

- informal support system care providers, including older adults themselves and families;
 - volunteers; and
 - special training areas, such as for minorities (Asian Americans, blacks, Hispanics, and Native Americans), elderly individuals, and other special older population groups (mentally retarded, developmentally and physically disabled), team approaches to the provision of care, etc.
3. educational materials and dissemination of information efforts should be further developed to (a) address stigma issues relating to mental health care of older adults and (b) provide information aiding in the recognition of mental health problems and the awareness of mental health interventions relevant to older patients. Such educational materials should focus on a diversity of target groups including:
 - older persons and their families;
 - the range of health care providers;
 - other service providers who come into contact with, and assume direct responsibility for, mentally ill older adults, including those serving as gatekeepers and those involved in the disposition of care, e.g., clergy, guardians;
 - the diversity of individuals and service settings utilized by older adults;
 - State and local level health, mental health, and aging departments and other specialized assistance programs, e.g., State pharmaceutical assistance programs;
 - foundations, corporations, and other grant makers.
 4. a directory should be developed, compiling a list of higher education programs with an emphasis on training and research opportunities in mental health and aging. Such a directory should be developed by a multidisciplinary group such as the Association for Gerontology in Higher Education.

In the area of service, we recommend that:

1. there be continued development of service systems for treatment/rehabilitation programs for mentally ill older adults, aimed at preventing unnecessary institutionalization of the elderly.
2. there be an expansion of service systems providing interventions to address the overlooked opportunities to promote mental health and prevent excess disability among nursing home residents and other older adults living in various institutional settings.
3. there should be continued development of service systems focused on self-help and the use of older persons as mental health service providers, e.g., through the use of an older volunteer program receiving funding and technical assistance through the collaboration of NIMH, ACTION, and HRSA.
4. given the access problems experienced by the frail elderly with mental health problems, mobile mental health outreach efforts, including assessment and treatment, and other mental health outreach services should be fostered at the local level.

5. since increased risk of mental health symptoms is associated with various problems, disorders, and treatments in the elderly, and prevention/intervention strategies can reduce the frequency of adverse mental health consequences (analogous to the impact of treating hypertension to prevent stroke), practitioners should pay particular attention to those high-risk situations which include:
 - untreated depression associated with increased risk of suicide (greatest frequency in the elderly);
 - medication misuse and unintended side effects (drug use and polypharmacy are greatest in the elderly) causing mental health symptoms (high frequency of depression, dementia, and delirium);
 - Alzheimer's disease leading to high frequency (25+ percent) of depression in close caregiving family members;
 - compounding mental health problems, e.g., delirium, depression, or delusion, causing excess disability in dementia;
 - hearing loss in later life (approximately 30 percent of older adults) associated with increased onset of delusional ideation (sensory deprivation phenomenon) and depression consequent to communication difficulties;
6. in light of the frequent use by the elderly of multiple drugs prescribed by multiple health care providers, services must be developed to protect against potential mental health morbidity, e.g., drug-induced dementia and altered mental status due to unanticipated drug interactions/adverse reactions (active coordination among the prescribers and pharmacists is needed in administering patient drug regimens);
7. communities need to assure the coordination of formal linkages among medical, social service, and family service agencies with mental health practitioners and the mental health service system.

In the area of research, we recommend that:

1. at the national level, research support should be strengthened for studies aimed at identifying risk factors which can influence the (a) onset, (b) clinical course, and (c) response to treatment of mental disorders (especially delirium, depression, dementia, paraphrenia and anxiety) in older adults.
2. further studies should be carried out on how mental problems influence the onset, clinical course, and response to treatment for general health and medical disorders.
3. further studies should be conducted on the potential for, and frequency of, mental health symptomatology resulting from side effects of medications (over-the-counter and prescription) used for the treatment of general health and medical disorders; similar studies should be conducted on psychotropic medications relevant to the onset of somatic symptomatology.
4. further studies on suicide (most frequent in the elderly) should be conducted with the goal of advancing our understanding of risk factors and the development of strategies for its prevention.

5. further studies should be conducted to identify strategies that foster positive adaptation to later life stresses; coping strategies that could be developed in earlier adulthood in anticipation of such possible stresses should also be further researched.
6. further studies should be conducted to determine mental health promotion strategies and risk factors influencing the onset of mental illness in mentally retarded older adults.
7. further studies should be undertaken to improve our ability to achieve early and accurate diagnosis of mental health problems, with attention to the development of necessary diagnostic tools, to foster early intervention and more rapid return to higher levels of functioning.
8. further studies should attempt to establish the optimal use of behavioral, psychosocial, and somatic interventions in prevention and mental health promotion approaches.
9. further studies should be conducted which focus on the range of existing services (home-based, community-based, and institution-based) utilized by older adults, to establish efficacious and cost-effective model approaches for addressing the mental health needs of elderly individuals and their families in those service settings that they more frequently utilize. Such studies should include attention to preventing unnecessary institutionalization.
10. studies should be expanded on mental health promotion efforts for special aging subgroups, such as minority and rural elderly, older widows, those over 85, etc. Research should focus on intergenerational approaches to mental health enhancement in later life.
11. further studies should be conducted to determine when and for which groups of older adults mental health services should be age homogeneous or age heterogeneous in design; similarly, studies should be conducted to improve our understanding of the impact on the mental health of older adults living in, or being treated in, age-homogeneous and age-heterogeneous settings.
12. further studies should explore effective models of using older volunteers in mental health promotion efforts focused on elderly individuals.
13. further studies should focus on alternative residential settings (other than home and nursing home), with attention to promoting mental health and preventing excess mental disability in the elderly.

