injury Prevention Plan identifies elderly falls prevention as one of the top three priorities in the state. Reducing the number of deaths from falls is a key focus area for the Agency of Human Services Stat 2013-2017¹³ and the Department of Health because of the higher than average number of falls, hospital admissions, and mortality rate.
- 1.2 Vermont lacks a consolidated State Action Plan with specific goals and strategies to affect sustained initiatives to reduce falls among older adults. In other words, there is neither a designated agency nor dedicated staffing committed to falls prevention.

Recommendations:

- VDH should take the lead role in developing a State Plan of action on Falls Prevention and Awareness to reduce falls and fall-related injuries and deaths for adults age 60 and older. Vermont needs strong leadership and commitment in the creation and delivery of a State Plan. Embedding falls prevention oversight into the Health Department's Injury Prevention Program would be an important step in falls prevention.
- VDH should include key stakeholders in the development of the Action Plan (e.g. Area Agencies on Aging, Department of Disabilities, Aging and Independent Living, Vermont Chapters of Physical and Occupational Therapists, Medical Practitioners and Hospitals).
- The AHS Stat on Falls Prevention should refocus its goal from "preventing fall related deaths", to "preventing falls and fall-related injuries and deaths".
- The State Plan should focus on development of an integrated approach to implement and consistently deliver evidence-based falls prevention programming with the following goals:
 - Increased public awareness about falls prevention and strategies to reduce risk.
 - Increased understanding of the importance of addressing fall risk in the elderly population for health care providers.
 - Increased knowledge in the medical community of the availability of evidence-based fall prevention programs and services.
 - Increased the number of older Vermonters screened for falls risk and if at risk, receive full assessment and referrals to appropriate evidence-based programs and services.
 - Increased participation in evidence-based falls prevention programs through the increase in the number of and geographical access to evidence-based falls prevention programs and services.
 - Increased number of older adults and caregivers making appropriate behavior changes to further reduce falls risk.
 - Reduced number of falls and fall-related injuries and deaths among adults 65+.

¹³ AHS Stat is a leadership strategy to identify desired outcomes, to analyze and monitor performance and to motivate individuals and teams to make the programmatic changes necessary to achieve specific performance outcomes.

2. **Key findings related to fall prevention efficacy and cost effectiveness:**

- 2.1 The findings of an encouraging CDC study that calculated the costs and benefits of falls prevention program delivery is soon to be published. Evidence-based falls prevention programs offer promising directions for simple, cost-effective interventions through eliminating known risk factors, offering treatments that promote behavior change, and leveraging community networks to link clinical treatment and social services. Integrated models linking the clinical intervention with community programs and services are being piloted and show promise. Randomized controlled trials of several community based programs have clearly demonstrated a reduction in falls¹⁴.
- 2.2 A CDC and Administration for Community Living (ACL – formerly AOA) report to the Centers for Medicare and Medicaid Services (CMS) on evidence-based falls prevention program efficacy cites Tai Chi for Arthritis, A Matter of Balance and Otago in the “highest tier” of recommended programs¹⁵.
- 2.3 When compared with controls, the risk of falling in the Tai Chi intervention participants was decreased 55 %¹⁶. Tai Chi for Arthritis is a low-cost program tailored to improve movement, balance, strength, flexibility and agility. Tai Chi also significantly reduced the risk of multiple falls by approximately 70%. The study suggests that Tai Chi is an effective and sustainable public health intervention for falls prevention for older people living in the community¹⁷.
- 2.4 The Matter of Balance program has been shown through two randomized trials to accomplish its primary objective, which is to increase falls self-efficacy (i.e., perceived self-efficacy or confidence at avoiding falls during essential, nonhazardous activities of daily living). In the most recent study, by self-report there were significantly fewer recurrent fallers in the intervention group. Prevention programs can help reduce health care costs associated with fall-related injuries and hospitalizations¹⁸.
- 2.5 CDC’s Injury Center developed the STEADI Tool Kit¹⁹ for health care providers who see older adults in their practice who are at risk of falling or who may have fallen in the past. The STEADI Tool Kit gives health care providers the information and tools they need to assess and address their older patients’ fall risk.
- 2.6 The Otago exercise program (OEP) is an effective falls prevention program that can be delivered alone or as part of a multifactorial program. It has been proven to effectively reduce falls by 35% when delivered to clients 80 years of age and older. Educating local physicians about its benefits and effectiveness would contribute to the goal of fewer falls.

