



August, 2007 Issue

A Life Services Network Publication

Welcome to the premiere issue of LSN's new monthly eNewsletter, **EngAge!** This publication is designed to keep aging service providers up-to-date with the most current information and resources in areas including research, education, aging trends, and innovations. You will find each issue includes five main categories of topics:

- **Innovations and Ideas** – providing information and evaluation of the newest programs and products for aging service providers.
- **Institute 2020** – LSN's newest initiative targeting key research and education projects that will shape the future of aging services.
- **The Latest in Aging Research** – summarizing research studies across the continuum of aging services.
- **What's Up with Boomers** – highlighting recent reviews, studies, and resources addressing the boomer generation.
- **Key Resources in Aging** – linking readers with vital resources available on the web relevant to aging services and programs.

INNOVATIONS AND IDEAS

Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program

The Green House model envisions a radical reconfiguration of the nursing home. A Green House is a self-contained dwelling for up to 10 residents needing nursing home levels of care. The physical environment provides private rooms and bathrooms to support a "residential" feel, while meals and activities provide for communal opportunities. Certified nurse assistants are assigned to a single Green House and have broadened roles encompassing personal and environmental care. Professionals form visiting clinical support teams to meet specific care needs for residents.

A comparison study of four Green Houses and a traditional nursing home showed significant improvements in Green House residents' quality of life. Related to quality of care, Green House residents had fewer residents on bed rest, fewer residents with little or no activity, and lower incidence of decline in late-loss ADLs.

The Green House model is a promising model to improve quality of life for nursing home residents with implications for staff development. (Source: *Journal of the American Geriatrics Society*, 2007, Vol. 55, pp. 832-839)

AFA and CJE's Adult Day Services Unveil *Quilt to Remember*

Over the past several months at Council for Jewish Elderly's (CJE) Adult Day Services in Evanston, everyone from staff to caregivers to individuals with Alzheimer's disease has been buzzing with activity—designing, painting, coloring, and gluing down sequins, glitter and yarn.

Their project: crafting a huge panel for the Alzheimer's Foundation of America's (AFA) *Quilt to Remember*, the nation's first grand scale dementia-related quilt, in which more than 300 organizations from coast-to-coast have participated. CJE was the only Chicago-based organization to participate in the project. A grand unveiling ceremony of the AFA *Quilt to Remember* took place on May 11, 2007 in Chicago's Grant Park, as the second stop on a nationwide tour to raise awareness for Alzheimer's disease.

Organized by AFA, the purpose is to bring attention to Alzheimer's and offer support to all of those whose lives have been affected by it. Many of the individual quilt squares pay tribute to the memory of a loved one with photos and pieces of fabric that have personal meaning, and even cite poetry and song that the individual artist utilized as part of the design. Exhibiting the quilt during Mother's Day weekend is especially significant, since many participants have created panels to honor their mothers and grandmothers.

Individuals with dementia were a major component of the quilting team, according to Judy Holstein, CJE's director of Adult Day Services, who spearheaded the agency's participation. "This project has given many of our members a chance to put their artistic imprint on a national project that speaks about and for Alzheimer's disease," she said. "For those with dementia, the hands-on, multi-sensory experience gives them meaning for their day and ultimately their lives. When their creativity is evoked, that's a gift, and a wonderful thing to do for their quality of life and self-esteem."

Currently, approximately five million Americans have Alzheimer's disease, including one in ten aged 65 and older and nearly one in two aged 85 and older. In Illinois, an estimated 210,000 people have the brain disorder, and the incidence is expected to rise 14 percent by 2025. AFA unveiled the massive quilt project for the first time last November in Central Park in New York City, drawing hundreds of visitors over two days. For more information, click here the link to www.alzquilt.org.

Health Coaching: A New and Exciting Technique to Enhance Patient Self-Management and Improve Outcomes

Health coaching is the practice of health education and health promotion within a coaching context to enhance the well-being of older adults and to facilitate the achievement of their health-related goals. Health coaching effectively motivates behavior change through a structured, supportive partnership between the participant and the coach. The coach helps the participant to clarify goals and provides insight into goal achievement through inquiry, collaboration, and personal discovery.

Health coaching also is sometimes referred to as "motivational interviewing." Many who practice health coaching applaud this method as a great way to help older adults achieve optimal wellness, to facilitate the learning process, and to engage them in health-seeking behaviors. For example, the health provider may start with a comment such as "Tell me what bothers you most." "Tell me what is hardest for you." "Tell me what you're most distressed about." This helps the clinician get to the core of what is most important to the older adult, and provides the best place to start making inroads to behavior change.

In the coaching model, the health provider does not try and solve the problem for the older adult, or not say "It will be okay." Rather, the health provider should validate the older adult's feelings and his or her capacity to deal with the problem. For example, the health provider should ask questions that help lead the older adult to his or her own solution – questions such as, "What do

you think would work?" "What have you tried in the past?" or "What would you like to try?"
(Source: *Home Healthcare Nurse*, 2007, Vol. 24, No. 4, pp. 271-274)

The Right Cure for Ailing Elder Care?

At the end of our lives, we can only hope to see the face of someone like Renee Roberts. She is a 42-year-old geriatric nurse practitioner employed by Evercare, a division of UnitedHealth Group Inc. that coordinates care for elderly clients. She also represents a possible solution to the worsening shortage of doctors trained to treat the elderly. "We know that investing in an NP up front leads to better care and a lower cost at the back end," says Evercare Chief Executive Dr. John Mach, himself a geriatrician. "We've achieved a 45% reduction in hospitalizations with no negative impact."

Roberts has a caseload of 80 to 100 very old patients around Augusta, GA. Most of them live in nursing homes, although she tries to keep patients out of institutions as long as possible. Her mission is to see that her patients get the best medical attention possible, the kind of care nursing-home staff and primary-care doctors might be too busy to provide. She visits up to 10 patients each day, five days a week, spending some 45 minutes to an hour per visit--three or more times the length of a typical doctor visit. She deals with a multiplicity of chronic illnesses, and because many of her patients are suffering from dementia, she can't count on their input to guide her. "I look for the geriatric symptoms they can't tell me about," says Roberts. "If they are leaning to one side, for example, that might mean they have a urinary tract infection."

Roberts also meets frequently with the families of her clients, discussing such uncomfortable issues as end-of-life directives, frequently left unaddressed until the patient is in crisis. "I'm more than a nurse practitioner," she says. "I'm a clinician, I'm a counselor, coach, communicator, manager, collaborator. For me, geriatrics is a very, very rewarding field."

