Post-Event Summary Report for White House Conference on Aging

Name of Event: National Gerontological Social Work Conference (NGSWC)

Date of Event: February 26 – March 1, 2005

Location of Event: The Times Square Marriott Marquis in New York, New York
(Include city and state)

Number of Persons attending: Approximately 1,000

Sponsoring Organization(s): CSWE Gero-Ed Center

Contact Name: Ashley Brooks

Telephone Number: 703-519-2077 **Email:** abrooks@cswe.org

Summary of the 2005 NGSWC

Since its introduction in 2003, the National Gerontological Social Work Conference (NGSWC) has served to disseminate gerontological resources to educators, students, and practitioners at the Council on Social Work Education (CSWE) Annual Program Meeting (APM). Just five years ago, aging was nearly invisible at the CSWE APM, with only one or two symposia offered. The annual NGSWC was initiated to change that by providing a highly visible national venue to feature and encourage social work educators' interest in gerontological social work research, teaching, and practice.

This year, the 3rd annual NGSWC was designated an official White House Conference on Aging event and was held in New York City from February 26-March 1, 2005. Due to this distinction and the visibility of aging and the NGSWC, there were more than 200 presenters from over 80 social work education programs taking part in 69 paper, symposia, and special presentations; 8 workshops; 10 roundtable discussions; and 34 poster presentations. Keynote speakers at this year's conference include New York City Commissioner on Aging, Edwin Méndez-Santiago and Dr. Dennis Kodner, Director of the Brookdale Center on Aging of Hunter College.

To celebrate the National Gerontological Social Work Conference's distinction as an official White House Conference on Aging event, this year the Association for Gerontology Education in Social Work (AGE-SW) and NGSWC hosted WHCOA roundtables. Roundtables were facilitated by experts in the geriatric social work from around the country and over 100 conference attendees participated. The attached resolutions are the results of this important event. Following the roundtable session, there was an honorary reception for Dr. Rose Dobrof of Hunter College, a pioneer in gerontological social work and founder of the *Journal of Gerontological Social Work.*

Please see the attached White House Conference on Aging Resolutions.

Summary of Resolutions for the
White House Conference on Aging
Council on Social Work Education's National Gerontological Social Work Conference & the
Association for Gerontology Educators in Social Work Roundtables
New York City, February 27, 2005

SOCIAL WORK WORKFORCE

Whereas social workers are a key member of the service team for older persons and their families in a wide variety of settings and a large cohort of social workers are approaching retirement age, resulting in a lack of sufficient workforce now and in the future; and
Whereas current workforce is in need of knowledge, skills or overall competency to provide services to an aging society; and
Whereas it is difficult to recruit new social workers to gerontological social work and retain the current work force due to low economic incentives, and retirement; and
Whereas there is a need to train the current work force so that they have the basic competencies to provide services to older adults and their families; and
Whereas there is a need to provide supervision to a workforce that is largely untrained.

THEREFORE BE IT RESOLVED by the 2005 White House Conference on Aging to:

Actively seek to attract and retain gerontological social workers by providing federally sponsored financial incentives such as loan forgiveness, student stipends, competitive and equitable reimbursement for services, senior practitioner fellowships, and continuing education funding.
Recognize that there will not be enough social workers to meet the needs of our aging society and as a result creative approaches must be used to provide supervision to the current and future workforce.
Require that economic incentives be created to keep social workers in the workforce longer to meet the expanding needs for their knowledge and experience as well as to train the workforce that will be required to work with older adults.
Require the creation of policies on the federal and/or state levels that provide incentives to recruit and retain gerontological social workers through such means as fellowships for senior practitioners, mentoring awards, and the development of community-based training modules that can be conducted in partnership with social work education programs.
Encourage schools and departments of social work to motivate students to consider careers in gerontological social work through financial and other incentives and to support the continuation of programs that have focused on building the aging competencies of both BSW and MSW students.
Encourage publishing companies to work together with social work education programs to infuse aging content throughout foundation textbooks.

MENTAL HEALTH

Whereas the 1999 Surgeon General's Report on Mental Health found that disability due to mental disorders, substance use or cognitive impairments in individuals aged 65 and over will become a major public health problem in the near future due to changing demographics; and
Whereas the 2003 President's New Freedom Commission on Mental Health identified as barriers to care:

- A fragmented service delivery system;
- Out of date Medicare policies;
- Stigma due to mental illness and advanced age;
- A mismatch between services that are covered and those preferred by older persons; and
- A lack of adequate preventive interventions and programs that aid early identification of geriatric mental illness; and

