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RURAL AGING IN AMERICA: PROCEEDINGS OF THE 2017 CONNECTIVITY SUMMIT

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Rural Aging in America: Proceedings of the 2017 Connectivity Summit

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Editorial

Creating a Movement to Transform Rural Aging

David B. Nash, MD, MBA, with Donato J. Tramuto,
and Joseph F. Coughlin, PhD

Each day 10,000 people reach age 65 in the United States, a trend that is projected to continue through 2030.¹ As we strategize about how to address the needs of our country's aging population, we must redefine what it means to age well in the context of contemporary society. Today, healthy aging is not just about living *longer* but about living *better*. An individual's health and quality of life are influenced by many variables outside the traditional purview of health care services delivery (eg, accessible and affordable housing, healthy foods, reliable and convenient transportation, social opportunities, access to affordable quality health care and community services). These social and environmental determinants are the backbone of population health, and there is growing recognition of their vital importance. The consequences of neglecting these determinants can vary based on geography; in rural areas, the potential for a negative impact on quality of life is amplified, especially for older adults.

Compared to their urban and suburban counterparts, older adults living in rural communities are at a disadvantage in terms of available services, resources, and activities and the social "glue" these provide. Although it may come as a surprise to many people living in the country's more populous areas, approximately 25% of Americans older than age 65 live in a small town or other rural area.² In some states, the percentage is much higher; for example, in Maine, 58% percent of adults older than age 65 live in rural areas.

Rural communities have a higher prevalence of chronic disease, a higher disability rate, a lower prevalence of healthy behaviors,³ and a widening gap in life expectancy⁴ relative to the nation as a whole. Moreover, they face additional obstacles and challenges:

- Cash-strapped local governments.
- Difficulty forming community partnerships because of proximity challenges.
- Migration of younger individuals to cities for career and social opportunities, resulting in a smaller pool of potential caregivers.
- Struggling small businesses and dwindling economic opportunities.
- An aging housing stock that also may be unsafe (eg, in need of repairs, containing falls risks, inaccessible for a person with mobility challenges).
- A raging opioid crisis that has turned many grandparents into caregivers.
- Inadequate resources available to meet the broad range of needs among older adults.

How can we overcome these considerable challenges and build a strong foundation for improving the health and well-being of rural-dwelling older adults? A comprehensive solution is beyond the reach or resources of any single group or organization working in isolation. Progress in addressing the seemingly intractable problems in rural health will take strong leadership, recognition of the considerable power of communities, and creation of collaborative partnerships that leverage their combined resources and skills to develop meaningful solutions to difficult problems – something that has become known in the business world as "collaborative IQ."

Tivity Health and Health eVillages, the MIT AgeLab, and the Jefferson College of Population Health are committed to working together to identify strategies that will ensure the brightest future possible for aging Americans. To that end, we partnered to organize and convene the inaugural Connectivity Summit: A Catalyst for Change in Rural Aging on June 21, 2017, bringing together key stakeholders from multiple disciplines and sectors of society to share ideas and work toward implementing solutions to some of the most pressing problems described above.

Our mission was to initiate a movement that would elevate the importance of the critical situation facing rural-dwelling

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older adults. The Summit increased our original “collaborative IQ” (as experts from the fields of aging, technology, and health care) by 10-fold as it extended the conversation and connected with experts from government, business and academia, as well as nonprofit, faith-based, and community organizations.

“Coming together is a beginning.
Keeping together is progress.
Working together is success.”
Henry Ford

What follows are the proceedings of this dynamic meeting that brought together committed partners with diverse sets of talents and resources and a passion for making a difference in the lives of others. We hope that it inspires you to join us on this journey to help today’s older adults and future generations to age healthfully and live more fulfilling lives.