Those last few words are rarely heard from physicians. Each year, U.S. medical schools graduate about 16,000 students, and only 2% seek careers in geriatrics. In a 2006 survey, only 49% of medical school graduates said they received any geriatrics training as part of their medical education. Those numbers translate into a looming health-care crisis as the Baby Boom generation starts hitting old age. Based on Census Bureau projections, the number of Americans aged 65 and older will double in size, from 35 million in 2000 to 70 million in 2030, while those 85 and older, already the fastest-growing age group, are expected to increase from 4.2 million to almost 9.6 million.

As a result, the Alliance for Aging Research estimates there will be a need for 36,000 geriatricians by 2030. In 2005 there were only 6,615 of these certified specialists for the aged--one for every 2,500 people over 75. By 2030 there will likely be only one per 3,600. "Geriatrics is a lost cause," says Dr. Robert L. Kane, director of the University of Minnesota's Center on Aging. "There are just too few [geriatricians] now, and no sign that there is any growing interest" among medical students.

Nurse practitioners, already used to serving poor and rural populations where doctors are scarce, may be more inclined to take on the aged. "They are filling in the gaps and are pretty much on the front lines in taking care of elders," says Dr. Wayne S. Saltsman, chairman of geriatric medicine at the Lahey Clinic in Burlington, Mass. This class of highly trained nurses, who usually hold master's degrees, are meant to work in collaboration with a doctor, although in 16 states they are allowed to practice independently. They can diagnose and manage acute and chronic illnesses and can write prescriptions in all 50 states. They can also specialize in geriatrics.

Doctors, however, are not keen on the idea of turning elder care over to NPs. "I love nurse practitioners, but that's like saying old people should get less-trained caregivers," says Dr. Robert N. Butler, president of the non-profit International Longevity Center in New York, and founder in

1982 of the first geriatrics department in a medical school, New York's Mount Sinai Medical Center.

Even Evercare insists the 500 NPs it employs in 38 states are not meant to replace doctors but to work with them. Yet study after study has found the primary care provided by NPs is as good as that of a doctor. The federal Office of Technology Assessment determined back in 1987 that NPs can effectively treat 80% of all adult patients, and "outcomes are equal to or better than care by physicians."

Some of the most persuasive arguments for boosting reliance on NPs are economic in nature. A 2003 study by the University of Minnesota, performed for the federal agency that administers Medicare, found that Evercare's greater use of NPs reduced hospitalizations by half when compared with an equivalent population of nursing home patients not enrolled. "On average, using an NP is estimated to save about \$103,000 a year in hospital costs per [nurse]," concluded the study, led by Kane. Plus, the nurses themselves are compensated by Medicare at only 85% of the rate of doctors.

Cutting the cost of elder care is no small matter because, while some American hospitals have top-notch geriatric programs, they usually lose money. Mount Sinai's Brookdale Geriatrics Dept., considered one of the best in the nation, has 24 doctors, 14 medical students, and two NPs to handle 12,000 visits per year from 1,500 patients with a mean age of 84. These are not in-and-out checkups; 80% of senior citizens have one chronic disease and 50% have at least two. Visits usually last at least 30 minutes, and an initial visit is always at least an hour. "This clinic is not economically viable," acknowledges Brookdale Chairman Dr. Albert L. Siu. "It's almost impossible to practice geriatric care under Medicare and make money."

Given that a third of all hospital patients are on Medicare, and count for almost half of all hospital charges, any inpatient reduction in this population could represent a huge savings. The problem is, there's a shortage of nurses as well as doctors. There are currently about 145,000 nurse practitioners in the U.S., and only some 4,000 have a specialization in geriatrics.

The John A. Hartford Foundation, a New York-based nonprofit focused on improving elder care, is trying to reduce this deficit, with some success. For the past seven years, the foundation has been funding geriatric nurse training centers and scholarships. "There's been a huge increase in graduates as a result," says Kathleen Dracup, dean of the University of California at San Francisco's nursing school. These NPs are not being trained as almost-doctors, she says. "Medical school curricula are still focused on making the diagnosis. But nurses don't come from that. Their training is focused on symptom management."

As it happens, symptom management is just what aging patients with a multitude of ailments often require. And NPs are often better prepared, logistically and mentally, to provide it. "The whole history of nurse practitioners is that we go where doctors don't want to go. We go where we're most needed," says Carolyn Auerhahn, director of the geriatric nurse practitioner program at New York University's College of Nursing. Her own institution is doing its bit. Last October, NYU opened an NP-managed health-care center primarily for older adults without primary care doctors, on the theory that regular preventive care would keep them out of hospitals and nursing homes.

Whether there will ultimately be enough NPs to staff such clinics, and doctors to back them up, is still a question. A handful of states are increasing funding for geriatric training, but the federal government has done little to nothing. Laments Kane: "My guess is we'll push things to the precipice, panic, and then come up with a draconian solution and pump a lot of money into something that we could have solved much more cheaply years earlier."

Can Nurse Practitioners Improve Geriatric Care?

To find out, Medicare funded a study of 3,653 nursing home residents, half of whom are managed by nurse practitioners*

A: PATIENTS WITH CARE MANAGED BY NURSE PRACTITIONERS

B: STANDARD NURSING-HOME CARE

Average number of hospital admissions per 100 residents

- A: 2.4
- B: 4.6

Average hospital length of stay per resident

- A: 4.6 days
- B: 5.4

Hospital cost savings per NP per year \$103,000

* Under the auspices of Evercare, a unit of UnitedHealth Group Inc.

Data: *Journal of the American Geriatrics Society*. Source: *Business Week* June 11, 2007

INSTITUTE 2020

LSN is Launching Its New Initiative – Institute 2020

LSN's Institute 2020 will select key research and education projects that will benefit LSN membership and organizations across the diversity of aging service providers, keeping in mind key opportunities that will shape the future of aging services.