¹⁴ NCOA State Policy Toolkit for Advancing Fall Prevention – Select Resources June 2014

¹⁵ Title III-D Highest Tier Evidence-Based Health Promotion/Disease Prevention Programs, ACL website

¹⁶ NCOA State Policy Toolkit for Advancing Fall Prevention – Select Resources June 2014

¹⁷ Voukelatos, Alex et al., “Largest Fall Prevention Study in the World,” Journal American Geriatric Society 55: 1185-1192, 2007

¹⁸ NCOA State Policy Toolkit for Advancing Fall Prevention – Select Resources June 2014

¹⁹ <http://www.cdc.gov/homeandrecreationalafety/Falls/steady/>

- 2.7 Bone Builders, Living Strong in Vermont and Growing Stronger are all programs designed to increase strength, agility, balance, flexibility and pain-free range of motion for older adults and are available in most areas of the State. These programs are not listed as top tier programs with the ACL but are noted as effective programs for increasing physical mobility, a prime cause of falls.

Recommendations:

- Support community-based, low cost, evidence-based programs and promote their expansion across the state, such as the Tai Chi for Arthritis (TCA) program, A Matter of Balance and other evidence-based falls prevention programs as available and appropriate.
- VDH should work with UVM's Center on Aging to expand the number of and accessibility of, hospital-based Falls Prevention Clinics in Vermont and encourage use of the STEADI Toolkit by medical practitioners.
- VDH should work with UVM Center on Aging, to promote Falls Prevention and Awareness at the annual Gerontology Symposium or host a Falls Prevention Summit, so key stakeholders can meet to expand the work and direction of prevention programs in alignment with a State Falls Prevention Action Plan (or to help recruit key partners in developing the plan with VDH leadership).
- VDH should encourage the Vermont Chapter of the American Physical Therapy Association and the CDC to promote training in falls prevention for Physical Therapists (PT) and establish a falls prevention track as one of the opportunities for PTs to comply with ongoing educational requirements.

3. Key Finding related to accessibility of information:

- 3.1 Falls prevention programs are offered in Vermont, but we lack a web-based repository in which to access this information. Consequently, medical practitioners, community health teams, and other stakeholders, don't have access to information on availability of Tai Chi for Arthritis, A Matter of Balance, and other evidence-based, community-based, falls prevention programs.

Recommendation:

VDH should work with key partners to establish a web-based, statewide, referral system that contains information on available community-based falls prevention programs and clinical interventions.

4. Key findings related to funding:

- 4.2 In a study of people age 72 and older, the average health care cost of a fall injury totaled \$19,440. Fractures are both the most common and most costly type of nonfatal injuries and account for 61% of the cost of nonfatal fall injuries. The average cost of a fall related hip fracture injury in 2006 was \$37,000. One in four of those with hip fractures will need to stay in a nursing home for at least a year, with most of these significant costs typically paid by

Medicaid. Up to 20% of these patients will die in less than 1 year²⁰. By 2020 the number of falls and related costs will have more than doubled.

Recommendation:

State agencies and partners should investigate potential sources of funding to invest in the expansion, management and marketing of prevention strategies for evidence-based programs such as Tai Chi for Arthritis, A Matter of Balance and Otago so they are more broadly accessible in the state.

6. Key Findings Related to Education and Awareness:

- 6.1 The NCOA is a valuable partner and resource in falls prevention and takes the lead role in spearheading the National Falls Free Initiative. Their website provides a plethora of educational information as well as templates and Power Point presentations intended for personalization by individual states. The Falls Free Vermont Coalition partners have capitalized by using many of the shared documents and educational material in their annual participation in the National Falls Prevention and Awareness Day Campaign each September.
- 6.2 Many individuals think falls are a normal part of aging and can't be prevented, however the reverse is true: most falls can be prevented. Media awareness campaigns educate and encourage older adults and their families to engage in falls prevention strategies and promote appropriate behavior change.