Introduction

Closing out the second decade of the 21st century, we have entered a new world of aging, one in which the image of retiring to a lounge chair has given way to a vision of healthy, active, socially-connected living. As the youngest members of the baby boomer generation quickly approach retirement age, the health care sector has been gearing up to accommodate their evolving needs and expectations. Wellness programs and activities (eg, SilverSneakers) and targeted education/support programs are widely available to help the growing population of older Americans achieve their optimal quality of life and successfully manage the age-related chronic conditions (eg, diabetes, heart disease, hypertension, arthritis, hyperlipidemia) that frequently arise during this stage of life.

With the anniversaries of Medicare (50th) and Social Security (75th) in 2015, the nation celebrated the great strides that have been made in addressing the physical health and financial security needs of older citizens. Although considerable progress has been made, it must not be permitted to overshadow the challenges that remain. In particular, there are substantial regional disparities that limit residents’ potential for vitality as they reach retirement age. Although the health care sector has anticipated the needs and expectations of the baby boomer generation and targeted initiatives accordingly, relatively few of these programs and resources are allocated to, or available in, rural areas.⁵

The term “rural” is used often, but there is no single standard for the designation, even under Federal government criteria; it is defined largely within the context of regional geography. The US Census Bureau defines rural as any population, housing, or territory that is not an urban area with a densely settled core.⁶ However, most of the rural population lives near one of 2 types of urban areas defined by the Bureau (“urban clusters” with populations of 2500 to 50,000, and “urbanized areas” with populations of 50,000 or more). The Office of Management and Budget uses an alternate, county-based definition of rural⁶ (ie, nonmetropolitan counties that are outside of a metropolitan or micropolitan statistical area). This description encompasses disparate areas – from small towns to frontier and remote areas – with different characteristics (eg, Native Americans have unique cultural needs

and reservations are often in very remote locations). Creation of a broad and unified definition of “rural” that is inclusive of the intensity and density of accessible activities and services also may help unify efforts to impact these communities.

The primary concerns that affect the health and well-being of all older Americans are access to health care and support services (including transportation and mobility support), nutrition, housing, and social isolation. For those living in rural areas these concerns are exacerbated by the geographic isolation that requires them to travel greater distances to obtain services of all types, the relative lack of infrastructure and connections (transportation systems, high-speed broadband, community centers), and the relative scarcity of resources because of economic constraints. The resultant social isolation can be an exceptionally challenging problem for rural-dwelling individuals who may also be trying to cope with food insecurity, mobility challenges and chronic health conditions.

There are approximately 10 million people ages 65 and older living in rural America today; in fact, 1 out of every 4 older adults lives in a small town or other rural area.⁷ Relative to their counterparts living in urban areas, statistics reveal that rural populations experience risk factors (geographic isolation, lower socioeconomic status, limited job opportunities) that contribute to health disparities and lower life expectancy. Rural residents receive lower Social Security and pension benefits than their urban counterparts, particularly rural-dwelling females with lower lifetime wages and greater longevity.⁸ In addition, they tend to have a higher prevalence of chronic disease, a higher rate of disability, a lower prevalence of healthy behaviors, and fewer health professionals available to provide the services they need.⁹

Geographic isolation requires rural residents to travel greater distances to fulfill basic needs such as quality health care, prescription medicines and healthy food. The number of physicians per 10,000 people is approximately 30% lower in rural communities than in urban areas,¹⁰ and travel to an urban center is often required for specialist services. Rural areas typically lack the infrastructure and connections required to transport people where they need to go, attract quality services to the community, and avail modern technology for in-home support. For example, 53% of rural area residents lack high-speed broadband (25 Mbps/3 Mbps of bandwidth) access compared with 4% of those living in urban areas.¹¹

According to the American Association of Retired Persons (AARP), 87% of people older than age 65 reported the desire to remain in their current homes and communities. However, aging in place is not a practical option for many older Americans living in rural areas because of limited access to preventive services, physical and behavioral health treatment options, and home health services. As younger generations move away, there are fewer caregivers to provide support and comfort. Moreover, the combination of proximity challenges and limited options for organized activities often results in significant social isolation for older adults who choose to remain in rural areas. According to the Gallup-Sharecare Well-Being Index, the widest gap between rural and urban communities across all aspects of well-being occurs with respect to social well-being.¹² In fact, social isolation is as predictive of mortality as clinical risk factors^{12,13}; older adults living in rural communities are more likely to be admitted to a nursing home because of a lack of the support necessary for aging in place.¹⁴