Institute 2020 will target opportunities to advance aging services through research, education, and innovation. An Institute 2020 page is currently under construction on the LSN website where members may learn more about current and planned projects. Several programs are already in place for LSN members including:

- The annual **LSN Salary and Benefit Survey** is conducted each spring to provide members current data regarding compensation and benefits for various levels of administration, staff, and consultants by region of the state. Reports are made available in early June and are used by organizations for budget planning and for recruiting and retaining the most qualified employees.
- The annual **LSN Member Staff Turnover Survey** is released in early July and provides important information for members comparing turnover rates for positions of registered nurses, licensed practical nurses, certified nurse assistants, housekeeping, and dietary workers by both levels of care and by region of the state.
- **BEST CARE** is an education and research initiative funded by the Illinois Department of Public Health that supports workforce development in Illinois nursing homes around the vision of person-directed care. **BEST CARE** strives to decrease staff turnover, increase staff and resident satisfaction, and improve quality outcomes.
- The **Confidence Satisfaction Survey Program**, a national level satisfaction survey program, provides senior living and long-term care communities with measures, tools, and applications that promote quality improvement initiatives. Significant enhancements in 2006 and 2007 now include executive summaries, priority index analyses, and resources for application of results. A quarterly newsletter, *The Pillar*, has also been developed that provides ideas on how to use results for quality management programs.
- The annual **Member Satisfaction Survey and Needs Assessment**, conducted in early fall each year, provides LSN the opportunity to learn from our members - not only what we are doing well, but also where we should prioritize research, education, and innovation needs based on what our members tell us.

BEST CARE to be Expanded and Enhanced through Continued IDPH Support

Developed by Anna Ortigara and Linda Hollinger-Smith, **BEST CARE** focuses on key components supporting workforce culture transformation in licensed long-term care communities. IDPH has granted a second year of funding totaling over \$157,000 to support expansion and enhancement of the program.

The Goals of **BEST CARE** are to:

- Increase staff satisfaction and feelings of empowerment and work effectiveness
- Decrease turnover rates of all staff
- Support a culture of person-centered relationships between staff, residents, and each other
- Encourage staff involvement in creating and implementing culture change practices within LTC organizations
- Provide LTC organizations with information about new employees and the performance of care teams

The grant will allow up to 90 Illinois nursing homes to participate in Part I of **BEST CARE**, consisting of a one-day workshop (locations and dates to be announced soon!) and a supporting web course. Part I targets three key components supporting workforce culture transformation: (1) A Framework of Person-Directed Care; (2) A Peer Mentorship Program; and (3) Primary/Consistent Assignments.

Participating nursing homes that successfully complete Part I of **BEST CARE** will be invited to participate in Part II, "Communication Skills for Building Relationships," an additional one-day workshop targeting enhancing communication skills of staff.

Key to measuring success of the BEST CARE program is a required **Evaluation Component**. All participating organizations are required to complete brief surveys at three time periods during the course of the project. Further information about how your nursing home may participate will be made available soon!

2007 LSN Member Staff Turnover and Vacancy Survey Report Released!

The results of the 2007 LSN Member Staff Turnover and Vacancy Survey Report highlight the continuing issue of workforce management for LSN members. A total of 156 organization members participated in the 2007 Salary-Benefit Survey and 144 of those organizations (92%) provided turnover data for the 2007 survey.

On average, manager turnover rates are significantly lower than non-management staff (12.2% compared to 42.6%). Independent living (market rate) and home/community based services reported the lowest turnover rates for both management (3.9% and 7.1% respectively) and non-management staff (24.3% and 30.8% respectively). Regarding categories of personnel, 2007 turnover rates declined for nursing homes in all categories except dietary workers compared to 2006 results. On average, respondents reported a 3.5% overall vacancy rate for management positions and a 12.1% vacancy rate for non-management positions.

As a new addition to the 2007 report, we compare LSN turnover rates to available national data for nursing homes, assisted living, and CCRCs. Management turnover of LSN member organizations is significantly lower than national results for all three settings, averaging 36.4% lower. RN and LPN turnover reported by LSN member nursing homes and assisted living communities is lower than national averages. LSN CCRC members reported higher turnover for all staff positions compared to national averages. Vacancy rates are generally lower for LSN member organizations compared to national vacancy rates particularly for management, RN, and

LPN positions. Access the full report and tables at www.lsnj.org/pdf/2007turnovervacancyreport.pdf.

THE LATEST IN AGING RESEARCH

Adult Day Care Slows Cognitive Decline

People with Alzheimer's disease experience acceleration in the rate of cognitive decline after being placed in a nursing home according to a new study by the Rush Alzheimer's Disease Center. The study, published in the June 2007 issue of the *American Journal of Psychiatry*, finds that prior experience in adult day care may lessen this association.

The observational study involved 432 older persons with Alzheimer's disease who were recruited from health care settings in the Chicago area. At baseline, they lived in the community and 196 participants were using day care services from 2 to 6 days a week for an overall mean of 1.7 days a week. At six month intervals for up to four years, they completed nine cognitive tests from which a composite measure of global cognition was derived.

On average, cognition declined at a gradually increasing rate for all participants. During the study period, 155 persons were placed in a nursing home, and placement was associated with a lower level of cognition and more rapid cognitive decline.

Study participants who had previous adult day care experience fared better. As level of day care use at study onset increased, the association of nursing home placement with accelerated cognitive decline substantially decreased. Thus, people using day care 3 to 4 days a week at the beginning of the study showed no increase in cognitive decline upon nursing home placement. "The findings suggest that experience in day care may help individuals with Alzheimer's disease make the transition from the community to institutional residence," said study author Robert S. Wilson, Ph.D., a neuropsychologist at the Rush Alzheimer's Disease Center.

The study also found that a higher level of education was associated with accelerated cognitive decline upon nursing home placement. Yet, day care use markedly reduced the association of education with accelerated cognitive decline in the nursing home; further evidence that there is a robust association between day care experience and cognition during the transition to a nursing home.

The authors considered the possibility that nursing home placement is simply a sign of increased severity of Alzheimer's disease. Yet, the nursing-home-related increase in cognitive decline was observed even after simultaneous control for cognitive and non-cognitive indicators of dementia severity at the time of nursing home entry.

Alternatively, the increased cognitive decline upon placement may reflect difficulty adapting to an unfamiliar environment, consistent with clinical reports of increased confusion and behavior problems in those with dementia during acute hospitalization or trips away from home. Individuals who had prior adult day care services may have been better able to adjust to the unfamiliar environment.

"The findings suggest that the transition from the community to a nursing home is particularly difficult for people with Alzheimer's disease and that those planning for their care should consider the possibility that experience in adult day care programs may help prepare affected persons for institutional living," said Wilson. (Source: *American Journal of Psychiatry*, 2007, Vol. 164, No. 6, pp 910-915)

Alzheimer's Will Affect More Than 100 Million Worldwide By 2050

The latest worldwide estimate of Alzheimer's disease prevalence shows that 26.6 million people were living with the disease in 2006, according to research reported at the 2nd Alzheimer's Association International Conference on Prevention of Dementia in Washington, D.C.

