May 2000

Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services

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Growing Older: Health Issues for Minorities

By Houkje Ross

Almost 35 million Americans are age 65 and over, according to the latest data from the U.S. Census Bureau. Three in five people in this age group are women. Over the next 40 years, the number of people age 65 and older will double, and the number of people age 85 and older will triple. Minority elderly, who now comprise almost 16 percent of the elderly population, are expected to grow to 22 percent of the elderly population in the next 20 years.

While white elders are expected to grow by 79 percent, the number of elderly minorities are projected to jump 226 percent, with Hispanics and Asian American and Pacific Islander (AAPI) populations experiencing the highest growth.

As a result of this growth, increased attention has been given to health issues facing this population. The U.S. Administration on Aging (AoA) has identified three areas that are of special concern to minority elderly: cardiovascular disease, diabetes, and immunizations.

Cardiovascular disease is the leading killer among men and women, and across all racial and ethnic groups. In 1997, cardiovascular disease caused 43 percent of all deaths among people age 65 and older, according to AoA. Diabetes, the seventh leading cause of death in the U.S, affects 6.3 million people age 65 and over, and occurs most often among older African Americans, Hispanic Americans, and American Indians. In 1998, influenza and pneumonia were the fifth leading cause of death for African Americans and Hispanics age 65 and over.

Asian Americans and Pacific Islanders

AAPIs consist of more than 40 distinct ethnic groups with various socioeconomic and health profiles. For example, Filipinos, Japanese, and Southeast Asian populations in the U.S. have high prevalence of blood pressure, while obesity and diabetes are problems among Pacific Islanders, according to a 1998 American Heart Association Statistical Update.

Keeping accurate mortality data can be difficult due to misclassifications of deaths and death rates for subgroups, according to the Asian and Pacific Islander American Health Forum (APIAHF). The types and prevalence of disease vary within the AAPI community too. Lung cancer is the most common cancer among Chinese, Hawaiian, Korean, and Vietnamese men. Prostate cancer is most common among Filipino and Japanese men. According to the National Cancer Institute, Vietnamese women age 55 to 69 have the highest incidence of invasive cervical cancer, at a rate more than three times higher than the second ranked group, Korean women of the same age group. According to APIAHF, cancer is a major concern for AAPI women, who are less likely than other women of color to have an annual pap smear or mammogram.

Language and cultural barriers pose challenges for elderly AAPIs, who may not be used to talking openly about their health problems, says Yolanda Sanchez, PhD, a minority aging specialist and program manager for the National Asian and Pacific Islander Council on Aging (NAPCA). "If you speak Khmer or Vietnamese, what are the chances of having a primary health care provider speak your language?" asks Dr. Sanchez, who stresses the importance of having bilingual and bicultural staff.

American Indians/Alaska Natives

In American Indian/Alaska Native (AI/AN) communities, diabetes is rampant, says Bill Benson, who works

...continued on page 2

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Inside

Minority Health Perspective..............3
Support for Caregivers.....................4
Older American's Act.......................5
Minority Health Perspective..............5
Managing Prescription Drugs............6
Healthy People 2010........................7
Breast Cancer Risks.........................7
Medicare Issues...............................8
Meals on Wheels..............................9
Adult Immunizations........................10
Recognizing Depression..................12
Common Diseases...........................13
Resources......................................14
Conferences...................................16

Growing Older...*from page 1*

with the National Indian Council on Aging (NICOA) and former deputy assistant secretary for AoA. Census Bureau statistics show that AI/ANs die of diabetes at nearly three times the rate of whites. And AI/ANs over age 65 are more than 2.5 times more likely to get diabetes compared to whites of the same age group, according to the Indian Health Service (IHS). Poor diet and lack of exercise contribute to the high rates, says Dave Baldridge, executive director of NICOA.

Congress recently gave $150 million to IHS to help combat diabetes in AI/AN communities. Many local exercise and health wellness programs are beginning to spring up in some tribes, but more needs to be done, Baldridge says. "Many tribal leaders feel we are not dealing with the sense of inevitability among AI/ANs," he says. "There is often a sense of *when* I get diabetes rather than *if*. More needs to be done to combat this."