Many of today's rural communities struggle with challenges that stem from the root causes described herein. For example:

- Younger people tend to move away to seek better career opportunities and, in so doing, diminish the potential workforce pool and disrupt the family fabric that has traditionally provided support to the older population.
- The recent economic upturn has been slowest to take hold in rural America; in some cases, there has been no upturn at all.¹⁵
- In rural communities, the opioid issue often manifests in the form of elderly parents of addicted children caring for their grandchildren.
- It can be difficult to access culturally or linguistically appropriate services for rural populations who tend to be overwhelmingly non-Hispanic whites or, in specific regions, other minority groups.⁹ In particular, Native Americans have distinct needs.

In addition to evaluating the core issues of aging in rural America, it is important to consider the direct effect of associated policy decisions on the quality of life for older adults; eg, home- and community-based services versus institutional care, Medicaid funding, housing, transportation, communication infrastructure, and access to quality health care and social service programs. The current decade has been notable for ongoing controversy over how to make the best use of our health care resources. Regardless of the final resolution on the policy front, the likelihood is high that the focus will remain on population health management under value-based care delivery and reimbursement models.

Rationale for and goals of the Connectivity Summit

Despite their considerable challenges, rural communities have strengths that can be leveraged to improve the well-being of their residents. Although the Gallup-Sharecare Well-Being Index showed a significant overall deficit in well-being for rural-dwelling older adults versus their urban counterparts, it revealed relatively higher community well-being (pride in the community, feelings of safety and security) and a stronger sense of purpose among rural residents.¹²

Today, each organization and agency works independently to develop and implement interventions and programs that address a broad range of concerns. Achieving optimal health and quality of life outcomes for older adults living in rural America will require targeted, innovative, solutions-based thinking from a broad-based coalition of leaders from every sector: corporations, academia, health care, government, and nonprofit organizations (including faith-based institutions). Given the urgency of the issues, and the potential impact on society as a whole, there is an enormous opportunity to make a positive difference in the health and well-being of rural-dwelling older adults through collaboration (ie, information and resource sharing, program scaling, policy advocacy efforts to communicate these issues to governmental and public entities). To that end, Tivity Health, Health eVillages, and the Massachusetts Institute of Technology (MIT) AgeLab partnered with the Jefferson College of Population Health to organize the 2017 Connectivity Summit on Rural Aging, held on June 21, 2017, that brought together some of the country's leading experts

to focus on this important topic. The Summit was convened in Portsmouth, NH, which borders southern Maine, the state with the nation's highest median age and where the proportion of older adults is projected to almost double between 2000 and 2030.¹⁶ The 2010 US Census revealed that 61.3% of Maine's population lived in rural areas.¹⁷

In welcoming participants, Donato Tramuto (Chief Executive Officer of Tivity Health) conveyed the overarching goal of the Summit – to foster a nationwide *movement* by means of:

- Partnering to identify the unique challenges of rural aging,
- Using the participants' Collaborative IQ to create targeted solutions, and
- Sharing the outcomes to inform policy debates and educate industry leaders and consumers.

Joseph Coughlin, PhD, of MIT's AgeLab, served as the event moderator and opened the formal program with a brief anecdote to set the context for the morning's presentations. When asked by a reporter about why she still enjoyed life, 119-year-old Sarah Knauss replied, "I have my health and I can do things." Healthy aging is not simply about living longer, it is about living *better*. Coughlin noted that heightened awareness of an important issue and the related changes made to address it usually occur as a consequence of a crisis or an event that triggers action. However, policy change also comes about as a result of individual "issue entrepreneurs." To that end, Coughlin urged participants to be "issue entrepreneurs" in an effort to place the issue on the national agenda and drive change to improve the quality of life for older adults in rural America.