The researchers predict that global prevalence of Alzheimer's will quadruple by 2050 to more than 100 million, at which time 1 in 85 persons worldwide will be living with the disease. More than 40 percent of those cases will be in late stage Alzheimer's requiring a high level of attention equivalent to nursing home care.

Researchers led by Ron Brookmeyer, Ph.D., Professor of Biostatistics and Chair of the Master of Public Health Program at The Johns Hopkins Bloomberg School of Public Health, Baltimore, M.D., created a multi-state mathematical computer model using United Nations' worldwide population forecasts and data from epidemiological studies on the incidence and mortality of Alzheimer's. The goal was to forecast the global burden of Alzheimer's disease and evaluate the potential impact of interventions that delay disease onset or progression.

The researchers also used their model to investigate the impact of medical advances and preventive strategies on disease onset and disease progression. They found that:

- Delaying Alzheimer's disease onset by one year we would reduce the number of Alzheimer's cases in 2050 by 12 million.
- Delaying both Alzheimer's disease onset and disease progression by two years would reduce burden by more than 18 million cases, with most of that decrease – 16 million cases – among late stage cases that require the most intensive care.

"A global epidemic of Alzheimer's disease is coming," Brookmeyer said. "However, even modest advances in preventing Alzheimer's or delaying its progression can have a huge global public health impact."

Sleep and Aging: Sleep Disorders Commonly Found in Older People

With age, important changes in sleep structure occur, perhaps most characteristic is a phase advance of the normal circadian cycle. Thus, older adults often go to bed early and report being early risers. With aging, the total amount of sleep time shortens: infants and young children sleep an average of 16–20 hours per day; adults, 7–8; and people over 60 years of age, 6 1/2 hours daily. Delta sleep (stages 3 and 4), the deepest and most refreshing form of sleep, diminishes with advancing age.

Sleep problems such as insomnia affect nearly half of all those over the age of 65 years. Elderly women tend to report sleep disturbances more frequently than elderly men – estrogen deficiency may be a contributing factor. Medical conditions, depression, and anxiety disorders also contribute to insomnia.

Sleep disturbance or disruption is common among patients experiencing dementia, particularly those with Alzheimer's disease. Such patients often have difficulty not only falling asleep but also with repeated nighttime awakenings.

Sleep-related movement disorders are an often-overlooked cause of interrupted sleep and daytime sleepiness or fatigue among older adults. Periodic leg movements represent a unique motor disorder, in that they occur specifically during sleep. The abnormal movements range from subtle contraction of the muscles of the ankles and toes to impressive flailing of the arms and legs. It is important to know that sleep patterns change as we age, and to recognize that sleep disorders are common among older adults. (Source, Canadian Medical Association Journal, 2007; Vol. 176, No. 9)

Study Finds Mix of Disease in Most People with Dementia

Few older people die with brains untouched by a pathological process. However, an individual's likelihood of having clinical signs of dementia increases with the number of different disease processes present in the brain, according to a new study. The research was funded by the National Institute on Aging (NIA), part of the National Institutes of Health, and conducted at the Rush Alzheimer's Disease Center at Rush University Medical Center in Chicago. Julie Schneider, M.D., and colleagues report the findings in the journal *Neurology* online in June 2007.

Among their findings is the observation that the combination of Alzheimer's disease and cerebral infarcts (strokes) is the most common mix of pathologies in the brains of people with dementia. The implication of these findings is that public health efforts to prevent and treat vascular disease could potentially reduce the occurrence of dementia, the researchers say in the paper. The researchers used data from the Rush Memory and Aging Project—an ongoing study of 1,200 elderly volunteers who have agreed to be evaluated every year and to donate their brains upon death. The current study compared clinical and autopsy data on the first 141 participants who have died.

Annual physical and psychological exams showed that, while they were alive, 50 of the 141 had dementia. Upon death, a neuropathologist, who was unaware of the results of the clinical evaluation, analyzed each person's brain. The autopsies showed that about 85 percent of the individuals had evidence of at least one chronic disease process, such as Alzheimer's disease, strokes, Parkinson's disease, hemorrhages, tumors, traumatic brain injury or others.

Comparison of the clinical and autopsy results showed that only 30 percent of people with signs of dementia had Alzheimer's disease alone. By contrast, 42 percent of the people with dementia had Alzheimer's disease with infarcts and 16 percent had Alzheimer's disease with Parkinson's disease (including two people with all three conditions). Infarcts alone caused another 12 percent of the cases. Also, 80 of the 141 volunteers who died had sufficient Alzheimer's disease pathology in their brains to fulfill accepted neuropathologic criteria for Alzheimer's disease, although in life only 47 were clinically diagnosed with probable or possible Alzheimer's disease.

"We know that people can have Alzheimer's pathology without having symptoms," says Dallas Anderson, Ph.D., population studies program director in the NIA Neuroscience and Neuropsychology of Aging Program. "The finding that Alzheimer's pathology with cerebral infarcts is a very common combination in people with dementia adds to emerging evidence that we might be able to reduce some of the risk of dementia with the same tools we use for cardiovascular disease such as control of blood cholesterol levels and hypertension."

NIA is conducting clinical trials to determine whether interventions for cardiovascular disease can prevent or slow the progress of Alzheimer's disease. On-going trials cover a range of interventions such as statin drugs, vitamins and exercise.

Study Touts Cure For Hepatitis C

Use of the drug peginterferon, either alone or in combination with the drug ribavirin, is a potential "cure" for hepatitis C, according to researchers. The findings were presented recently at the 38th annual Digestive Disease Week conference, in Washington, D.C. In the study, 997 patients with hepatitis C or with both hepatitis C and HIV were treated with the drug and then monitored for an average of 4.1 years, and as long as seven years, reported HealthDay News.

The researchers found that 99% of patients had no detectable virus for more than five years. "This is the first long-term study that confirms what we believed for many years that these individuals are truly cured of hepatitis C," said lead researcher Dr. Mitchell Shiffman, a professor at Virginia Commonwealth University School of Medicine and chief of hepatology and medical director of the school's Liver Transplant Program. Hepatitis C is the leading cause of cirrhosis,

liver cancer, and the need for liver transplants in the United States. *Source: Infection Control Monitor*

Vitamin D And Calcium Reduce Fracture Risk

Vitamin D supplements alone are not enough to lower the risk of hip fractures for the frail elderly and those with osteoporosis, new research indicates. The risk of hip fractures decreases only if they take oral vitamin D supplements along with additional calcium, according to a report in *The Journal of Clinical Endocrinology & Metabolism*.