In the area of policy, we recommend that:

1. treatment, diagnosis, and care of mental disorders should be reimbursed by all insurance providers at comparable levels to general medical disorders in order to assure adequate access to mental health services by older patients and their families, in order to prevent mental disability.
2. to promote mental health and encourage maximum independence, the provision and reimbursement of mental health services in specific community settings, e.g., housing programs, health centers, nutrition settings, and outreach to in-home family providers, should be mandated.

3. since homebound persons at risk for mental health problems have limited access to mental health diagnostic and treatment services by mental health professionals and primary care physicians, third-party payers (public and private sector) should be encouraged to remove the financial disincentives to mental health home visits to the elderly aimed at preventing excess disability.
 4. nursing homes should be mandated at legislative and regulatory levels as sites of mental health services and should be evaluated for the quality of their services designed to promote mental health and prevent excess disability.
 5. State licensing agencies should develop policies that promote the role of the nursing home medical director in preventing excess mental disability in nursing home residents.
 6. all Federal, State, and local public agencies that serve older persons should develop policies relevant to the promotion and coordination of mental health—such should be reflected in the development of national, State, and local plans.
 7. State mental health agencies should be mandated to specifically target mental health services for the elderly.
 8. there should be a legislative commitment to protect the mental health of the spouses, family, and other lay caregivers of the elderly. Specific funding for mental health care for caregivers could be incorporated into the upcoming rural health bill, long-term care bills, and/or catastrophic health benefits and/or existing Medicaid programs.
 9. third-party coverage (Medicare and private insurance) should be available for hearing aids and other assistive devices to prevent mental health morbidity.
 10. reimbursement under the PPS/RUG should have an allowance for psychosocial care in institutional and community settings.
 11. drug utilization review to prevent psychotropic drug misuse among the elderly should be required in all Federal or State programs that provide access to pharmaceuticals for the elderly.
 12. the Food and Drug Administration should require inclusion of elderly subjects during new psychotropic drug trials to assure that risk potential will be understood in medication management of older patients. Postmarketing surveillance of such drugs should similarly include a focus on older patients.
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NUTRITION WORKING GROUP

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Members of the working group on nutrition stated that the overriding goals basic to their recommendations are:

1. improved quality of life for older Americans and the promotion of continued autonomy; not cost containment.
2. good nutritional status is essential for a high quality of life, and food contributes to the quality of life through psychological and social, as well as physical, mechanisms.

In addition, the following assumptions are basic to their recommendations:

1. older people vary greatly in their social, economic, and life-style situations; functional capacity; and physical conditions.
2. nutrition policy should be crafted from a multidisciplinary framework.
3. a critical shortage of knowledgeable personnel in the areas of nutrition education, research, and service now exists (see "Health Personnel for the 1990's").
4. the research base for nutrition of older Americans is evolving; therefore, specific recommendations must be periodically updated.

In the area of education, we recommend that:

1. in all aspects of training for dietitians and other health care professionals (e.g., physicians, nurses, and pharmacists) and para-professionals (e.g., nursing assistants), basics of geriatric nutrition should be required in core curriculum, in-service training, and continuing education.
2. Federal agencies (e.g., NIA, USDA, and FDA), professional societies (e.g., ADA, SNE, AIN, and ASCN), and private health organizations (e.g., the American Heart Association and the American Diabetes Association) should develop new or adapt existing health promotion nutrition messages to the special concerns of the elderly,

e.g., multiple use of drugs, low energy intakes, and existing chronic diseases. These groups should coordinate efforts to assure wide dissemination of nutrition education materials and messages to older persons.

3. Federal agencies supporting nutrition research should provide health care professionals with criteria for the evaluation of diets of older adults and information on efficacy and safety of commonly used nutrient supplements for use in counseling on their proper use as a supplement to, but not as a replacement for, adequate diet.
4. all DHHS agencies that have responsibilities for provision of services for older persons must provide ongoing formal geriatric nutrition training for staff with nutrition responsibilities in their service networks.
5. Health promotion messages from the public and private sectors should utilize advanced communication techniques:
 - recognizing different life-styles;
 - adapting to different sensory capacities;
 - adjusting to different cultural experiences; and
 - recognizing different learning styles.
6. Data bases should be developed by the Public Health Service for use by pharmacists and dieticians in counseling older persons on drug-nutrient interactions.
7. Primary and secondary school districts can have a positive influence on health status of parents and grandparents of students by providing nutritional information to students, promoting a better understanding of the relationship of good nutrition to health status in old age.

In the area of service, we recommend that:

1. assessment be done at admission or enrollment in all institutional or community-based health services for older adults, e.g., acute and long-term care inpatient services, hospital-based outpatient services, alcohol and drug treatment programs, community health services, and home delivered meals programs.
2. nutrition counseling by a credentialed nutrition professional/registered dietician be a part of all institutional or community-based programs providing health services to older adults.
3. hospital discharge planners assess the need for in-home nutrition services for patients and refer patients to the appropriate area agencies on aging to link older persons with services in the community.
4. in providing outpatient nutrition services to older adults, program models should minimize the burden placed on patients, e.g., encourage health professionals to coordinate services and function as patient advocates.
5. any evaluation of institutional or community-based nutrition services providing meals or nutritional supplements for older adults should include an assessment of the various nutrition-related characteristics against criteria such as the RDA, dietary guidelines, therapeutic considerations, and cost and food preferences.

6. nutritional data bases that include dietary or nutrition data on older adults, e.g., NHANES, NHIS, and the Nationwide Food Consumption Survey, should be linked with data bases that have outcome variables, e.g., the National Death Index and the National Hospital Discharge Survey.
7. national nutrition data collection for older adults, i.e., NHANES, USDA, and the Nationwide Food Consumption Survey, should be based on samples sufficiently large and representative to support analysis within age-sex-income-race/ethnic categories.