The focus was on developing interventions to enable people to age in a way that has meaning, and on maintaining connectivity with the community at large by leveraging the right combination of technology and hands-on services. The immediate objective was to identify and/or describe pilot programs and actionable items that the participants could work on to move forward, together, over time.

Each action-oriented session was designed to elicit ideas and stimulate conversation among participants to identify common needs for rural aging populations, with special attention to developing integrated strategies to improve access to health care and services and reduce social isolation.

Summit Proceedings

Roundtable 1: *The Power of Community – Enabling Social Connections and Access to Health Resources through Community-Based Programs*

To set the stage for discussion, several participants were invited to share information about their work in the rural aging field on the community level.

Brita Roy, MD, MPH, MHS (Assistant Professor and Director of Population Health, Yale School of Medicine), whose research focuses on identifying positive social and psychosocial factors that allow people to live healthier lives, has found that individuals who exhibit optimism and have strong social supports have a lower risk of cardiovascular disease. At the community level, she noted that individuals are greatly influenced by the places they live and the choices available to them – this includes the built (or physical) environment and social factors such as community resilience and social cohesion. Community-based participatory research shows that, by identifying and leveraging these assets

and resources, communities can be empowered to help lower costs and improve health.

Dr. Roy is also a participant in the 100 Million Healthier Lives (100M Lives) (100mlives.org) metrics workgroup. Recognizing the importance of improving quality of life for disadvantaged groups and older adults, 100M Lives is working to help communities build road maps to become Communities of Solution. These are characterized by strong relationships, an ability and willingness to address inequities, and a positive approach to change that supports vulnerable populations such as older adults. Leadership is key; Communities of Solution lead together, lead from within, lead for outcomes, lead for equity, and lead for sustainability. The initiative website houses an Aging Well Hub (www.agingwellhub.org/), a group of communities focused on improving the well-being of older adults. Any interested person or group may join the initiative or hub.

Sandy Markwood, MUEP (CEO, National Association of Area Agencies on Aging – n4a) stated that the overarching goal of n4a and its members is to support older adults to live with dignity and independence in their homes and communities for as long as possible through the provision of a broad range of community-based, on-the-ground services and supports. The Association's members include more than 622 Area Agencies on Aging and 250+ tribal aging programs that collectively engage and support millions of older adults and their caregivers in every community in the United States by offering services (eg, home-delivered meals, transportation, personal care, chore services, senior center and adult day programming) that promote wellness and combat social isolation.

More than 40% of agencies' programs explicitly serve Americans living in rural or frontier areas. Recognizing the unique nature of rural areas, n4a has a rural caucus that is convened by the Association to discuss and develop strategies to address the primary issues and challenges to health and well-being, especially assuring access to home care services and support and responding to increased needs for care coordination and mental health services in rural America.

Although it is estimated that 20% of the US population will be older than age 60 by 2020, in rural America the percentage will be higher. The fastest growing segment of this demographic is the population of older adults older than age 85,¹⁸ more than half of whom likely will need to rely on formal or informal supports to continue living independently. Statistics show that 1 out of every 3 people over age 85 struggles with Alzheimer's disease or a related form of dementia¹⁹; 60% of these people live in the community. Given that America is aging rapidly, there is a critical need for communities to value and support residents as they age by developing age- and dementia-friendly communities.

Despite the urgent need for aging services and supports, traditional governmental funding sources are not growing to meet the increasing demand. For that reason, the Aging Network is looking to partner with the health care, transportation, and volunteer/philanthropic sectors for the financial and human resources needed. Different approaches that leverage but do not rely on government funding must be found. For example:

- Through the National Aging and Disability Transportation Center (co-led by n4a and EasterSeals), n4a is supporting the development of expanded volunteer driving programs in rural communities.

- Working with the national coalition Dementia Friendly America, n4a is helping the community of Sheridan, Wyoming, support residents living with dementia and their caregivers by engaging businesses and faith-based and other volunteer organizations.