The risk of hip fracture was cut by 18% in study participants receiving vitamin D plus calcium, the report indicates. Vitamin D and calcium work together to restore calcium balance and reduce fracture risk restore bone health, researchers concluded.

WHAT'S UP WITH BOOMERS

Population Aging; Is Government Ready for Baby Boomers?

As one generation approaches retirement, a new generation takes its place, both socially and economically. However, transitioning the "baby boom" generation will present some unique challenges to society and to government programs particularly. Soon this generation will begin to leave the workforce; a change which will have a significant impact on Illinois' financial climate, especially in regard to the increasing costs of long term care and Medicaid, and the funding of programs provided through the Illinois Department on Aging.

The Baby Boomers

When analyzing generational impacts, demographers look to generational cohorts, which break down groups based on birth year. For instance, people born between the years 1928 and 1945 are known as the "Silent Generation" or "War Babies," while those born after World War II are commonly referred to as the "Baby Boomers," due to the significant increase in birth rates that followed the war. Those born between the end of the baby boom era and the late seventies/early eighties are known as "Generation X," followed by the most recent grouping, defined as "Generation Y."

During the baby boom era (1946-1964), the United States experienced its highest birth rate increase in two decades with 4.3 million births recorded in 1957. The live birth rate for the United States in 2000 was approximately 4 million, which gives this baby boom figure some historical context. Illinois hit its baby boom peak in 1959, recording 239,871 live births; in 2000 this number was just 185,003.

Today, baby boomers account for nearly 30% of the total population, both in Illinois and nationwide. However, as the "leading boomers" begin to retire and move out of state, Illinois may see a decrease in boomers, although the age 65 and over group is expected to grow to over 2.4 million by 2030. In a report on demographic trends in the 20th Century, the U.S. Census Bureau declared that many retirees are relocating to Florida. Trailing Florida as states most appealing to persons 65 and older were Pennsylvania, West Virginia, Iowa, North Dakota, Rhode Island, and Maine. Thus, the Census Bureau projects that by 2030, baby boomers will account for nearly 22% of Florida's population, compared to only 14% of the population in Illinois.

The U.S. Department of Health and Human Services predicts that by the year 2030, the number of seniors nationwide (those 65 and over) will nearly have doubled. **In Illinois alone, the Census Bureau predicts the population of seniors over 65, which stood at over 1.5 million in 2005, will increase by 60% in the same time period.** Moreover, the Congressional Budget Office estimates that the nationwide number of seniors 85 and older, which represented roughly 225,000 individuals in Illinois in 2000 and is the largest cohort of senior citizens in long term care facilities, will increase three-fold by 2050.

National Implications

Experts have warned that the growth in the over 65 age group relative to younger age groups will threaten the solvency of the nation's Social Security retirement system. Others have suggested that Medicare in particular will be financially strained. These concerns are based on a number of factors including the concept of support ratios.

For example, the older support ratio is the number of people age 65 and over per 100 people of working age (20-64 years old). In 2000, the older support ratio was 21 which indicates that there is about 1 older person for every 5 working-age persons. By 2030, the older support ratio is expected to be 36 which indicates 1 older person for less than 3 working-age persons. Given current stereotypes of old age, it would be easy to conclude that by 2030 nursing homes will be overflowing and that costs for medical care and prescription drugs for the elderly will bankrupt governments. However, recent data indicate that the future is far from certain.

Life expectancy has increased and the health of older persons is improving. The financial condition of older people is also improving. The proportion of older people age 65 and older in poverty has decreased from 35% in 1959 to 10% in 2003. With the baby boomers reaching age 65 the future older population is expected to be better educated with better health, higher incomes and higher standards of living. In addition, some experts believe genetic and medical research will produce significant improvements in the prevention and treatment of chronic conditions such as diabetes and Alzheimer's disease.

Implications for Illinois

State government will not be immune from the rapid increase in the over 65 age group. Undoubtedly there will be spending increases for programs that currently serve the elderly, and there may be new costs associated with new services offered in future years. In addition, as the older support ratio increases, there will be fewer wage earners to support programs and services offered to more seniors.

Medicaid

The projected growth of the over 65 demographic will directly affect Medicaid, the health care program funded equally with state and federal dollars. This is due, in part, to the long term care for low-income seniors which is covered by Medicaid, rather than through the federally funded Medicare program. Long term care includes nursing homes and mental health facilities, as well as home health and personal care.

As of fiscal year 2004, there were 372,400 elderly Medicaid enrollees in Illinois, making up 16.4% of the state's Medicaid population. With the national average standing at 10.1%, this places Illinois second-highest in the nation for elderly Medicaid enrollees. With the 2005 Census reporting an Illinois senior population of around 1.5 million, this means almost 25% of the state's seniors are enrolled in Medicaid. Thus, Illinois can expect, and should plan for, increases in Medicaid spending, particularly as the baby boom generation becomes dependent on long term care.

According to the Kaiser Family Foundation, Illinois spent approximately \$11 billion in fiscal year 2005, including federal matching funds, on its Medicaid program. Of this, about \$2.4 billion went toward long term care services involving the elderly, with \$937 million dedicated to home health and personal care, \$56 million apportioned to mental health facilities, and the bulk, \$1.4 billion, allocated to nursing facilities. Citing a survey by Genworth Financial, the AARP indicates that in 2006, the cost of private nursing home care in Illinois averaged \$156 per diem, not including the cost of medication or rehabilitation. Illinois' Department of Healthcare and Family Services reports that per diem long term care charges for Medicaid enrollees stood at \$105.10 in fiscal year 2006, of which Medicaid paid on average \$80.72.

Steep long term care costs push nursing home residents into the Medicaid program even though they were previously considered ineligible, and once enrolled, Medicaid does not fully reimburse

their care. Data from the Congressional Budget Office suggests that two-thirds of nursing home residents end up relying on Medicaid by the time they are discharged. And according to the Illinois Department of Public Health, more than 50% of Illinois' senior nursing care residents currently are reliant on Medicaid.

Nursing Home Beds

According to the Department of Public Health, Illinois had 106,028 certified nursing care beds in 756 licensed nursing care facilities in 2005. The average number of beds in use at licensed nursing facilities stood at 83,870, meaning the occupancy rate of these facilities was around 79 percent. As some baby boomers move into nursing facilities, the 64,355 elderly residents currently in nursing care facilities is likely to increase. To accommodate this population, additional nursing care beds would be needed, and as the average nursing home currently has 120 beds, the state is likely to need a significant number of additional facilities.