In the area of research, we recommend that:

1. funding agencies, e.g., NIH and USDA, establish permanent study sections composed of experts in aging and nutrition.
2. Federal agencies provide adequate, additional funds to support the research efforts described below:
 - definition of nutrient and energy requirements of older adults, now extrapolated from younger age groups, and establishment of recommended dietary allowances;
 - studies on the interactions between nutritional status and activities of daily living and other aspects of life-style and behavior;
 - research on the effects of nutrition on age-related impairment of organ system functions, e.g., cardiovascular, gastrointestinal/oral cavity, immune, musculoskeletal, nervous, and other systems;
 - studies on the efficacy and cost-effectiveness of dietary assessments and interventions for reducing the risk of age-associated diseases among populations over 65 years of age;
 - research on interactions among nutrients and between nutrients and drugs in older adults;
 - development of age-specific methods to assess the nutrient, nutritional status, and body composition of older adults;
 - studies directed toward comprehensive dietary recommendations relevant to common morbidity patterns among older adults.

In the area of policy, we recommend that:

1. credentialed nutritionists/registered dietitians be employed as staff at all levels of the Federal and State Government in all agencies involved in policy, planning, administration, and evaluation of aging programs. Examples of agencies at the Federal level within DHHS include NIH's Nursing Institute, other NIH Institutes, HRSA, AOA, HCFA, CDC, NCHS, and FDA. Other relevant agencies include both the Federal and State offices of the VA, and AID, USDA, and DOD.
2. State and local agencies on aging use the expertise of credentialed nutritionists/registered dietitians and encourage other appropriate agencies to use such expertise.
3. Federal, State, and local legislators and agency administrators give high priority to nutrition services, education, and research on the aging when they allocate FTE's and target both existing funds and future increases.

4. HCFA require that staffing in long-term care and skilled nursing facilities include credentialed nutritionists/registered dietitians.
 5. third-party payers (Federal and private insurance entities) pay for nutrition counseling services provided by credentialed nutritionists/registered dietitians for older persons at nutritional risk.
 6. State and Federal agencies encourage development and implementation of innovative public-private sector models for health promotion and education including nutrition for older adults.
 7. *successful* public-private sector models for nutrition, health promotion, and education for older adults, e.g., Healthy Older People, Age Well, and OASIS (Older Adult Service and Information System), be widely disseminated by Federal and State agencies.
 8. by 1990, an NIH Consensus Conference be held and information disseminated on dietary recommendations for older adults, both well and ill.
 9. funding be provided from third parties and other sources, e.g., Medicare, Medicaid, OAA, and private insurance, for outpatient and in-home nutrition and other services that permit older Americans who are ill to remain in their own homes with an optimal quality of life and function.
 10. existing guidelines for categorical funding of nutrition services for older adults should be evaluated to determine if they permit sufficient feasibility for overcoming specific situational barriers and accommodating preferences of individuals and cultural subgroups.
 11. the Interagency Committee on Human Nutrition Research:
 - assign responsibilities for interagency coordination in aging to a nutrition researcher at the Secretary's office in each department and agency;
 - continue to give aging research priority; and
 - continue to coordinate aging research efforts at NIH, CDC, and elsewhere in DHHS, USDA, DOD, AID, etc.
 12. all research, service, and education programs should be periodically reviewed to keep pace with a constantly changing knowledge base.
 13. nutrition education and service programs should be designed to meet the diverse needs and living situations of older adults.
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PREVENTIVE HEALTH SERVICES WORKING GROUP

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Working group members agreed that effective preventive care of the elderly requires an appreciation of problems outside the more traditional focus of primary and secondary prevention. Health in the elderly is often best measured in terms of functional status as well as the absence of disease.

Effective prevention strategies must recognize that informal caregivers are appropriate recipients of information about preventive services needed by the elderly. Preventive services should not be arbitrarily started at a specific age. Ideally, health promotion for the elderly would not begin in old age, but would be part of an ongoing program begun in childhood. Individuals of all ages need to be encouraged to take increased responsibility for their own wellness and health promotion.

The World Health Organization's model which underscores the transition from disease to impairment to disability and to handicap is a useful framework since interventions may be made at one or more of these stages.

Preventive services for the elderly should foster the development of effective environmental and social support systems.

The recommendations that follow address these two goals:

- To prevent physical, psychological, and iatrogenic disorders.
- To prolong the period of independent living with particular attention to quality of life.

A significant inhibitory factor in the provision of preventive health services is lack of reimbursement. Preventive services should be reimbursed. While reimbursement will surely increase utilization, the working group agreed that only those preventive services that have been scientifically shown to have merit should be reimbursed. Several expert groups like the U.S. Preventive Services Task Force have systematically reviewed preventive services on the basis of rules of evidence and it seems reasonable to

reimburse those services for which there exists good evidence in favor of efficacy. For example, medicare coverage should be expanded to include yearly influenza immunization for the elderly. The working group felt strongly that curative or diagnostic services should also be reviewed with the same level of scrutiny.

It is important to emphasize that preventive services need to be individualized according to the following characteristics:

- active life expectancy;
- physical activity;
- cognitive capacity; and
- presence, nature and stage of disease(s) processes.

This individualization of preventive services should respect these principles:

- Minimize unnecessary disruption of life-style.
- Preserve the patient's autonomy.
- Minimize iatrogenic insults.
- Recognize that avoidance of death may not be the ultimate goal of preventive services.

In the area of education, we recommend that:

1. certifying organizations for health professional and allied health training programs should require inclusion of didactic and clinical training on health promotion and disease prevention in the elderly.