According to *Gillian Sealy, MGPH (CEO, Clinton Health Matters Initiative, Clinton Foundation)*, the Health Matters Initiative (Initiative) views communities as the centers of innovation because they are best equipped to describe their own challenges and suggest solutions. The County Health Rankings uses a lens of social determinants of health (eg, built environment, community safety, sexual activity, alcohol/tobacco/drug use) to frame their work with 7 communities, 2 of which are in rural areas (Galesburg, Illinois and Adams County in southwestern Mississippi).

The Initiative addresses a variety of unique needs in each of the communities including: determining readiness for change, guiding communities to resources to meet physical and emotional needs, ensuring access and resources for health and well-being, promoting engagement in civic and social activities, and encouraging independence and empowerment via inclusion in discussions. Partnerships with purpose, policy review and change, and feasibility/sustainability over the long run are key elements in the Initiative's program.

Communities are beginning to realize that they must develop their own solutions. The Initiative functions as a neutral convener and facilitator in eliciting, cultivating, and implementing the communities' ideas.

Lori Parham, PhD (AARP State Director – Maine) described ways in which AARP works to enroll US communities in the international network of Age-Friendly Communities, a collaborative endeavor with the World Health Organization. Based on feedback from people ages 50 and older, WHO defined 8 domains for successful aging in place, including transportation, affordable housing, and civic engagement. AARP Maine works with 47 mostly rural communities across the state to provide technical assistance and support for local governments and community residents. Once a community is enrolled in the network, AARP focuses on community building and support at both the local and regional level. With AARP's guidance, communities conduct a thorough assessment to identify local assets and those of neighboring areas, with the goal of pooling resources if possible. They also identify local needs and areas for improvement. AARP has supported communities in developing local transportation programs, winter support programs, and age-friendly business programs. It also promotes local activities (eg, Free Coffee Fridays, walking clubs, gardening clubs).

Key outputs from the group discussion

Transportation. Transportation for medical and non-medical purposes was viewed as a necessity by many summit participants.

A primary focus for many volunteer organizations is helping transport older adults to their medical appointments. One challenge faced by these organizations is the volunteers' unease with requirements regarding background checks, personal insurance liability coverage, and bonding. To mitigate this issue, some local governments have enabled volunteers to be covered under their umbrella liability policies. Because the cost of group policies is generally high, some organizations/

agencies are beginning to work with state governments on legislation to protect volunteer drivers with a policy.

Ride-sharing companies such as Lyft and Uber are working with local governments and the Veterans Administration on a process to provide transportation services with billing directed to an entity other than the consumer. AARP Foundation described an upcoming pilot program with Lyft; payers have an incentive to support the initiative because it helps people get to their doctors. One caveat: Lyft may not be “rural” enough yet.

Some enterprising organizations are optimizing underutilized resources, which otherwise would be idle, to transport older adults to social or recreational activities or shopping. It is important to keep in mind that, for rural-dwelling older adults, travel to appointments itself often serves as a social event.

Power of community partnerships. Even in the face of a declining population base and employment challenges, community pride is strong in rural communities. One important opportunity lies in helping community-based organizations leverage the power of partnerships; for instance, partnering with Habitat for Humanity to work with volunteers on home repairs, partnering with the Masons to provide handyman services, or bringing older adults into preschools to foster intergenerational connections in communities. A compendium of success stories might serve as part of an evidence-based approach to solving some of these problems.

To help scale services throughout rural communities while preserving the uniqueness of each and accommodating their cultural differences, some organizations hire regional directors from the community. It is important to be culturally and linguistically appropriate with communication and educational materials. The 100 Million Lives Initiative is taking a similar approach, and regional leaders are now responsible for partnering with other nearby communities.

Roundtable 2: *Technology and Rural Health: Innovative Solutions to Bridge the Distance, Improve Care, and Deliver Programs*

Several participants were invited to share information about their work on technological issues in the context of aging in rural communities.