The majority of long term care facilities operate under non-profit or for-profit ownership, and the facilities are therefore responsible for their own capital expenditures. In 2004, the Illinois Health Facilities Planning Board reported that over \$158 million went toward capital projects in long term care facilities. The addition of new nursing care facilities would necessitate new private investment on top of current upkeep costs.

Long Term Care Trends

With the baby boom generation reaching retirement age and the continued advancements in medicine, the cost of providing services to the elderly will probably experience significant growth in the near future. One of the state's major expenditures for the elderly is providing long term care for lower income seniors under the umbrella of the state's Medicaid program. Spending for long term care has fluctuated over the years. Since fiscal year 1996, expenditures have varied from a high of \$1.531 billion in fiscal year 2004 to a low the following year (fiscal year 2005) of \$1.204 billion. The fluctuations in spending are due primarily to changes in Section 25 which allows the deferment of liabilities from one fiscal year to the next. Deferred Section 25 long term care liabilities have ranged from \$92 million in fiscal year 1998 to \$450 million in fiscal year 2006.

However, long term care liabilities, which are the costs incurred in a year and not what was spent, have generally increased over time with an exception for fiscal years 2003 and 2004. According to data from the Department of Healthcare and Family Services, fiscal year 1996 long term care liabilities totaled \$1.154 billion. By fiscal year 2006, liabilities were \$1.587 billion. This represents an increase over the eleven-year time frame of \$433 million or 37.5%. During this period, the Department on Aging has more than doubled its spending on services, from \$123 million to \$296 million, to help keep the elderly out of long term care facilities.

The average monthly caseload of Medicaid nursing home patients has declined slightly from 57,005 patients in fiscal year 1996 to 54,468 patients in fiscal year 2006. As expected, the average monthly caseload of the Community Care Program has increased over this time frame from 30,982 to 42,954. While the Medicaid caseload has been decreasing, increases in the costs for nursing home care have offset this decline.

Fiscal year 1992 was the first year long term costs started to exceed \$1 billion. A nursing home assessment program was implemented that year to get additional federal monies but was limited to two years. In an effort to reduce the strain of long term care costs on the General Funds, cigarette taxes were increased from 30 cents to 44 cents per pack in fiscal year 1994. Some of the additional revenues from this increase were deposited into the Long Term Care Provider Fund. Cigarette taxes were increased again to 58 cents in fiscal year 1998 and to 98 cents per pack in fiscal year 2003. Distribution of cigarette taxes to the Long Term Care Provider Fund has varied over the years depending on the fiscal condition of the General Funds. Since cigarette taxes are based on consumption, revenues tend not to grow over time and would be limited in funding long term care costs. Therefore, expenditures for long term care from the General Funds

will likely increase in the near future. Fiscal year 2007 spending for long term care from the General Funds is already over \$100 million higher than the prior year.

In about ten years, the baby boomers will be approaching the age where they may begin to need of the services provided by the state. Assuming no funding changes, the increase costs for long term care will just add to the spending pressures on the General Funds.

Did You Know? . . .

- Baby boomers (born between 1946 and 1964) account for nearly 30% of the total population, both in Illinois and nationwide.
- By 2030, persons age 65 and over will account for about 19.7% of the U.S. population, up from 12.4% in 2000.
- In Illinois, the percentage of persons age 65 and over is expected to increase from 12.1% to 18.0% between 2000 and 2030.
- Overall expenditures for the Illinois Department on Aging increased from \$195 million in fiscal year 1997 to \$420 million in fiscal year 2006. A major part of that increase was the transfer of the senior citizen circuit breaker and pharmaceutical assistance programs from the Department of Revenue in fiscal year 2005.
- The Community Care Program administered by the Department on Aging is designed to help senior citizens avoid institutionalization. In fiscal year 2006 the average monthly caseload totaled almost 43,000 persons. Based on an average monthly cost of \$541 compared to an average monthly cost of about \$2,400 for Medicaid nursing home care, the department estimated a potential monthly savings of \$79.8 million.
- There are 13 Area Agencies on Aging which contract with local providers to provide an array of services to senior citizens throughout Illinois.
- Other state agencies are involved in helping senior citizens. In addition to property tax relief and income tax exemptions for most pension and retirement income, Illinois offers reduced rates for driver's and vehicle licenses as well as for hunting and fishing licenses and camping fees.

**Source: Illinois State Comptroller; Fiscal Focus*

Construction Boom in Retirement Complexes

As Baby Boomers prepare to become senior boomers, the retirement community industry and its financial backers are playing the numbers and forging ahead on developments based on future market potential and not immediate needs.

"There is no question that the demand is increasing across all socio-economic levels for senior housing," said John Day, president of the DuPage Housing Authority.

While most of the Baby Boom generation is still hard at work, the first wave has reached early retirement age and some have already taken that step. Many experts predict that due to the high demand for experienced workers, boomers will work longer than the previous generation and perhaps hold positions well past the age of 65.

However, whether they like it or not, eventually age will play a part in many future decisions for even the longer-working boomers.

According to the American Association of Homes and Services for the Aging (AAHSA) the population of Americans 65 and older will double to 71.5 million by 2026. Among those turning 65 today, it is predicted that 69 percent of those will need some form of long-term care, whether in the community or a residential care facility, reports the AAHSA.

In the past it seemed common for retirees to leave the Midwest for a different climate, but now, many are finding that the majority of seniors decide to stay. "We are beginning to find that more people want to stay where their friends, family and doctors are," said the DHA's Day. "We are seeing less of an outward migration today."

In response to this demographic change, new retirement communities are springing up and other, older facilities are being renovated to meet the demands of the next generation. The types of facilities differ from the very costly to relatively affordable, given the wide range of economic diversity across such a large population, but growth is expected at all levels nonetheless. Retirement communities can be broken down into different categories. There are independent living communities that require occupants to meet a certain age, 55 for some and others 62. These communities provide activities and a social atmosphere, but few health services. Nursing homes and assisted living homes provide occupants with long-term health services, while Continuing Care Retirement Communities (CCRC) provide all three atmospheres.

Many facilities are building new units before their existing inventory reaches capacity. Because of the staggering numbers behind the demographics, financial supporters are not hard to find and the investment is viewed as a sure thing.

Construction firms are also taking notice of this growth market. Work may not be directly related to retirement communities, but because of the demographics, many general contractors are investing in upscale condominiums that are marketed towards seniors looking for an active lifestyle. "Baby boomers are an incredibly wealthy demographic," said Randy Lindenberg, vice president, project development for FCL Builders, Inc. "We are trying to align ourselves with that market. Condo living is making a comeback now."