A lack of long-term care services for AI/AN elders is another major concern, Baldridge adds. Medicaid is the main source of funding for long-term care, but these services rarely reach the reservations, he says. The program is state based, but many tribes are sovereign. "There either isn't a relationship established between states and tribes, or the relationship isn't a good one," Benson says. Medicare, which has limited long-term-care services, rarely reaches reservations either, perhaps because an area is remote or there are no certified providers in the area.

African Americans

The largest challenge for elderly African Americans may be their high levels of poverty. Thirty-three percent of elderly blacks live in poverty, according to a 1999 Kaiser Family Foundation report, *Key Facts: Race, Ethnicity & Medical Care.* This is the highest rate of all races. Ten percent of elderly whites live in poverty.

"A lifetime of increased levels of stress due to poor economic conditions and less adequate health care increases the incidence of disease," says Marion Becker, PhD, associate professor in the Department of Mental Health at the University of South Florida.

Diseases already prevalent in the elderly show up more often and with more complications in African Americans. According to the January 2000 *Healthy People 2010* report from the U.S. Department of Health and Human Services (HHS), African Americans have the highest overall risk of chronic kidney disease and develop end-stage kidney failure at an earlier age than whites (55.8 years compared to 62.2 years).

African Americans are also twice as likely as whites to have diabetes, and experience higher rates of hypertension, a risk factor for heart disease. Although African American women are 12 percent less likely to get breast cancer than their white counterparts, their likelihood of surviving it is 16 percent lower than white women, according to the report.

Hispanics/Latinos

Data from the CDC shows Hispanics age 65 and older are among the least likely to get vaccinated for pneumonia. In 1999, their rate of vaccination for pneumonia was 16 percent, compared to 31 percent for whites of the same age group. Hispanics' rate of influenza vaccination was 44 percent, compared to 57 percent for whites.

Hispanics have higher rates of cervical, esophageal, gallbladder, and stomach cancers, compared to non-Hispanic whites, according to the HHS report. Hispanic women over 40 have a 51 percent rate of mammography, compared to 61 percent for white women of the same age.

The rate of poverty for Hispanics is only slightly lower than the rate for African American elderly—approximately 30 percent, according to the Kaiser Family Foundation. But language is an additional barrier to health care. "Because they don't speak English, many Hispanic elderly don't know their rights when it comes to getting social security or health care services through Medicare," says Virginia Barron, a 75-year-old Mexican-American outreach specialist for the National Association for Hispanic Elderly. As a result, many go without coverage.

For information on health resources for minority elderly, call the Office of Minority Health Resource Center at 1-800-444-6472. To order *Healthy People 2010: Understanding and Improving Health*, call (202) 512-1800 and refer to stock #017-001-00543-6 or visit http://www.health.gov/healthypeople.~

In the New Century, the Future is Aging

Guest Editorial By Jeanette C. Takamura, PhD, Assistant Secretary for Aging

America's minority population is getting older, living longer, and becoming more racially and ethnically diverse. These population trends present our nation and its families with many new challenges and opportunities. The Administration on Aging (AoA) remains determined to serve America's minority racial and ethnic groups.

AoA is committed to encouraging America's elders to be prepared for a potentially long life through its work with the aging network, comprised of 57 state agencies on aging, 655 area agencies on aging, 221 American Indian tribal organizations, 11,463 senior centers, and thousands of nutrition sites.

Highlighting Life Course Planning

In its Older Americans Act re-authorization proposal, AoA called for the establishment of a nationwide Life Course Planning Program. Specifically, the program, run through the states, would establish comprehensive public information and counseling programs to advise middle-aged and older people and their families on the critical aging issues for which they must prepare. AoA and the Aging Network would serve as access points at the national, state, and local levels to provide information, consumer protection, counseling, and education to communities, families, and individuals.

A life course planning approach would encourage Americans to:

- Maintain the best possible health status and address long term care needs;
- Establish long-term economic security through the use of pensions, savings, investments, and public benefits;
- Secure living arrangements that accommodate any special needs;
- Engage in productive, satisfying activities including volunteer work; and
- Be informed consumers.