Some areas which should be addressed include:

- Awareness of the determinants of successful aging and development of positive attitudes about normal aging and the preservation of independent function.
 - Appreciation of the heterogeneity of elderly persons with respect to functional status, individual values and goals.
 - Knowledge of basic principles of preventive medicine, methods of assessing values of screening and intervention programs.
 - Development of professional learning practices which allow for incorporation of emerging information regarding the utility of specific preventive practices.
 - Training in identification of individuals "at risk" for decline in health status which may be preventable based on the model of progression from wellness to disease to disability.
 - Training in functional assessment methodologies.
 - Experience in multidisciplinary approaches to wellness and health promotion.
2. all primary care training programs emphasize geriatric wellness and disease prevention.
 3. continuing education programs for practitioners focus on preventive medicine practices for the elderly.
 4. all certification and licensure examinations include testing for knowledge of preventive medicine strategies in the elderly.
 5. service agencies educate and train their staff to recognize elderly who are at high risk for preventable conditions.

6. service agencies develop educational programs for their staff in disease prevention and health promotion in the elderly.
7. service agencies develop training programs for informal caregivers about preventive strategies in the care of the elderly including knowledge of community resources.
8. service organizations develop well being and stress reduction programs directed at caregivers themselves.
9. private and government employers provide information to their older employees regarding normal aging, wellness and disease prevention.
10. programs be developed by the aging network and professional organizations that educate the elderly consumer to actively seek out preventive services as a part of their regular health care.
11. public and private funding sources provide faculty development programs designed to enhance knowledge and skills in the teaching of health promotion and disease prevention in the elderly.

In the area of service, we recommend that:

1. mass screening programs should be viewed with skepticism unless they adhere to standardized criteria (WHO), are targeted to a focused population, and are linked to the primary care system for follow-up. Freestanding screening programs are to be avoided, since they are often ineffective and potentially exploitive.
2. the provision of preventive services should take into account the heterogeneity of the elderly population.
3. preventive services for the elderly should address factors that prevent disease from producing disability and that prevent disability from becoming handicaps.
4. hospital/nursing home admissions and discharges should be viewed as opportunities to assess preventive services or special risk factors (iatrogenic disease, dependency).
5. preventive services should be targeted for the elderly living in nursing homes.
6. health promotion programs should emphasize self-responsibility for health and life-style modification.
7. recommendations for behavioral change, especially for the very old, should be balanced against life-style disruption.
8. prevention strategies should include families and informal caregivers.
9. secondary prevention (screening) services in the elderly should be addressed in primary care settings since the effective provision of these services depends on detection, response and follow-up of subtle changes in functional status.
10. primary health care providers should be encouraged and assisted to look for easily detected and treatable conditions, e.g., depression, incontinence and vision, hearing, foot and oral health problems.

11. primary health care providers should carefully evaluate physical, mental, functional status, and existing social support systems for each of their elderly patients.
12. primary health care providers should use checklists and other specific tools that facilitate and guide specific preventive services for the elderly.

In the area of research, we recommend that:

1. with regard to those preventive services for which effectiveness in the elderly has not been established, a vigorous, well funded, and well coordinated research program should be undertaken to investigate their applicability to the elderly.
2. specific research efforts should be devoted to strategies aimed at behavioral changes in the elderly. Such research should encompass a variety of life-style changes among elderly in different functional categories.
3. studies to measure and control adverse events secondary to medical intervention should be encouraged and funded.
4. studies of the determinants of behavioral change in the elderly and utilization of preventive services should be funded.
5. agencies funding health care training programs should develop incentives aimed at increasing researchers in health promotion and disease prevention.

In the area of policy, we recommend that:

1. medicine and other third-party payers should reimburse for those preventive services that have been found to be efficacious and effective for the elderly by independent panels such as the U.S. Preventive Services Task Force.
 2. quality assurance standards promulgated by health care organizations should include standards for the provision of preventive services to the elderly.
 3. both Federal and nonfederal research organizations should develop mechanisms for the prompt translation of prevention related research findings into guidance for health care providers, payers and the public.
 4. a preventive geriatrics grant program analogous to the Preventive Cardiology Career Development Award should be established to provide the academic leadership essential to the further advancement of the field, and such a program should accept applications from researchers in a number of health care disciplines.
 5. AoA, NIA, and other relevant PHS agencies, and the VA should develop a joint strategy for ongoing consumer education on preventive services.
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SMOKING CESSATION WORKING GROUP

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The smoking cessation working group bases its recommendations on the following tenets:

1. Cigarette smoking produces serious disease in smokers.
2. Environmental tobacco smoke can cause disease, including lung cancer, in healthy nonsmokers. Furthermore, the simple separation of smokers and nonsmokers provides inadequate protection of the nonsmoker.
3. Older Americans have the right to protect their health from the toxic chemicals of tobacco smoke through a smoke free environment.
4. Older Americans should quit smoking. By doing so, they can realize immediate gains in their quality of life through substantial improvements in physiological, psychological, and functional status.
5. The addictive nature of nicotine creates a dependency on cigarettes which threatens the health of older smokers.
6. The dearth of smoking cessation initiatives for older Americans, in spite of the growing scientific evidence showing both short- and long-term health benefits, constitutes a serious public health need.
7. Smoking cessation initiatives aimed at older Americans should give special attention to the concerns and needs of minority and low income older people and should include in their planning the representation or involvement of these subgroups.
8. The decision to stop smoking—and the behavior that follows—is not the result of one or two exposures to smoking-related information but is a cumulative effect.