Cedarlake is presented as an "affordable" retirement option that is a step higher than the group's Mayslake Village, a section 202 public housing facility for low-income seniors, but still below many high-end retirement communities. "We found that there was a niche demographic of seniors who were too well off to buy into Mayslake, but couldn't afford to buy into a \$200,000 condo," said Frigo. "Cedarlake provides something in the middle." Section 202 housing requires occupants to have an income of \$26,000 or less. Cedarlake is based on monthly payments, but does not follow the typical CCRC set-up that requires a down payment. In many cases that down payment is fully refundable, or it will go toward assisted care, but Frigo points out that many seniors can't afford the upfront cost. The facility offers 1-2 bedroom units, with monthly fees ranging from \$1,449-\$2,199.

Friendship Village in Schaumburg recently opened Bridgewater Place, a 170-unit building that has made the 30-year-old facility the 15th largest retirement community in the nation. Seventy of the new units are currently filled and officials expect the rest to go quickly. "We expect to be 95 percent full at Bridgewater Place within a 20-month period," said Cathy Ritter, vice president for marketing and communications for Friendship Senior Options in Schaumburg. "When it is full, we will have more than 1,000 residents." Ritter said that the next step for the facility is to renovate much of its housing to provide top quality amenities for the next generation. "We are still serving the G.I. generation, but we have to position ourselves for the next generation," said Ritter.

The next generation positioned to enter retirement homes is actually the Silent Generation, or those born from 1925-1942. While the expansions and upgrades are in preparation for the influx of Baby Boomers, the reality is that most won't be moving into such communities for some time. "Most seniors don't enter a retirement community until they are in their 70s," said Randalynn Kaye, director of marketing for Wyndemere Senior Living Campus in Wheaton. "We target 62 and

over, but most don't come until their mid-late 70s. "Baby Boomers may work longer, which could delay this kind of lifestyle even more. We may not see them until their 80s. Today's 60 is yesterday's 40."

Wyndemere is an all-encompassing campus that provides independent, assisted and nursing care and is affiliated with Central DuPage Hospital. The community of just less than 300 is not planning for expansion to meet the next generation, but like Friendship Village, it will undergo some renovations in many of its units to update the 14-year-old facility.

Monarch Landing in Naperville is approaching its first anniversary and has 150 residents. However, the community rests on 78 acres and is poised for substantial growth. Recently, it received approval from both Warrenville and Naperville to accommodate 1,500 tenants. "Ultimately, if the market responds, we could see 2,000 residents living here," said Patty Luessenhop, executive director.

Retirement communities are a choice of lifestyle, and it is that choice that the majority of facilities see as their competition. They all have separate programs and benefits, but because of the potential in the industry, executives aren't looking at each other as competition.

"It is not really competition between retirement communities," said Monarch Landing's Luessenhop. "There are a lot of wonderful senior living options. Our competition is homeownership and people who want to continue that lifestyle. "Our challenge is to get people who want to eliminate the hassles of homeownership and want a more social environment to see this kind of lifestyle." One way to do that is to market what matters most—health. "People who come here will live an average of seven years longer than most actuaries' predictions," said Wyndemere's Kaye. "It is a healthier lifestyle."

Generation Gap? About \$200,000

The growing divide between the rich and poor in America is more generation gap than class conflict, according to a *USA TODAY* analysis of federal government data. The rich *are* getting richer, but what's received little attention is who these rich people are. Overwhelmingly, they're older folks. Nearly all additional wealth created in the USA since 1989 has gone to people 55 and older, according to Federal Reserve data. Wealth has doubled since 1989 in households headed by older Americans.

Not so for younger Americans. Households headed by people in their 20s, 30s and 40s have barely kept up with inflation or have fallen behind since 1989. People 35 to 50 actually have lost wealth since 1989 after adjusting for inflation, federal data show.

Older people have always been wealthier than younger ones. What's changed is the disparity between the generations. Old people have been racing ahead, helped by government retirement benefits. Young people are running in place, partly because they're delaying careers to get more education. The growing gap between rich and poor has raised concerns about social justice, the fairness of the tax system and other issues. Congressional Democrats, Federal Reserve Chairman Ben Bernanke and President Bush have expressed concerns about economic inequality, although there is no consensus about what, if anything, should be done.

Much attention has focused on the multimillion-dollar paychecks of corporate chief executives and hedge fund managers, who've enjoyed windfalls at a time when the wages of ordinary workers have stagnated. But the graying of wealth and income may be the most important twist in the new inequality.

The implications are far-reaching and can turn conventional wisdom on its head. Social Security and Medicare increasingly are functioning as a transfer of money from less affluent young people to much wealthier older people. Because the older generation hasn't set aside enough money to

cover promised government benefits, young people will have to make up the difference or older people will face benefit cuts. The financial shortfalls of Social Security and Medicare over the next 75 years are so large — \$340,000 per household — that they dwarf the wealth of every age group. This hidden debt will make it a challenge for young people to accumulate as much wealth late in life as their parents have.

A growing imbalance

In the USA, income typically peaks at age 57 and wealth tops out at 63, according to the Fed's Survey of Consumer Finance. Wealth describes a person's net worth — assets minus debts — and reflects a lifetime's accumulation of income, investments and inheritances. Income measures how much a person earned in a single year.

Inequality *within* age groups hasn't changed much. People in their 30s or 60s have roughly the same wealth distribution among themselves as in 1989. What's changed is inequality *between* age groups.

Older people are thriving in wealth and income. Younger people are not. How wealth and income have changed for two age groups, after adjusting for inflation:

- **Ages 55-59:** Median net worth — the middle point for all households — rose 97% over 15 years to \$249,700 in 2004, the most recent year for which data is available. Median income rose 52%.
- **Ages 35-39:** Median household net worth fell 28% to \$48,940. Median income fell 10%.

The increase in the wealth of older people tracks a sharp reduction in elderly poverty that began in the 1960s, when Medicare was introduced and Social Security benefits were improved. The wealth gap between young and old is on a path to grow even more extreme. Baby boomers — 79 million people born from 1946 to 1964 — are entering their years of greatest wealth and maximum government benefits. Today, the oldest baby boomer is 61. The youngest is 43. As tens of millions of people head into their years of peak wealth, inequality could soar until baby boomers pass on inheritances to their children or grandchildren.