Whereas almost 20% of persons age 55 and over experience specific mental and cognitive disorders that are not part of the "normal" aging process including a prevalence rate of 11.4% for anxiety disorders (Department of Health and Human Services, 1999); and
Whereas as many as 20% of older adults in the community and up to 37% in primary care settings experience symptoms of depression (Department of Health and Human Services, 1999); and
Whereas older persons who are dually eligible for Medicare and Medicaid may lose access to medications that they had under their state Medicaid plan when the prescription drug benefit of the Medicare Prescription Drug Improvement and Modernization Act of 2003 takes effect on January 1, 2006; and
Whereas comorbidity of mental illness and substance abuse exacerbates symptoms and often leads to treatment noncompliance, more frequent hospitalization, greater depression and likelihood of suicide, incarceration, family friction, and higher service use and cost (Department of Health and Human Services, 1999); and
Whereas it is estimated that 17% of older adults misuse and abuse alcohol and medications and although the majority (87%) of older adults see a physician regularly about 40 % of those who are at risk do not self-identify or seek services for substance abuse problems and are unlikely to be identified by their physicians (Barry, et al., 2001; Substance Abuse and Mental Health Services Administration, 1998); and
Whereas undetected or inappropriately treated mental and behavioral health disorders lead to extraordinarily high rates of suicide among older adults and substantially increased risks of mortality from other diseases (people 85 years of age and older having a rate almost double [21 per 100,000], and older white men having a rate almost six times [65 per 100,000] the suicide rate of the general population [10.6 per 100,000]; and
Whereas there are effective interventions for most mental and substance abuse disorders experienced by older persons; and
Whereas older adults and aging baby boomers present a growing and widely diverse ethnic and cultural population that will present major challenges to the nation's public and private mental health, primary care, and substance abuse systems (Administration on Aging, 2004; Whitfield, 2004);
Whereas major national studies, including the 2003 President's New Freedom Commission on Mental Health, recognize that there is a severe shortage of practitioners in the mental health, behavioral health, and aging workforce to treat the mental disorders and substance abuse of older adults due to stigma and economic disincentives; and
Whereas, as the diverse baby boom generation ages, there will be increased demand for culturally competent geriatric mental and behavioral health practitioners; and
Whereas health and mental health professions often fail to provide basic curricula in geriatric mental health and substance abuse for all students

THEREFORE, BE IT RESOLVED by the 2005 White House Conference on Aging to support policies that:

Assure access to an affordable and comprehensive range of quality mental health and substance abuse services including:

- outreach
- home and community based care
- prevention
- intervention
- acute care
- long-term care;

Assure that these services are age appropriate, culturally competent, and consumer driven;
Amend statutes that address public and private health and long-term care insurance plans to:

- ***guarantee parity in coverage and reimbursement for mental health, physical health, and substance abuse disorders***
- eliminate exclusions based on pre-existing conditions
- ensure that benefits packages provide full access to a comprehensive range of professionally coordinated and quality services
- ensure that older persons who are eligible for Medicare have access to a full range of medications;
- eliminates disparities in reimbursement between geriatric mental health, behavioral health, and substance abuse practice and other areas of mental health and health care practice.

Promote the development and implementation of home and community-based care as an alternative to institutionalization through a variety of public and private funding mechanisms;
Support the integration of older adult mental health and substance abuse services into primary health care, long term care and community-based service systems;
Actively seek to attract new providers in mental health, particularly social workers, by expanding geriatric traineeships to non-physician providers, and target national financial incentives such as loan forgiveness programs and continuing education funding; and
Require that professional mental health and behavioral health education programs that receive federal funding infuse gerontological course work or rotation for all students; and mental and addictive disorders;
Encourage states to revise licensing and continuing education requirements so that geriatric mental health, behavioral health, and substance abuse training are required for all licensed health, mental health and social services professionals.

HEALTH CARE

Whereas U.S. healthcare generally does not focus on aging populations and the aged; and
Whereas there is need for a more efficient, cost-effective health care delivery system; and
Whereas Medicare and Medicaid historically and currently are focused on an acute care medical model and not chronic care model or transitional care;
Whereas Medicare and Medicaid as well a many of the health professionals do not address health promotion and disease prevention; and
Whereas significant barriers to quality health care exist in such areas as prescription drug plans; and
Whereas health care financing issues are exacerbated at the end of life; and
Whereas comprehensive chronic care necessitates a team approach that includes care management that addresses both physical and psychosocial needs.

THEREFORE, BE IT RESOLVED THAT by the 2005 White House Conference on Aging to:

Advocate that Medicare and Medicaid provide integrated and comprehensive chronic health care for older adults with chronic illnesses, and support model programs for such care.
Advocate that Medicare and Medicaid assign a chronic care management team (CCMT) to each patient from the time of first diagnosis of chronic health problem. The CCMT should include a physician, pharmacist, nurse, and social worker.
Advocate that Medicare and Medicaid promote comprehensive chronic care management that includes provision of support, information, and access to: Prescriptions, transportation, food, Home visits, etc. to transport to hospital; provide support until chronic care team/social worker arrives *or* calls chronic care social worker who advises emergency team.
Increase Medicare hospice eligibility criteria.
Advocate that Medicare and Medicaid require every primary care practitioner for older adults to be linked with a social worker to manage patient care.