Anthony Versarge, MBA (Product Management Director - Connected Health, Comcast) stated that many cable companies began as connectivity companies for rural communities. An important goal for Comcast is to bring health and wellness options into homes (eg, leveraging platforms to enable adult children to check on their aging parents and to help ease the burden of care coordination). Technology can help improve the quality of life for older adults, their family supporters, and caregivers by increasing engagement and facilitating social interactions. For example:

- Partnered with academic medical institutions and retirement communities to create 150 three- to five-minute videos on healthy aging that are delivered via Comcast’s On Demand service.
- Low-Power Wide-Area technology can be employed in a device with a multiyear battery to facilitate low-power home monitoring.

Portia Singh, PhD (Research Scientist, Philips Healthcare) described the Active Care Solutions Innovation Center where 150 researchers look to the academic and advocacy communities for future direction. The population health management research division has a *hospital-to-home business unit* (telemedicine, prevention of readmissions) and a *personal health arm* (technologies for healthy living and wellness, home monitoring for chronic conditions). Examples include:

- Connected Aging examines how families and communities organize, then develops and implements initiatives to support this.
- Care Partners App provides a log and decision support for an individual.
- The Qualitative Research team works on ways to capture data sources that are not otherwise readily available. Caregiver anecdotal notes are collected over time to provide insights regarding care decisions.

However, technology is not always the answer. Although machine learning is often positioned as a replacement for humans, it is most useful in supporting and augmenting the data to improve care decisions.

Jim Firman, EdD (President and CEO - National Council on Aging) stated the overarching goal of his organization: achieving meaningful improvement in 10 million lives by 2020 by means of 4 core strategies: (1) facilitate collaborative leadership (government relations); (2) identify 2000 community not-for-profit organizations to deliver solutions; (3) develop and scale innovation; and (4) promote social enterprise (partnering with business). He provided an update on the Council’s work with regard to rural solutions as well as universal designs. With a major focus on improving access to benefits, the Council is rethinking how social services are delivered and accessed. The plan is to (1) employ people, (2) enlist friends/family, and (3) engage health care providers. For example, an evidence-based health promotion and fall prevention initiative involved partnering with Neal Kaufman, MD, to offer face-to-face and online diabetes prevention programs.

Using education and behavior change tools, the Aging Mastery Program encourages people to take actions that will improve their quality of life. The program operates in 200 communities, 55 of which are in rural areas. Public health solutions and social enterprise solutions (financial planning, socialization) are essential to help people make this major life transition over 20 years. There is an opportunity to meet people where they are; older people spend many hours per day watching television; this can be leveraged on a massive scale. For instance, a Washington State pilot uses community-based programming for digital devices, TV, and in-home monitoring. Now is the time to take responsibility for the inevitable challenges associated with a growing population of older adults.

Key outputs from the group discussion

High tech vs. high touch. It is not a matter of either/or but rather how to integrate them in a way that makes the best use of both. Technology is available but the connections needed are not happening on a large enough scale.

Consumer engagement in using technology. There is concern about the paucity of trust in this country, particularly

as we grow older. Technology is efficient but lacks the empathy of human interaction, and it is not necessarily a trusted medium when people are frightened. We must develop solutions to help to overcome this limitation.

State universities in rural areas might be helpful in recruiting younger people to connect with elders to provide support regarding technology use. One community college is offering the first associate degree program in gerontology in the state of Maine.

Focus on the end user. Codesign activities are crucial to successful technologies, yet users and their caregivers are only minimally involved in the design and development of the technologies created for them. Involve communities in the codesign of prototypes to be sure they are affordable, user friendly, portable, minimally intrusive, and stylish.

Broadband connectivity. If we think of connectivity as a basic utility, there is insufficient penetration in rural communities – and low-income older adults present the last frontier. Internet Service Providers (ISPs) must extend eligibility models to older adults (not just households with children). Copper wire maintenance must be replaced with substantial, affordable broadband. A potential immediate action might be an online exchange and marketplace to facilitate connections between groups. One caveat: it is expensive to keep a broadband product up to date, and an outdated product is useless to the end user.