Why Life Course Planning is Important for Minorities

Some minority Americans are not adequately aware of what is needed to sustain oneself over a long life. Minorities, especially minority women, tend to have lower lifetime earnings, smaller pensions, and are more reliant on Social Security than others. Unfortunately, community planning and individual and family lifestyles, plans, and behaviors, as well as current retirement and pension policies do not yet reflect an extended life expectancy and the diversity that will be more commonplace in this century. In 2020, older minority Americans will comprise 22 percent of the population 65 years of age and older, up from 13 percent in 1990.

Health and long term care: Minority older Americans tend to have poorer health status and are disproportionately at risk of preventable, costly chronic diseases and disabilities compared to the older adult population in general. Minority persons also need information about available health and long term care options.

Economic Security: Most minority persons do not realize that Social Security only pays the average person about 40 percent of their earnings when they retire at age 65. Older minorities, especially women, are at special risk of impoverishment. In 1995, 31 percent of African American women age 65 and over and 28.9 percent of older women of Hispanic origin were living in poverty, compared to 14 percent of white women and 13.6 percent of all older women.

Living Arrangements: Life course plans ought to include considerations of living arrangements. People must consider whether arrangements will work if they become frail or chronically ill. Other factors to take into account include the extent to which the environment facilitates access to transportation, doctors' offices, shopping, and other services, and supports ongoing social engagement.

Active Aging and Social Engagement: Many minorities have more of an interest in an active lifestyle, including the option to continue to work, than their parents' generation. Some are even more likely to view retirement as an opportunity to start a new life with new activities and interests. Active engagement, as part of one's life course plan may include the pursuit of employment, volunteer opportunities, lifelong learning, and community involvement.

Consumer Protection: The pace and course of societal and market-place changes create compelling consumer protection needs for older Americans, especially minority elders, who are often the targets of unscrupulous business practices. AoA and the aging network plan to identify and assist with access to pertinent consumer information and protection resources.

May is Older Americans Month, and this year's theme is, "In the New Century....The Future is Aging." The observance spotlights the impact of longevity on nearly every aspect of society. To achieve and maintain quality of life in the older years, we must all anticipate a range of economic, health, and social needs and undertake our own life course planning. AoA is addressing this topic at its national symposium entitled, "Building the Network on Aging Toolkit" at the Drake Hotel in Chicago from May 23-25, 2000.

There are other Older Americans Month activities planned throughout the country. Check AoA's Web site: www.aoa.gov for links to find out about events in your community, and for updated information on its Life Course Planning Initiative.

Who is Helping the Caregivers?

By Jean Oxendine

More than seven million Americans are informal caregivers, according to the 1994 National Long Term Care Survey. These caregivers, most of whom are spouses, are critical to the survival of their elderly loved ones. If these caregivers were to be replaced by paid home care staff, the cost to our nation would be $94 billion per year.

With caregivers dedicating an average of 20 hours per week, and even more time when the older person has multiple disabilities, the physical and emotional toll can be extreme. Two-thirds of working caregivers report problems with juggling work and caregiving.

According to the 1996 National Alliance for Caregiving and AARP survey, the typical caregiver is a 46-year-old woman who is employed and also spends around 18 hours per week caring for her mother who lives nearby. The average duration of caregiving is 4.5 years. And the typical recipient is a 77-year-old woman who lives alone and has a chronic illness. Caregiving is mainly a woman's role, both for white and minority populations. Fifty-two percent of Asian, 77 percent of African American, 74 percent of White, and 67 percent of Hispanic caregivers are women.

According to Jim Steen, aging program specialist with the Administration on Aging (AoA), "In the last 10 years, there has been increasing attention paid to differences in caregiving across racial and ethnic groups." Early studies compared African Americans and Whites, and more recently, researchers have studied Hispanic and Asian subgroups as well. The 1996 National Alliance for Caregiving and AARP survey reported a higher incidence of caregiving among Asian-American (31.7 percent), African-American (29.4 percent), and Hispanic (26.8 percent) households than in the general population.

Asian American, African American and Hispanic caregivers are more likely than the general population to provide care for more than one person. They were also more likely than White caregivers to live with the care recipient and to have help from other persons.