END-OF-LIFE

Whereas there is social stigma associated with death and dying in our society; and
Whereas, end-of-life issues are broader than "death & dying" and include preparedness, grief, bereavement, trauma, sudden death due to accidents, natural disasters, and terrorism; and
Whereas the increasing diversity of the U.S. population creates varying ideas and beliefs about end-of-life issues; and
Whereas dying can be seen, in part, as a series of psychosocial crises.
Whereas there is major disparity between where people die (80% in a hospital or nursing home) and where they wish to die (at home); and
Whereas there is limited knowledge by the general population about advanced directives; and
Whereas people are dying in pain, despite the fact that most pain is treatable and advance directives are not being consulted until the very end of life, if at all; and
Whereas Medicare hospice eligibility rules limit the number of people who can be served by hospice; and
Whereas health care financing issues are exacerbated at the end of life; and
Whereas religious diversity is not considered with regard to dying experiences.

THEREFORE, BE IT RESOLVED by the 2005 White House Conference on Aging to:

Ensure that professionals trained in psychosocial issues, in particular social workers, must be part of the end-of life team approach to care.
Promote a major public education campaign about the realities of contemporary end-of-life issues (at professional, paraprofessional, and community levels).
Support funding for broad health and mental health profession education enhancement in the area of area of end-of-life and palliative care.
Assure that HHS requires education for first responders, human service professionals, and educators at all levels about EOL issues.
Increase Medicare hospice eligibility criteria.
Recommend and increase funding for EOL research and interventions.
Develop *national standards and portability for advanced directives that include cultural diversity issues.*

HOUSING FOR OLDER ADULTS

Whereas adequate shelter is the right of every individual in the United States, and too many older individuals live in unsafe and substandard housing, with some older people not having a permanent home; and
Whereas there is a documented need for affordable housing for older people, particularly since many are on low or modest fixed incomes, as well as a choice of housing options; and
Whereas studies have consistently documented that the overwhelming majority of older adults wish to "age in place", or remain in their current homes and communities; and
Whereas "elder friendly" communities, consisting of sufficient and convenient health, social, recreational and religious services and programs, and the availability of home repair and modification services, as well as universal design, promotes "aging in place"; and
Whereas there has been a steady decline in federally funded and subsidized housing for older adults, and a concomitant lack of integrated services with these housing programs; and
Whereas *there are a lack of incentives for private developers to build senior housing.*

THEREFORE BE IT RESOLVED by the 2005 White House Conference on Aging to:

Develop and advocate for incentives for developers to design elder friendly housing with array of "elder friendly" services (e.g., shopping, medical, places of worship);
Advocate for increased federal and state funds to provide incentives for developers to build affordable and accessible senior housing options (e.g., tax credits, mix of income);

Advocate for developer/CBO partnerships for inner city elders;
Require government funding for home repair and renovation programs;
Encourage the promotion of policies for intergenerational housing and service funding streams (e.g., HUD and DHHS);
Advocate for a minimum income level (retirement income) for older adults;
Develop waivers for family and friends to help frail older adults remain in their own homes (e.g., the Arkansas model); and
Fund demonstration projects to test new models of housing and service integration (e.g., converting public housing, evaluating assisted living options).

TRANSPORTATION

Whereas, *by the year 2020, more than 15% of older drivers will be over the age of 65; and*
Whereas, *drivers age 75 and older have the second highest accident rate of all drivers in the US, exceeded only by those under the age of 25; and*
Whereas*, in a study of motor vehicle trauma cases, hospital admission and fatality ratios were nearly twice as high for the 75-and-over population as they were for any other age group; and*
Whereas *there is an increased crash rate per mile driven for drivers over 70 as compared with other adult age groups; and*
Whereas, *most communities in the US require the use of an automobile to access services; and*
Whereas *there are no clear standards of when to stop driving; and*
Whereas*,* the inability to drive can lead to significant isolation for the elderly.

THEREFORE, BE IT RESOLVED THAT by the 2005 White House Conference on Aging to:

Advocate that the Department of Transportation and Department of Housing fund studies and demonstration projects to examine new ways to help meet transportation needs of older adults.
Encourage government agencies and the private sector (insurance companies) to support education of families and health and mental health providers about how to assess and intervene with older drivers.
Encourage states to reassess license renewal processes and insurance requirements for older drivers.