In the area of education and training, we recommend that the Surgeon General undertake the following:

1. emphasize, in his contact with opinion leaders and the media, the short- and long-term health benefits of smoking cessation for older smokers, and the effects of passive smoking on older people, particularly those with disease.
2. encourage health care educators to incorporate the importance of smoking cessation for older adults and effective interventions in curricula for health care professional students, including preventive medicine, nursing, social work, dentistry, gerontology, public health, and other allied health disciplines.
3. stimulate the training of professionals to incorporate a strong smoking cessation message into their encounters with older adults in emergency room and community and rural health center settings, in order to reach lower income older adults who lack access to the health care system.
4. encourage State and local professional societies and other organizations to include information on the importance of smoking cessation for older adults in continuing medical education programs for health professionals.
5. urge the development and adoption of smoking cessation messages and interventions as standards for primary health care delivered to older persons to include:
 - identification of the individual's risk factor (smoking);
 - identification of potential medical and pharmacologic complications of smoking;
 - delivery of strong cessation and educational messages to all smokers;
 - referral to or direct behavioral cessation therapy; consideration of pharmacologic therapies; and
 - monitoring of progress toward cessation and maintenance at each encounter between the patient and the health care provider.
6. work with the Administration on Aging to promote the establishment of "No Smoking" policies in all settings in which services are provided to older persons. The work site and service delivery areas of the aging network, as authorized under the Older American Act, should be models for older persons in the provision of smoke free environments to encourage smoking cessation for older persons.
7. convene the Interagency Committee on Smoking and Health to address the issues of smoking and older adults.
8. provide information to State and local governments on the health effects of smoking in public places, restaurants, workplaces, public transportation vehicles, and on airplanes. These deterrents would protect nonsmokers from the adverse health effects of passive smoking and eliminate the possibility of fires caused by smoking.
9. encourage long-term care providers to facilitate smoking cessation for older persons in long-term care facilities through:
 - providing access to cessation materials for residents and their families;

- educating staff to the benefits of cessation for themselves and older adults; and
 - designating nonsmoking resident rooms and no smoking in all common areas.
10. recommend that pre-retirement programs currently conducted by public and private employers, private insurers, and labor unions contain a health promotion focus, including an emphasis on the positive health benefits of smoking cessation for older adults.
 11. designate responsibility to a PHS working group to meet with relevant public and private sector agencies and organizations to coordinate the development of a public education initiative. The group would explore the feasibility of sharing resources and networks to stimulate community program development.
 12. encourage public and private sector agencies/organizations actively engaged in anti-smoking education activities to examine existing educational materials and public service announcements on prevention, cessation, and maintenance for cultural, ethnic, racial, and gender relevance to the older audience.
 13. insure that the Office on Smoking and Health include an overview of smoking and older adults in the 25th Anniversary Surgeon General's Report on Smoking and Health and biannual reports to Congress.

In the area of education and training, we recommend that:

1. State and local health departments, voluntary health agencies, advocacy groups, and coalitions be strongly urged to work with public and private organizations serving the social service needs of older Americans to support them in:
 - the development, implementation, and enforcement of restrictive smoking policies directed toward clients and staff;
 - the education of staff in such agencies to serve as credible and effective sources of smoking cessation support;
 - the provision of cessation materials (pamphlets, posters) to support clients and staff in their attempts to stop smoking.

Such organizations would include:

- churches;
 - senior centers;
 - veterans' groups;
 - fraternal organizations;
 - congregate meal sites;
 - minority and ethnic clubs and centers;
 - self-help groups; and
 - area agencies on aging.
2. the organizations and agencies that serve older adults and the private, public, and voluntary agencies that focus on smoking control issues create a coalition to organize their resources in order to create

a smoke free environment that repeats and reinforces, through many and varied channels, smoking cessation messages specifically targeted to older adults, and that encourages participation in such national smoking cessation activities as the Great American Smokeout.

3. agencies, organizations, and medical facilities distributing information to older persons about smoking cessation methods refer, whenever possible, older persons to local self-help/mutual aid groups formed to encourage ex-smokers to stay nicotine free.
4. providers of direct services to the older population, including social workers, educational specialists, nutritionists, and other support personnel be targeted with smoking cessation messages which identify the benefits of quitting for older adults.
5. professional and accrediting organizations be encouraged to offer seminars and workshops on smoking cessation and that supplemental materials (e.g., posters, brochures) be made available.

An underlying assumption is that research on smoking cessation with older adults must address the difficulties inherent in reaching a population for whom smoking is likely to have been a lifelong habit. Associated with this lengthy duration is a history of nicotine addiction, unsuccessful quit attempts, and psychological and situational dependencies on smoking. By the very nature of the duration and cumulative exposure to smoking, older smokers may present the most significant challenges to smoking cessation efforts. Furthermore, because of decades of self-selection, the population of older people who still smoke are heavier smokers and are more likely to have low incomes and be members of minority groups.

Research on smoking and smoking cessation among older adults can benefit from advances in research design and methodology that occur with younger target groups. Moreover, as with other populations, research on smoking and aging should investigate smoking as it broadly affects the lives of older persons, not only its morbid and mortal outcomes.