Legislation

The Older Americans Act (OAA) requires that priority in service provision be given to "older individuals with the greatest economic and social need, with particular attention to low-income minority individuals." The same priority applies to caregivers.

The issue of caregiving is garnering national attention with the announcement of President Clinton's Long Term Care Initiative which proposes a number of measures to meet the country's long term care needs. Last year the Initiative included a proposed National Family Caregiver Support Program which would be funded as part of a reauthorized OAA and administered by AoA. This proposal is still under consideration by Congress. This year the Initiative includes a FY 2001 budget request of $125 million, utilizing existing OAA authority. These funds would finance respite, adult day care, caregiver training, in-home assistance, and other caregiver support services identified by State and Area Agencies on Aging. In FY 2001 AoA also is requesting additional funds to meet the long term needs of American Indians, Alaska Natives, and Native Hawaiian elders, many of whom are living well into their eighties and nineties. A portion of these funds are to be devoted to caregiver support services.

Resources

Although the research is preliminary, most evidence shows that despite its high cost, respite is a desired service, whether it is several hours during the day, or for a night or weekend. Individual states decide which type of respite care they will cover.

Other critical assistance is outreach, information, and assistance to caregivers, caregiver training, counseling, and care management. Caregivers often do not realize that they are in a formal caregiving role; they see it as part of their job of being a spouse or a son or daughter. They often don't realize that there are supportive services out there, Steen says.

AoA supports a nationwide, toll-free information and assistance directory called the Eldercare Locator, which can locate the appropriate Area Agency on Aging to help an individual needing assistance for their loved ones, relatives, or friends. Older persons and caregivers can call the Locator at 1-800-677-1116.

AoA also provides assistance to elderly individuals and those who care for them, through its Web site. The "Elderpage: Information for Older Persons and Their Families" page includes fact sheets, informational booklets, information on taxes, prescriptions, financial planning, mental health, and housing at: www.aoa.gov/elderpage.html.

There is also *The Resource Directory for Older People*, administered by the National Institute on Aging and AoA, which contains names, addresses, phone numbers, and fax numbers. You can find the directory on the web: http://www.aoa.gov/aoa/dir/intro.html.

The Older Americans Act and the AoA

By Sibyl K. Bowie

To help families sustain their efforts to care for an older relative who has a chronic condition, illness, or disability, the U.S. Administration on Aging (AoA) proposed legislation to amend the Older Americans Act (OAA) for the establishment of the National Family Caregiver Support Program (NFCSP). President Clinton also announced the NFCSP, one of four proposed long-term care initiatives, in January 1999 and January 2000.

The President has requested $125 million in the fiscal year 2001 budget for the caregiver support program to be funded under Title III-B of the OAA. Funds would support respite, adult day care, in-home assistance and other caregiver support services needs as identified by states and Area Agencies on Aging, as authorized by Title III-D of the Act.

Under the authority of the OAA, the AoA was established in 1965 to organize, coordinate, and provide community-based services and opportunities for Americans 60 years of age and older and their families. Priority is given to those in greatest need.

As the federal focal point and advocacy agency for older persons, the AoA administers most OAA federal programs that provide assistance to older persons and their caregivers, as well as critical support services, such as nutrition and transportation, for older persons at risk of being prematurely or unnecessarily institutionalized. Other AoA programs protect the rights of vulnerable and at-risk older persons and educate them and their communities about the dangers of elder abuse and consumer fraud. The agency

continued on page 14...

Minority Health Perspective

Preparing Now for Long-Term Care

Editorial By Nathan Stinson, Jr., PhD, MD, MPH

In February 2000, the U.S. Administration on Aging (AoA) released results of focus groups that examined American women's planning and attitudes when it comes to long-term care. The focus groups zeroed in on women because women make up 60 percent of the nearly 35 million Americans aged 65 and over, and approximately 75 percent of current caregivers.

Many focus group respondents were anxious about the emotional aspect of receiving care. "I would find it totally frustrating," says one African American woman. "Not being able to do for myself and get about…the idea of losing independence, I think that's one of the hardest things."

A common thread throughout the focus group was the need for information that will help seniors and caregivers make smart decisions and plans for their future. Most respondents reported wanting to remain in their homes as long as possible as they grow older. But most were not fully aware of services that would help them stay at home, such as Meals on Wheels and adult day care.