Roundtable 3: An Integrated Experience: The Exponential Potential of a Collaborative Approach to Rural Aging

To set the stage for discussion, several participants were invited to share information about their work in rural aging with respect to leveraging collaborations.

John Feather, PhD (CEO - Grantmakers in Aging) reported that his organization works on the full range of aging – health, housing, arts, and rural aging. According to Feather, a paltry 2% of philanthropy in America is now focused on aging,²⁰ and only 7% of that amount is geared toward rural aging. The current concept of philanthropy for children as an investment and philanthropy for older people as an expense must be reframed in a way that articulates the return on investment on charitable giving to the aging in terms of its positive impact on services, economic security, and health care. Collaborations can be difficult because organizations rarely share the same vocabulary and the drivers are different. Grantmakers in Aging prefers to approach aging in a positive manner, and the contributions of partners can make a positive difference.

Bob Blancato, MPA (President - Matz, Blancato & Associates) spoke to the need for an advocacy strategy and closer examination of imminent threats to rural-dwelling older adults' access to resources. For instance, Medicaid cuts likely will have a more profound effect on rural communities where enrollment is higher than in urban centers. Although 11% of US physicians work in rural areas, 20% of the population lives there. There are budget proposals under consideration that would cut the community block grants that support the 7 state learning collaboratives in rural areas. A potential undercount in the upcoming 2020 census would

have serious consequences for rural communities. The current administration must be held accountable to the people who elected them, especially given that they predominantly represent rural communities.

David Nash, MD, MBA (Dean – Jefferson College of Population Health and member of the Humana Board) spoke to innovations in the way insurance companies are managing patient populations. He described ways in which Humana is working toward the Bold Goal, a 20% improvement in the health of the population served by 2020. The Medicare Advantage Program has grown by 40%, and Humana is experiencing per-member-per-month savings by means of electronic monitoring for members with chronic conditions. He noted that there is no shortage of physicians per se; rather, physicians are distributed inequitably in the United States, where there are 3 specialists for every primary care physician.

Key outputs from the group discussion

Workforce issues. A revolution in clinical care is taking place. Advanced practice nurses (APNs) trained in gerontology are obtaining independent practice licenses without the traditional requirement for physician supervision. APNs can be positioned to fill gaps in access and care management in rural communities by providing preventive care and overseeing coordinated care delivery.

In Maine, there are general workforce shortages that must be addressed. Even when they are able and willing to pay, older adults are unable to find people to help with tasks such as home maintenance, cleaning, and cooking, among others.

Role and future of critical access hospitals. Via Medicare reimbursement, the federal government covers 101% of costs at 1300 critical access hospitals.²¹ Some experts have forecasted that these hospitals will be forced to close within 40 years. Several important questions must be addressed:

- Should critical access hospitals be a safety net for acute care?
- What is the role of hospitals/health systems, and what is the incentive for these hospitals to manage care?
- Should there be a hub for activities that support at-risk populations?
- What is the role of the 55 US health systems that currently cover 28% of the population?

Following the presentations, the participants separated into small discussion groups and brainstormed collaborative follow-up actions to develop solutions to some of the challenges identified during the morning session.

General Discussion and Recommendations

The Summit represents the first opportunity for interested stakeholders to cut across sectors and work toward a comprehensive action plan. Two major focus areas emerged from the 3 roundtable and breakout sessions: (1) the need for access to improved broadband service for low-income older adults, and (2) creation of a web portal designed to share information, promote communication and collaboration among public and private organizations across regions, and to provide access to models of excellence and success stories.

Recommendation: broadband service to low-income older adults

Broadband can serve as a foundational tool for implementing interventions that target social connectedness, telehealth, and workforce development. ISPs can be helpful in bringing people together to form the business and policy case around extending eligibility to low-income older adults. Broadband service could become the highway for delivery of existing services and products (eg, telemedicine, remote monitoring, health education) as well as new ones. Products could be leveraged to help individuals monitor and manage chronic health conditions without requiring a high degree of digital literacy on the part of the beneficiary.