In the area of research, we recommend that:

1. knowledge of smoking and older adults be improved and refined by studies that include but are not limited to:
 - the interaction of smoking status and smoking history with other risk factors of mortality, morbidity, and loss of functional health in older adults;
 - the association of smoking with older adults' status on other health-related practices;
 - the benefits of smoking cessation in improving the quality of life which extend beyond the biological, behavioral, and health aspects of smoking;
 - evaluation of age-related or intergenerational differences in the smoking cessation process, strategies used in quitting, and factors influencing relapse;
 - development of a research agenda that examines the value of self-help groups as a mechanism to help older people stop smoking and stay nicotine free; and

- investigation of the effects and consequences of nicotine withdrawal which are affected by aging, coexisting illness, and the duration and intensity of smoking.
2. the Centers for Disease Control (CDC) be encouraged to expand the National Health Interview Survey to include the smoking supplement annually, and that its sample be sufficient to report statistically significant results for subgroups of the older population (e.g., the young-old, blacks, Hispanics, and Native Americans).
 3. the National Ambulatory Care Survey of Physicians in Private Practice, conducted by the National Center for Health Statistics, include questions on advice and assistance physicians provide to their patients, especially older patients, regarding the benefits of smoking cessation. Although U.S. physicians view smoking as a serious health risk, less than one-fourth offer any kind of structured assistance in helping patients quit, and physicians are less likely to give a strong cessation message to older adults.
 4. CDC should encourage states to include smoking data on older adults in The Behavioral Risk Factor Surveillance System (BRFSS).
 5. research focus on epidemiologic analyses to improve chronic disease risk estimates for continued smoking into the seventh and eighth decades of life, particularly for female smokers.
 6. researchers incorporate questions about smoking status and smoking history into longitudinal epidemiologic studies of older populations.
 7. major trials and other studies of smoking cessation be encouraged to include older persons in numbers sufficient to make separate analyses meaningful and useful.
 8. academic researchers evaluate the application of smoking cessation techniques and materials for older adults.
 9. academic researchers evaluate the delivery of smoking cessation messages by physicians, dentists, and other health care professionals to older adults.
 10. the Surgeon General encourage the Food and Drug Administration to formally ask drug companies (holders) of already approved New Drug Applications (NDA's) to initiate pharmacokinetic studies on the interaction of nicotine on serum and tissue levels of the companies' drugs and to include such information in the physician's package insert.
 11. foundations with health promotion and/or aging agendas be encouraged to fund demonstration and other research projects that focus on smoking cessation and to incorporate information on smoking cessation into new and existing health promotion programs.

In the area of policy, we recommend that:

1. the Social Security Administration be encouraged to include health promotion messages, including smoking cessation information, in beneficiary mailings.

2. private insurers be encouraged to charge differential rates to smokers in their Medicare supplemental and long-term care policies.
 3. the Surgeon General encourage the United States Pharmacopeia, the American Society of Hospital Pharmacy, the American Pharmaceutical Association, and other organizations that disseminate patient package inserts to develop a section on "Effects of Smoking on Drug Serum and Tissue Levels" focused especially on the potential for such interactions in older persons.
 4. the Surgeon General encourage the Food and Drug Administration to require drug companies to undertake pharmacokinetic studies on the interaction of nicotine on serum and tissue levels of the sponsor's drug, especially in older persons, as a condition for completion and approval of all forthcoming NDA's, and that such information be included in the physician's package insert.
 5. the sale of all tobacco products be eliminated from all government health facilities.
 6. the Surgeon General encourage the Administration on Aging to establish a priority in its discretionary grants funding for model State level smoking cessation campaigns for older persons and for dissemination of smoking cessation materials targeted for older persons.
 7. the year 2000 health objectives should be set which measure:
 - reductions in smoking prevalence by sex and race for older adults;
 - increases in public awareness of cessation benefits at older ages; and
 - increases in the frequency of smoking cessation advice being given in primary care settings.
 8. the Surgeon General urge the tobacco industry to manufacture only fire-safe products, in order to reduce the risk of morbidity and mortality in older persons from residential fires.
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Response to Workshop Recommendations

Presented by C. Everett Koop, MD
Surgeon General, United States Public Health Service
Wednesday morning, March 23, 1988

This is the moment that I always look forward to at the close of a Surgeon General's workshop, but it also is a moment that I dread. You've all made my task today much simpler than is usually the case and for that I am grateful.

I would like to extend my congratulations to the chairpersons of the various working groups and my thanks to all of the participants. You have done an outstanding job.

As I told you in my charge, what you have presented to us as recommendations will not be edited as to substance. Grammatical and syntax changes will be kept to a minimum.

It is almost impossible to have a workshop such as this without having several participants who come with private agendas which supersede the work at hand, but to my knowledge that has not happened on this occasion and I am not only pleased but very grateful. You have indeed shown what a cooperative effort can be.

This has been the best organized Surgeon General's Workshop, and I ought to know. My thanks again to DSG Faye G. Abdellah, SR PHARM Steve Moore, and countless others for a job exceedingly well done. My thanks to Social and Scientific Systems, Inc. of Bethesda, Maryland. This was our contractor and people worked all night to type the recommendations you will receive at the end of this conference.

I didn't work *all* night, but almost. As I make my response, I will stumble, stutter, appear to lose my place but be assured none of these are the result of the short night, my age, or my eyesight. Rather, it is my penmanship which is at fault which is vintage physician. It is unreadable, even by the author.

When President Reagan nominated me to be his Surgeon General, back in 1981, I was just a youngster of 65. But, unfortunately that was the age at which—traditionally—Surgeons General were supposed to *leave* the Public Health Service—not enter it for the first time.

So a great hue and cry went up, alleging that I was too old for the job. You can imagine that this did not sit very well with the man who nominated me. President Reagan had just celebrated his 70th birthday, when he sent my nomination to the United States Senate.

I don't recall that he took very kindly to the idea that someone who was 5 years *younger* than he would be considered *too old* to serve his country.

Senator Hatch spend many hours of many months convincing his senate colleagues to accept the idea that *chronological* age ought not to be the sole and final criterion of an individual's personal or professional worth.

Senator Hatch prevailed ... and I became your Surgeon General. I am indebted to him for the courage and foresight he demonstrated at that time. I also happen to think he was right.

And just as a footnote to all this history, I am pleased to say that, when the President re-nominated me for a second term, the whole process took less than 5 minutes and there were no "nay" votes.