Recommendations:

- VDH should take a lead role in coordinating a social media campaign, using a variety of print, media and web based venues with emphasis on the theme "Most falls can be prevented". This should include cross-cutting causation factors such as: physical mobility, medications management, vision and hearing, home and environmental safety.
- VDH should partner with the Falls Free Vermont Coalition in its goal to increase public and stakeholder (e.g. policymakers) awareness and education around falls prevention.

²⁰ NCOA Falls Free Issue Brief: Funding for elder falls prevention

Mental Health, Substance Abuse, and Dementia

The mental health of Vermonters age 65 and older is fundamental to their overall health and well-being. Efforts to support a healthy aging population begins with public and leadership awareness of the social determinants of healthy aging such as safe and affordable housing, access to health and social services, opportunities for social and civic participation, incentives for physical activity, and sufficient, accessible, and safe indoor and outdoor space for activities. There clearly are health-related vulnerabilities of growing older as well as prevention strategies to address them. Recommendations at a level of specificity that could shape policy initiatives will require the analysis of resources, system capacities, and ongoing health reform efforts. Still, there are significant areas in which Vermont's array of public and private agencies can make a real difference toward the goal of enabling people to age in supportive communities with dignity, respect and independence.

Older adults are subject to certain age-related mental health needs. Mental health disorders increase the complexity of health problems, increase poor health outcomes, and increase costs as compared to a person without mental disorders. There is a persuasive cost argument for putting more resources into prevention, treatment, and supports that enable an older adult to cope with age-related health issues such as vision and hearing loss resulting in less vulnerability to stress, anxiety, and social isolation, precipitous of depression.

Evidence-based geriatric mental health services were central in the model of care presented to the Health Reform Subcommittee by Stephen Bartels, M.D., Professor of Psychiatry and Community and Family Medicine at Dartmouth and Director of the Dartmouth Centers for Health and Aging. The subcommittee also heard from Commissioner Susan Wehry, M.D., Department of Disabilities, Aging and Independent Living and a geriatric psychiatrist. Dr. Wehry discussed the 4D's – dementia, delirium, depression, and drugs to which older people are susceptible. Much can be done to prevent these age-related conditions. Depression is not a normal part of aging, but a consequence when certain risk factors are present: illness or disability, social isolation, loss of family and friends, financial strain, change, and prior history of depression. In older persons, substance misuse occurs in two prevalent forms: mixing alcohol with drugs such as opioid pain medicines and anti-anxiety medications, both of which are commonly prescribed for older persons; and over-use of alcohol related to the common lack of awareness that smaller amounts of alcohol have greater effects on aging bodies. Delirium, a state of acute confusion, could result from a urinary tract infection, for example, or from too many drugs, and is most serious but treatable. There are some types of cognitive decline or dementia that may be reversible such as those resulting from adverse drug reactions or depression unlike the degenerative form leading to Alzheimer's disease.

Healthy aging for people 65 and older has some if not all of the following key ingredients: choice, independence, control, connectedness, and engagement in ongoing learning, thinking, problem-solving and remembering. Exercise, both physical and mental, is a key ingredient. The financial means to access health services and nutritious food not covered by Medicare is essential. Overall, it is a time of life for continued growth and development, experiences, and personal reflection. For this to prevail, the mental health challenges of aging must be recognized and responded to by the individual and her/his neighbors, family, friends, community, and through a combination of services at many levels. For older Vermonters, the Person- and Family-Centered Care²¹ model needs to be embraced in all aspects of health

²¹ The Person- and Family-Centered Care model delivers health and supportive services taking into consideration an older adult's needs, goals, preferences, cultural traditions, family situation, and values. It places the person and the family at the center of the

and mental health service delivery as it intentionally promotes choice, purpose, and meaning in daily life, and supports well-being for individuals and families.

Goal: Improve the mental health status of older Vermonters.

1. Key findings related to mental health services:

- 1.1 Adults 65 and older present a set of risk factors that calls for an integrated array of health, mental health, and substance abuse services.
- 1.2 The demographic bubble²² will triple the number of people over 80 years of age by 2025.
- 1.3 There is a need to enhance the elder care workforce both in size and skills to respond to the complications of aging, including restrictions on mobility, hearing and vision loss, isolation, absence of a work place support system following retirement, substance misuse, depression, incidence of dementia, and other mental health issues.