A potential downside is that such a program would be heavily dependent on the broadband service providers for delivery. From a financial perspective, even \$10/month may be too expensive for some people. Subsidies may be available for those meeting income eligibility criteria. Achieving 100% access will require a long-term policy solution.

Recommendation: create a Web portal to support the rural aging movement

Use a web portal to link Summit participants' and other organizations' resources and knowledge rather than creating new compendiums. The Tri-State Learning Collaborative on Aging's website might serve as a small-scale model for sharing success stories. The new portal would facilitate interorganizational communication and the formation of partnerships. Potential benefits might include shared data systems, consolidation of services and entities to resolve issues (nonprofit, government, for profit), intergenerational integration, and collaborative approaches to program funding and insurance.

The portal also could be useful as an educational platform (eg, sharing curricula designed to train providers in caring for older adults, sharing program designs for teaching college graduates how to care for rural dwelling older adults).

Post-Summit Debriefing

Strategy and objectives

Based on discussions at the Connectivity Summit and current research, the organizers identified the following potential strategies and associated objectives for future consideration:

Reduce social isolation and loneliness

- Collaborate with leading organizations to establish a consensus on measurement and guidelines for impacting social isolation
- Use technology to enable social connectedness
- Leverage the SilverSneakers model and network to increase rural engagement in group activities

Ensure safe, quality housing options

- Technology or in-person options for assessing home safety
- Health and safety monitoring and caregiver enablement
- Provide alternative options for independent living

Improve access to health care and other social and community-based services

- Expand broadband availability
- Increase transportation options
- Explore technology solutions to improve access to quality health care

Empower communities to identify local strengths to build on for proactive, tailored solutions

- Local strengths and needs assessments
- Involvement of local leaders and organizations to develop and enact solutions
- Identify and activate local ambassadors/volunteers

Improve nutrition and end hunger

- Ensure a balanced daily meal for the at-risk population
- Ensure availability of fresh fruits and vegetables at 1 or more community location(s)
- Distribute tablets to provide education on selecting and preparing healthy foods

6–12 month action plan

The Summit organizers committed to the following steps:

- 1) Assure the rural aging “movement” that began at the Summit continues via communication and prioritized action steps that engage participants in, and attract new organizations and key leaders to, the effort.
- 2) Establish a communication hub and strategy with a focus on timely updates; sharing best practices, community engagement tactics, and other resources; and facilitating the execution of activities.
- 3) Identify key policy issues from the Rural Aging Summit that can be communicated to Capitol Hill and other key stakeholder groups.
- 4) Facilitate the visibility of policy issues and create a change-focused agenda for action.
- 5) Review the 2017 Summit recommendations and identify 2–3 pilots that can report progress in 2018.
- 6) Engage stakeholders and strategic partners in scaling ideas and strategy.
- 7) Frame and move forward with plans for the 2nd Rural Summit in 2018.

Conclusion

Individuals living in rural areas frequently encounter unique challenges that impede their access to services and opportunities for meaningful social interaction. These issues take on even more importance in the context of the health and well-being of rural-dwelling older adults. Various local organizations and agencies have undertaken independent initiatives to address the unmet needs of older adults, but their impact has been limited.

Programmatic and policy solutions will not arrive quickly. The most effective way to resolve them is by gathering interested stakeholders, across multiple relevant sectors, to pool their resources and collaborative wisdom using a collective impact model to create long-term change. The Connectivity Summit was the first step on a journey forward. The participants left inspired by their colleagues, energized to begin the

hard work ahead, and committed to making a difference for older adults.

Author Disclosure Statement

Dr. Skoufalos and Ms. Clarke are employed by the Jefferson College of Population Health; Ms. Ellis is employed by AgeLab at the Massachusetts Institute of Technology; Ms. Shepard and Dr. Rula are employed by Tivity Health, one of the funders of the Summit.

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