Now, my personal story had a happy ending. I got the job. But that's not always the case for everyone, as I'm sure you all agreed at your work groups.

As so many of us know from personal experience, age prejudice is still far too common in America. Yet, that makes no sense at all, because the new scientific information coming to light ought to be pointing society in exactly the *opposite* direction.

We're now coming to understand that—medically speaking—there is such a thing as a *disease free aging process*. A process during which all systems in a person's body continue to function normally.

So let's get a few things straight:

- Gray or white hair is *not* a sign of disease. Never has been. Never will be.
- Dry skin is a natural phenomenon of aging. We don't know why it happens—but it's not the result of disease.
- Taking things a little easier is *not* a disease condition, either. It's more like a sign of maturity.
- And getting a stronger prescription for your eyeglasses or being fitted for a hearing aid is not evidence that you have one foot in the grave and another on a banana peel. It just isn't so.

From this common-sensical, scientifically accurate perspective, you soon realize that a *great many* older Americans today enjoy a *disease free old age*, mentally and physically healthy.

And we'd better get used to the idea that that's the way it's going to be perhaps for *most* older people in the future, because *tomorrow's* elderly are today's bikers, joggers, and swimmers.

They're people who snack on salad and yogurt.

They're today's young and the middle-aged Americans who've given up cigarettes and hard liquor ... who wear seat belts and sensible shoes ... and who do more about managing stress than just to pop another valium.

We need to remember that the aging process is not just a *biophysiological* process. As the work groups have amply demonstrated, the aging process is also a *social* ... and *political* ... and an *economic* process as well.

Good health in one's senior years may be a result of good diet, regular exercise, and an overall healthy life-style.

But it is also the result of decent housing ... and public order ... and environmental safety.

It can be the result of a life spent in steady and safe employment, closing with one's senior years protected by financial security.

It is also the sum-total of a lifelong sense of personal and family well-being ... and of one's ability to continue to live an independent, private life ... a life that is not a burden to one's self, to one's loved ones, or to society at large.

In hearing these remarks, I'm sure some of you recognize how your recommendations triggered these thoughts as I was preparing them in the not so wee hours of the morning.

And now to the specific recommendations of the working groups:

There are a number of recommendations that are common to several work groups. For example, not exhaustively:

1. Adequate dissemination of the material to specific special interest groups.

This will be done. More on that subject later.

2. Public-Private Partnerships and Coalitions.

We intend to implement these relationships by education, by precept, and by arrangement.

3. Inclusion in core curricula of health and professional schools of the basic precepts peculiar to the unique needs of older people.

Your recommendations will be circulated to those who can make a difference, to the best of our ability to do so.

4. The assistance of the Surgeon General when and where advantageous.

I pledge to do this within time constraints, but you tend to win on this one because of my compulsive personality.

5. Access to care.

This perennial problem is not easily addressed. We will try where we can.

Alcohol

I feel a little foolish addressing these issues in the presence of Dr. Gordis who understands so well those concerns expressed in the research agenda, such as the need to understand the differences between lifetime and late onset alcohol abuse.

I will transmit to the National Heart, Lung, and Blood Institute your concerns in reference to cardiovascular disease and premature aging and their relationship to alcohol.

Secretary Bowen has recently launched a very comprehensive initiative on alcohol abuse and alcoholism. He will be pleased with your educational comments and a special letter of transmittal will be sent by me to the group responsible for this initiative.

To HCFA and the private insurance carriers I will pass on your concerns about third party payment for detoxification and rehabilitation.

Finally, the Veterans Administration will be apprised of the specific concerns and recommendations made regarding veterans.

Oral Health

I was pleased that these recommendations recognized that the mouth contained more than teeth because that concept conforms to my life-long professional belief that the mouth was part of the body and that dentists belonged in the mainstream of caregivers.

The suggestions for a research agenda will be transmitted personally to Dr. Harold Loe, Director of the National Institute of Dental Research. Through the Chief Dental Officer, every private sector organization will also be notified about service recommendations.

The particular concerns about oral health in long-term facilities and the need for financing will be delivered to appropriate umbrella organizations involved with long-term care, with HCFA, and private insurance carriers.

Physical Fitness and Exercise

I am impressed by and endorse your concerns directed toward types and levels of physical activity in terms of intensity, frequency, and duration to achieve, safely, the potential benefits in health and functional capacity across a wide age span and range of abilities.

[Dr. Williams was asked to comment on this research agenda and spoke at this time.]

Dr. Williams:

I agree fully with the major emphases in the recommendations on physical fitness and exercise. In particular, the recommendations in the area of research are clearly germane to the mission of the National Institute on Aging (NIA); we are already involved in research related to a number of the recommendations and expect to increase our activities in the field.

Overall, I urge emphasis on *incorporating fitness into daily living*. We should encourage, and practice ourself, walking briskly up and down stairs and between sites in our work place, at home, in retirement activity, and should encourage fitness programs as a part of all employment and living settings.

We should emphasize maintenance of function. It is also important that we learn more about how to tailor fitness programs and daily exercise activities to the needs and capabilities of persons who have varying types of chronic disabilities or disorders, just as we tailor fitness programs to the needs and capabilities of generally healthy older people.

.....

The educational component is universal and complete. We will seek appropriate community endeavors to take on this responsibility.

My penultimate Surgeon General's Workshop was on Self-Help and Public Health. I will attempt a cross fertilization of appropriate groups to see that some of these excellent educational suggestions see practical application.

And now a personal note. There are, as you know, Presidential Awards for young people who pass rigorous fitness examinations. Some of us

believe others who do not get superlative ratings on these exams deserve some recognition. Therefore, we are working on a Surgeon General's Award for physical fitness for youngsters.