Recommendations:

Provide a new focus on the mental health needs of older adults in the Department of Mental Health's *System of Care Plan*, specifically:

- State government, particularly the Vermont's Departments of Mental Health, Disabilities, Aging and Independent Living, and Health, should work collaboratively and seek input from Designated Agencies²³, community partners, stakeholders, and other resources of state government to define action steps and strategies designed to strengthen prevention and treatment interventions for Vermonters age 65 and older.
- DMH and DAAL should expand the Elder Care Clinician Program into a statewide resource, making it available in each part of the state. Elder care clinicians should utilize best practice approaches in addressing social isolation and depression as they encounter indications of vulnerability among the older adults they serve.²⁴
- State support of the five Area Agencies on Aging for outreach mental health services to people age 60 and older in partnership with designated mental health agencies (DAs) is essential and should be expanded to meet need.

care team, along with health and social services professionals and direct care workers. See the Institute for Person and Family Centered Care, www.ipfcc.org, for more information.

²² The aging of the Baby Boomers, those born between 1945 and 1965, will cause a demographic bubble.

²³ Vermont has ten Designated Agencies, private, nonprofit community-based mental health services agencies that each serve a defined catchment area and provide services through contracts and funding mechanisms overseen by the Department of Mental Health. There is one Specialized Services Agency serving the mental health needs of children statewide as well.

²⁴ The Elder Care Clinician Program addresses the mental health needs of homebound, older Vermonters. It is administered by the Vermont departments of Mental Health, and Disabilities, Aging and Independent Living.

- DMH should help to increase public and leadership awareness of the mental health status of Vermont’s older population through its publications, reports, website, and media opportunities, emphasizing the preventive benefits of enhancing social connectedness and improving access to treatment of age-related mental health challenges.
- DMH and DAILE should develop strategies to train, support, and increase the number of peer and family support specialists such as Senior Companions²⁵, community health workers, direct care workforce, and family caregivers.

2. Key findings related to isolation, loss and stress:

- 2.1 Many seniors live alone. Nationally, 19% of men and 35% of women aged 65 and older were living alone in 2013.²⁶ Vermont has seen increasing mobility among families, making it less common for adult children and grandchildren to be nearby older relatives. Many small towns where people knew nearly everyone and where the need to check on a homebound senior traveled by word-of-mouth, have less of this natural infrastructure. Women in the workforce, concentration of jobs out of town, and fewer local institutions such as post offices, granges, general stores, and other local meeting grounds have combined to limit the time and the chance to keep in touch with the needs of neighbors aged 65 and older who experience isolation, loss and stress.
- 2.2 Losses that occur frequently in old age, such as the death of a spouse, partner, close relative or friend can trigger emotional responses that cause or exacerbate depressive disorders and symptoms, leading to severe, debilitating grief.
- 2.3 Acute and chronic physical health conditions that are common in older adults such as vision and hearing impairment, pain conditions, sleep disorders and medications to treat such conditions can cause and exacerbate mental disorders.
- 2.4 Loss of employment and consequent changes in social status and supports impact the structure of daily living and personal income, negatively affecting health and mental health.

²⁵ Senior Companions is a national program that recruits income-eligible persons, age 55 and over, to serve frail older adults to help them remain in their homes. A small stipend is paid for this much-needed support that may range from light housekeeping, grocery shopping, and reading to checking in and reminding homebound elders to take their medications. It operates in some areas of Vermont, but there is an increasing need for this service.

²⁶ U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

Recommendations:

- Social services and faith communities should be encouraged to reach out to older Vermonters who experience a loss to offer their support and, if necessary, professional help to respond in coping with loss.
- Community development planning should include senior-friendly, Livable Communities²⁷, with elements such as opportunities for social and civic engagement that can reduce social isolation of older Vermonters.
- Expand the Senior Companion program to provide a peer resource for any older Vermonter who is socially isolated.
- Support the role of senior activity centers and their collaboration with civic and faith-based community organizations. Encourage all such groups to conduct outreach and to offer attractive programming for all seniors, particularly those who may be experiencing social isolation.