The inequality debate has focused mostly on the super-rich, who have been getting super-richer. The top-earning 1% of taxpayers — those who make more than \$310,000 annually — collected 17% of total income in 2005, up from 13% in 1989 and 8% in 1975, according to Internal Revenue Service data analyzed by economists Thomas Piketty at the Paris School of Economics and Emmanuel Saez of the University of California, Berkeley.

IRS data don't include information on age, race and education. A *USA TODAY* analysis of Federal Reserve and Census data found that demographics — especially age — could be the most important and overlooked factor behind the widening gap. Most wealth accumulation happens rapidly and late in life — after the kids' leave, when income is high, debts drop, 401(k) accounts fatten and home equity swells, according to federal data. The safety net — Social Security, pensions and Medicare — also has resulted in big increases in income for the elderly and a sharp decline in the rate at which they dissipate their assets in old age. Most people over 60 have no mortgage debt, no credit card debt and no car loan.

Trends for younger people have gone in the opposite direction. Mortgage debt peaks for people in their late 30s, the same time they have the most kids at home. About 11% are at least 60 days behind paying on some debt. Younger generations now delay the start of wealth accumulation. They postpone careers to get more education. They marry later (delaying the financial benefit of a shared household), have children later (delaying the arrival of lower-cost, kid-free days) and inherit money later (their parents live longer).

Younger people may not look poor. They have more stuff than ever — more valuable houses, cars and other assets. But they are so much deeper in debt than their parents — student loans, credit cards, mortgage, car loans — that their net worth has shriveled.

What's not clear is whether today's younger people will catch up. Will they reap financial rewards late in life as their parents did? "Young people have a great future ahead of them, but the rules of wealth creation have changed," says economist Kay Strong of Bowling Green State University in Ohio. She says young people will have to work longer and switch jobs more often than their parents for financial success. "The baby boomers were the last generation able to ride the old industrial economy that let you hold one job for a long time and retire with a pension," says Strong, 54. "The new economy is going to require people to adapt, hold more jobs over a lifetime and give up the concept that you will retire at 62." *Source: USA Today, May 24, 2007*

Volunteering Promotes Good Health

A number of studies are showing that the act of serving in a volunteer capacity in itself promotes good physical and mental health. Volunteering has a positive effect on social psychological factors such as one's sense of purpose in life. Volunteering may also enhance one's social network to buffer the impact of stress and disease. Particularly for the boomer generation who are more active in volunteering efforts, the health benefits of volunteering may have a positive impact on their later health.

The corporate for National and Community Service recently published a report on the health benefits of volunteering. Access the full report at www.nationalservice.gov/pdf/07_0506_hbr.pdf.

KEY RESOURCES IN AGING

Growing Older in America: The Health & Retirement Study

There is no question that the aging of America will have a profound impact on individuals, families, and U.S. society. The Health and Retirement Study (HRS), sponsored by the National Institute on Aging under a cooperative agreement with the University of Michigan, follows more than 20,000 men and women over 50, offering insight into the changing lives of the older U.S. population. Launched in 1992, this multidisciplinary, longitudinal study has become known as the Nation's leading resource for data on the combined health and economic conditions of older Americans.

Growing Older in America: The Health & Retirement Study describes the breadth and depth of the HRS to help familiarize a broad range of researchers; policymakers; media; and organizations concerned with health, economics, and aging with this data resource. Published in 2007, this colorful data book describes the HRS's development and features and offers a snapshot of research findings based on analyses of the Study's data. Sections of the report look at older adults' health, work and retirement, income and wealth, and family characteristics and intergenerational transfers. More than 65 figures and tables illustrate the text. The full report is available at www.nia.nih.gov/NR/rdonlyres/D164FE6C-C6E0-4E78-B27F-7E8D8C0FFEE5/0/HRS_Text_WEB.pdf

National Guideline Clearinghouse

The National Guideline Clearinghouse is a public resource for evidence-based clinical practice guidelines. The Clearinghouse is an initiative of the Agency for HealthCare Research and Quality (AHRQ) of the U.S. Department of Health and Human Resources.

The purpose of the Clearinghouse is to provide health professionals and other health providers an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination and implementation.

Key components of the guidelines include:

- Summaries about each clinical guideline and its development

- Links to full-text guidelines when available and/or ordering information for print copies
- PDA downloads of the complete summary for all guidelines represented in the database
- Guideline comparison utility to do side-by-side comparisons for two or more guidelines
- An electronic forum for exchanging information on clinical practice guidelines
- A searchable annotated bibliography for further publications and resources about guidelines.

Access the National Guideline Clearinghouse at www.guideline.gov.

Also visit the LSN website's page, "Resources and Links" and click on the "Health, Wellness, and Clinical Issues" to access the Clearinghouse and numerous other valuable resources. [\[www.lsn.org/resources/resources.htm\]](http://www.lsn.org/resources/resources.htm)

The State of Aging and Health in America 2007

Last updated in 2004, the Centers for Disease Control and Prevention and the Merck Foundation recently released an updated report, *The State of Aging and Health in America 2007*. By 2030, the number of Americans aged 65 and older will more than double to 71 million. Subsequently, the nation's health care spending is projected to increase by 25% due to demographic shifts unless improving and maintaining the health of older adults is more actively addressed.

This report presents the most current national data available on 15 key health indicators for older adults related to health status, health behaviors, preventive care, screening, and injuries. A "State by State" report card compares these data for each state.

Model intervention programs such as reducing fall-related injuries are also featured in this latest report. Access the full report at www.cdc.gov/aging/saha.htm.

"A Healthier US Starts Here" – A CMS Prevention and Wellness Initiative

The Centers for Medicare & Medicaid (CMS) Prevention Tour Bus is traveling to the 48 continental states this summer. Government officials and national groups launched the tour to "motivate seniors and others with Medicare to make the most of Medicare's preventive services." CMS lists Medicare medical nutrition therapy (MNT) for diabetes and chronic renal disease among its preventive services. The goal is to promote these preventive services to beneficiaries, families, caregivers, health professionals, community organizations, civic and state leaders and others who want to help people live longer, healthier lives.

The tour will also teach people how to make the most of a special prevention-targeted CMS website "MyMedicare.gov" – a one-stop, user friendly website designed to give registered Medicare users access to personalized information on benefits and services. CMS is also making available to providers a toolkit that includes publications, training materials and a video loop so that all can work together to ensure that "A Healthier US Starts Here!" Click the following link to access materials: http://www.cms.hhs.gov/MyHealthMyMedicare/02_HealthierUS.asp