I don't know quite how, yet, but I will seek ways to provide senior citizens with a Surgeon General's Recognition for physical performance appropriate to age. Perhaps the best place to start is with Commissioner Carol Fraser Fisk, and I will do just that.

I will lend my own powers of moral suasion to this effort.

Injury Prevention

The preamble of this excellent summary calls for coordinated effort among the Centers for Disease Control, the National Institute on Aging, and the Administration on Aging. This already exists as CDC and NIA are components of the Public Health Service, and we already have a coalition with AoA. That's why you are here! But, we will seek to strengthen and refine it.

The suggestions about injury prevention are quite valid. I will seek to provide all participants with some pilot program information on this subject.

Many of the research recommendations are in line with surveillance and epidemiology studies now underway at CDC. I will be certain that the specific recommendations made here are transmitted to the CDC.

Some of the policy recommendations overlap with education but whatever the recommendations are, they will be passed on to the various agencies that establish and enforce safety standards.

Drugs

The detailed exposition of 33 recommendations is noted. The PHS is composed of 11 disciplines. One large group are the pharmacists. Our pharmacists function, in many instances, at an interactive level with patients somewhat higher than is the usual expectation. Experience with pharmacists in the Indian Health Service has proven the worth of this interactive relationship.

It is my intent to turn the recommendations and proposals over to the Chief Pharmacist of the Public Health Service and ask him and his Professional Advisory Committee to implement the service, policy, and education components in cooperation with the Administration on Aging with whom we have already an initiative on medications for the elderly.

The research proposals will be turned over to the NIA and FDA. Financial implications will be directed to HCFA and the private sector.

Mental Health

Many of the recommendations of this workgroup grew out of a recognition of risk factors that have the potential of influencing the onset, clinical course, and response to treatment of mental health problems in elderly individuals.

Many also recognized that older persons with mental health problems, alcoholism, or other drug problems have had physical health problems which bring them into multidisciplinary and service coordination settings. The recommendations of this group cross cut many of those for other work groups as you might imagine. Some will in a sense be covered as we seek to implement the recommendations of other groups.

Many of the suggested outcomes are being addressed by the AoA and I'd like Commissioner Fisk to speak to some of them after which I've asked Dr. Williams to address some of the research agenda items.

Commissioner Fisk:

Thank you Dr. Koop. I was impressed with the Workshop recommendations in this area, so many of which emphasized collaboration between the aging and mental health networks. The Administration on Aging has conducted a number of demonstration projects at the State level that have been targeted at coordination. Clearly, we need to do more in this area. Also, this seems to be a good area for State Coalitions on Health Promotion to get involved in.

My agency is currently funding six projects in the area of mental health promotion. Through these projects, we hope to address some of the concerns of the participants such as drugs and depression, access, problem recognition and identification.

I see mental health issues, and especially depression among the elderly, as a serious concern. You have my assurance that AoA will continue to address these issues and will involve other agencies in our efforts.

Dr. Williams:

In considering the recommendations and needs related to mental health it is important to note, as is done in these recommendations, the close interaction of mental health with physical and social health issues.

Among the recommendations for research, I would emphasize in particular the importance in identifying risk factors, attention to coping strategies, and again the need for further studies on the interactions of mental problems with other characteristics including medication.

.....
The specific policy issues that touch on reimbursement will be called to the attention of HCFA and the private sector. Others, where appropriate will find their way to the proper agency such as FDA.

Hearing problems were also addressed by this group. Some of you may have noted the announcement in MMWR that the National Institute of Occupational Safety and Health will be starting a prevention of hearing loss initiative for the present work force that will be the next generation of the elderly. I am starting an information program on what can be done for those already suffering from hearing loss.

Finally, copies of the final report of this Workshop will go to the members of the State and Territorial Health Officers Association carrying the strong recommendation to the state concerning their responsibility in mental health to the elderly.

Nutrition

As with the mental health recommendations, the nutrition recommendations overlap and intertwine with many others. I note with pleasure that one of the overriding goals is "improved quality of life for older Americans and the promotion of continued autonomy, not cost containment."

Many of the policy recommendations were specific in reference to Federal and state responsibility, as well as agency cooperation. We will endeavor to bring the concerns to those who can make a difference.

There is almost no agency in or out of government—at all levels—that is not involved in nutrition. We will attempt to build bridges and transmit specific recommendations not only to the individual groups mentioned, but also to others who will have an increasing role to play such as the JCAHO committee on accreditation of hospitals, interagency committees, etc.

The specific recommendations of computer data bases for use by pharmacists and dieticians on medication-nutrient interaction will be given serious consideration and I will seek a niche for it in the Public Health Service.

These promises of catalytic action apply to service, education, and research.

There is in preparation by the Office of Health Promotion and Disease Prevention a new—first time "Surgeon General's Report on Nutrition." I see the launching of this report—much of which deals with the specific concerns of the nutrition work group—as a mechanism of bringing attention to your recommendations above and beyond the reach of this Workshop.

Incidentally, the attention paid to the elderly in the Surgeon General's Report on Nutrition is considerable, including medication—nutrition incompatibilities.

Preventive Health Services

Preventive health services are inexpensive, not glamorous, very effective, and seldom reimbursed. Those are my words,—not those of the working group, but many of the recommendations recognize these four truths.

Many of the concerns of this group were addressed in my generic remarks early on this morning; especially in education as it affects the core curricula of health schools.

I was impressed with the working group's understanding of the relevance of their goals to primary care. Accordingly, I will take special care to direct this working group's concerns to those organizations which draw together and serve family practitioners as well as those umbrella organizations specifically concerned with preventive medicine.