INCOME SECURITY

Whereas, without income from Social Security, 48% of older adults in the US would be under the poverty threshold, but with Social Security income, only 8% are under the poverty threshold; and
Whereas, 40% of those receiving Social Security are within 200% of the poverty level; and
Whereas changes to the Social Security should strengthen the program and not subject future retirees to income risks, reduced risks or special risks for single women and minorities; and
Whereas, health costs will absorb a higher share of seniors' income (and the GDP) in coming years; and
Whereas, many older persons wish to continue work after retirement.

THEREFORE BE IT RESOLVED by the 2005 White House Conference on Aging to:

Modify Social Security to allow for phased retirement and flexibility of work.
Eliminate the Retirement Earnings Test for all seniors collecting Social Security
Strengthen enforcement of the ADEA, a primary source of reported EEOC violation.
Eliminate or raise the Social Security wage cap (raise up to 90% of income level – about $140,000 and then tie to wage inflation).
Create sound federal programs to insure employer retirement plans such as 401K's against fraud and bankruptcy.
Strengthen SSDI as the Social Security retirement age is raised to cover blue-collar workers and people of color who have higher rates of disability.

Advocate for a national program to educate the public and social service providers about the SSI program, OAA programs such as AAAs, Meals on Wheels, and other community-based programs such as APS.

LONG-TERM CARE

Whereas, long-term care (LTC) is now an array of services such as adult day care, assisted living facilities (ALFs), nursing homes (NHs), paid or family caregiving; and
Whereas, since 1999 there has been a push towards home and community based care due to the Olmsted decision which emphasizes least restricted housing alternatives; and
Whereas there are many new forms of mixed housing and services (driven by the private pay market), including assisted living and small group homes, yet much of these services are unaffordable for many and services are fragmented and unregulated; and
Whereas there is need to humanize nursing homes (culture change) to make them less hierarchical and to normalize relationships; and
Whereas there is a the LTC work force is undervalued, underpaid and under trained; and
Whereas we are approaching a Baby Boomer crisis in LTC, both in current needs for their own family members and for their own future needs.

THEREFORE BE IT RESOLVED by the 2005 White House Conference on Aging to:

Change Medicare and Medicaid focus to community-based long-term care services that provide more for psychosocial care so that older adults can continue to live in the community even with substantial care needs.
Reduce "over-servicing" (e.g. over-medicalized approaches) in Medicare and Medicaid and encourage consumer-directed cash payment programs.
Advocate for government programs that allow for more choices for older people and community based choices regardless of income.
Promote government regulations that encourage continuing training of the direct care workforce in LTC.
Require that psychosocial and cognitive issues of older adults residing in long-term care facilities are addressed.

KINSHIP CARE

Whereas, there is a shortage of people able to provide care and permanent home situations for children unable to remain with their parents; and
Whereas there is a lack of public awareness and misinformation about the millions of grandparents and great grandparents who are caregivers, including that most are Boomers; and
Whereas, only 10% of funding for the National Family Caregiver Support Program is for grandparents; and
Whereas there are often legal barriers to kinship guardianship; and
Whereas there are multiple financial and housing problems for grandparent caregivers.

THEREFORE, BE IT RESOLVED by the 2005 White House Conference on Aging to:

Advocate for Kinship Guardianship that has financial and other resource parity (e.g., clothing allowances etc.) with other child welfare programs benefits.
Reduce restrictive housing and encourages innovative and affordable multigenerational housing (e.g. Grand Families Project, Specialized Housing).
Expand intergenerationally sensitive and coordinated school-based and state/federal child welfare programs such as school-based programs for grandparent caregivers and guardians, grandparent skills training, community mental health services, transportation programs and mentoring programs.

Require training of child welfare workers in kinship family issues.
Promote national, state and local community education programs regarding grandparent caregivers.

CAREGIVING

Whereas, there is a severe lack of support for caregiving (formal, informal, and financial); and
Whereas caregivers, of all ages lack knowledge of community resources; and
Whereas there is growing diversity among caregivers; and
Whereas the current model for caregiving is a Medical/institutional model; and
Whereas care giver issues such as psychosocial well-being of caregiver, gender issues such as male caregivers, and non-relative caregivers are often ignored; and
Whereas the value of caregiving, both paid and non-paid is grossly undervalued in society.

THEREFORE BE IT RESOLVED by the 2005 White House Conference on Aging to:

Recognize the value of caregiving by providing tax credits for informal caregivers.
Advocate for a federal/state government mini-social security benefit for family caregivers.
Promote consumer directed care.
Require that federal and state programs for older persons provide funds to support innovative intervention programs or experiments in caregiving such as encouraging younger family or community members to participate in caregiving (from which the caregivers can benefit from the wisdom and experience of the elderly).