3. Key findings related to at-risk alcohol and/or medication use:

- 3.1 Substance misuse by older people affects work, health, mental health, and relationships.
- 3.2 Screening tools for substance use as well as for cognitive impairment and depression are available yet underutilized in the health care system.
- 3.3 The nature of the substance abuse problem among people age 65 and older is more a problem of misuse. Many older persons misuse medications in different ways such as: taking a medicine that was prescribed for someone else; taking a larger dose than prescribed; use with alcohol; skipping or hoarding drugs; taking medicine in different ways than prescribed.
- 3.4 Twenty-five percent (25%) of older adults consume a larger quantity of alcohol than recommended by the National Institute on Alcohol Abuse and Alcoholism and SAMHSA, or drink alcohol while taking psychoactive medications; the majority does not meet criteria for a substance use disorder.²⁸
- 3.5 Vermont ranks 43rd worst amongst states in chronic drinking by seniors, according to a 2014 report by the United Health Foundation.

²⁷ Livable Communities refers to public policy and planning initiatives for land use, housing and transportation that help the older population age in place and that enhance a community's livability for all ages.

²⁸ Vermont's Behavioral Risk Factor Surveillance Survey (BRFSS) is a tracking system that uses a telephone survey of adults. The results inform Department of Health goals such as Healthy Vermonters and many other BRFSS data reports.

Recommendations:

- Develop and implement substance misuse prevention strategies targeting older persons.
- Create guidelines for screening and treatment of older adults by primary care and by substance abuse treatment providers.
- Recommend providers use evidence-based tools for screening and follow-up treatment for older adults with identified substance use or abuse problems Examples of tools are:
 - SBIRT (Screening Brief Intervention and Referral for Treatment) <http://sbirt.vermont.gov/what-is-sbirt/>
 - S-MAST-G <http://sbirt.vermont.gov/screening-forms/older-adult-alcohol-screening-instrument/> and
 - DAST-10 screening tools <http://sbirt.vermont.gov/screening-forms/dast/>

4. Key findings related to depression

- 4.1 There are a number of risk factors for depression that accompany aging, including loss of loved ones, loss of employment, reduction of income, health and mobility challenges.
- 4.2 Older Vermonters are identified as having a depressive disorder (including depression, major depression, dysthymia, or minor depression) at a higher rate than the national average---16% as compared to 13% nationally in 2011 and 2012 (Vermont Green Mountain Care Board Data Brief “*Depression Among Older Vermonters*,”2012).
- 4.3 Vermont ranks 44th worst among older persons with depression, according to a 2014 report by the United Health Foundation.²⁹

Recommendations:

- Promote universal screening for depression among older adults in primary care.
- Encourage the development and implementation of protocols for screening for depression in all mental health services programs for older adults.
- Expand utilization of evidence-based depression treatment programming such as PEARLS, Program for Encouraging Active Rewarding Lives, and Healthy IDEAS, Identifying Depression, Empowering Activities for Seniors.³⁰

²⁹ The United Health Foundation (UHF) was established by United Health Group in 1999 as a not-for-profit, private foundation to improve health and health care.

³⁰ PEARLS is an evidence-based treatment program developed by the University of Washington Health Promotion Research Center to reduce depressive symptoms and improve quality of life in older adults and in all-age adults with epilepsy. Healthy IDEAS is an evidence-based program developed by Baylor College of Medicine’s Huffington Center on Aging that integrates depression awareness and management into existing case management services provided to older adults.

5. Key findings related to suicide prevention

5.1 Suicide was the eighth leading cause of death in Vermont (2010 data) as compared to the tenth leading cause in the United States. Among females, the suicide rate peaked in the 65 and older age group at 15.8 per 100,000. Males tend to commit suicide more frequently later in life.³¹

In Vermont the suicide rate for older men, 65+ in 2010, was 37.2 per 100,000, slightly less than the highest rate for any population group which was 38 per 100,000 for men 45 – 64.³²

Vermont ranked the 41st worst state regarding the incidence of older person suicide, according to a 2014 report by the United Health Foundation.

5.2 Protective factors include good clinical care for physical, mental, and substance abuse disorders, restricted access to guns, and family and community support.

5.3 Among older adults who die by suicide, approximately 77% have seen a primary care provider within their last year of life and 58% have within their last month of life.³³

Recommendations:

- Support senior-specific strategies in the Vermont Platform for the Prevention of Suicide,³⁴ which include a distinct approach to suicide prevention.
- Implement the concept and practice of “Zero Suicide” programming in all mental health, primary care, and elder care programs. “Zero Suicide” is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. www.zerosuicide.com
- Screen for suicidal ideation among older adults receiving mental health or substance abuse treatment
- Implement evidence-based practices for suicide prevention in primary care such as PROSPECT: Prevention of Suicide in Primary Care Elderly³⁵.
- Promote the use of palliative care to optimize treatment of pain, sleep problems and other physical symptoms that can decrease older adults’ quality of life and increase suicidal thoughts.
- Train providers of senior services and laypersons to identify warning signs and refer to services those older adults who are at-risk for depression or suicide (e.g., “gatekeeper” training).

³¹ Vermont Vital Statistics System, 2010, as reported in Vermont Department of Health “Suicide Data Brief”

³² Vermont Vital Statistics System, 2010, as reported in Vermont Department of Health “Suicide Data Brief”

³³ Lisa M. Furst, LMSW, MPH, *Depressed Older Adults: Education and Screening*, Springer Publications, p.23

³⁴ The Platform was launched in 2012 as the Youth Suicide Prevention Platform by the Center for Health and Learning (Brattleboro, Vermont) on behalf of the Vermont Youth Suicide Prevention Coalition. Recognition of the incidence of suicide across the lifespan is broadening the focus to include suicidal behavior later in life.

³⁵ Among many resources on PROSPECT is the article *Designing an Intervention to Prevent Suicide* (Dialogues in Clinical Neuroscience, Martha Bruce, PhD, MPH, and Jane L. Pearson, PhD, 1999)

6. Key findings related to dementia

- 6.1 Dementia is the loss of cognitive functioning—ability to think, remember, or reason as well as behavioral abilities to an extent that it interferes with a person’s daily life and activities.
- 6.2 Various disorders and factors contribute to the development of dementia, including neurodegenerative disorders such as Alzheimer’s disease, Lewy body dementia, and multi-infarct dementia.³⁶ Currently, there are no cures for these progressive neurodegenerative disorders.
- 6.3 Other types of dementia can be halted or even reversed with treatment.
- 6.4 Many older individuals suffer from mixed dementia, a combination of neurodegenerative and vascular dementia.

Recommendations:

- Implement proposed recommendations of the Governor’s Commission on Alzheimer’s Disease and Related Disorders (ADRD)³⁷ which include:
 - Raise community and leadership awareness about the incidence, effect, and needs of those affected by Alzheimer’s disease and related disorders.
 - Increase the practice of early detection and early screening for cognitive impairment, a major strategy for this being primary care.
 - Increase supports for family caregivers.
- Broaden outreach, eligibility for, and capacity of the Dementia Respite Program to provide respite to family caregivers <http://www.ddas.vermont.gov/ddas-programs/programs-dementia-respite-default-page>.
- Provide training to increase person-centered skills of all caregivers in residential and day settings.
- Increase availability of family caregiver support models such as Powerful Tools for Caregivers, an evidence-based education program that uses a train-the-trainer method of dissemination. <http://www.powerfultoolsforcaregivers.org/about/>.

Conclusion

As Vermont moves ahead with health reform, it will be important for policy makers to consider the unmet needs of individuals who have Medicare insurance. In spite of Medicare’s coverage of acute and ambulatory care, there are many preventive and health needs of older adults that are not covered. For those who are not able to pay for these services out-of-pocket, needs such as oral health care and mental health care go unmet. And, because of the health risks posed by falls, the prevention of falls will serve not only as a way to preserve quality of life but also a way to avoid health care costs resulting from falls. Attention to these needs will contribute to older adults maintaining independence and dignity.

³⁶ Multi-infarct dementia, which is caused by a series of small strokes, is also called vascular dementia.

³⁷ The Vermont Legislature established the Governor’s Commission on Alzheimer’s disease and Related Disorders in 1991.