Results also showed a need for more intensive outreach to communities of color and other historically underserved communities. In some minority groups, such as Asian Americans, Hispanics, and American Indians, conflicts among family members about long-term care decision-making included the extended family.

Across racial and ethnic lines, most focus-group participants had not made any concrete plans for their long-term care needs. Baby boomers (ages 40-55) were less aware about long-term care insurance than seniors (ages 65 and older). The small number of people who did purchase a policy were motivated because they had seen other family members suffer financially. As one Asian American senior said, "I saw my mother's meager savings go down the drain. So I wanted to protect mine." Senior Hispanics and American Indians tended to put their "trust in faith" that everything will work out.

We have to show racial and ethnic minorities that they should still plan for their future. Without planning, families are more likely to face physical and emotional strain, especially residents of rural areas and Indian reservations.

Keep your communities informed about policy efforts that can help support seniors and their caregivers, and let's work together to increase education about AoA's Eldercare Locator (1-800-677-1116). The toll-free line is a link to a network of state aging agencies, local agencies on aging, and Indian tribal organizations, and is dedicated to identifying resources for older people. Help us spread the word that preparing for our future can't wait.~

Elderly Face Challenges in Managing Medication

By Michelle Meadows

Forgetting to take prescription medication is a common mistake among older patients. There are also times when they deliberately don't take medication, according to Jeff de la Fuente, professor and director of geriatric programs at Virginia Commonwealth University's School of Pharmacy. "Some hoard medicine and save it for a rainy day." Other patients have the opposite problem and take too many pills. "They'll tell themselves that if one is good, two is better," de la Fuente says.

Health providers have also observed a dangerous tendency among elderly people to share medication with friends and relatives. People often aren't aware that medicine behaves differently in older people. "There are critical differences in the way younger people and older people absorb medicine," says Mary Lee, Pharm.D, dean and professor at the Chicago College of Pharmacy.

"Because kidney and liver function diminish as you get older, you have less ability to metabolize and eliminate drugs," Dr. Lee explains. And because drugs stay in the body longer when you're older, medication timing and dosage are even more critical than normal. Take hypnotics and sedatives. "Older people generally require only half the dose of a younger person."

"They're faced with: Do I buy medicine or do I buy food?"

Experts agree that helping older people manage medications more effectively requires commitment not only from patients, but also doctors, health educators, pharmacists, drug companies, and policymakers.

Among the medication issues that need more attention:

- **Managing multiple medications.** Because older people tend to have concurrent illnesses and take multiple medications, the likelihood of drug interactions is higher. Research has shown that patient compliance improves with fewer doses, says Dr. Lee, who notes that pharmacists can look for ways to give patients one pill to take per day instead of three. Patients can also be encouraged to use memory devices such as pill boxes with alarms and timers. Other pill boxes label the days of the week and time of the day.
  Diane Justice, deputy assistant secretary for aging at the U.S. Administration on Aging (AoA) notes that some older people may be unable to prepare their own weekly pill boxes due to vision or cognitive limitations. Area agencies on aging can assist older people link up with home care providers who can help lay out medications for the week, she says.
- **Reading labels and understanding instructions.** Patients who have difficulty reading labels can employ tactics similar to those related to managing multiple medication. For example, color coding bottles may help (take the blue one six times a day.) Doctors and pharmacists also need to tell patients what six times a day means. Does it mean at evenly spaced intervals? Does it mean you need to take a dose in the middle of the night?
- **Ensuring consistency in care.** Cost is an important issue because older patients tend to shop around for cheaper prices. But experts recommend using one pharmacy for all medication needs so that your record is in one place. De la Fuente says he once received orders to fill two prescriptions from two different doctors for the same patient. The problem is that it was the exact same medication. One doctor wrote a prescription for the brand name Valium and the other ordered the generic version Diazepam. "It was the same medication, but different color pills and different strengths," he says. "So if both were filled, the patient would have taken them without knowing."
- **Reporting *all* medication use**. Many patients mistakenly don't think of herbs and over the counter products when asked about their medication use. Doctors need to do a better job of asking and patients need to understand that herbs and OTC medicines can interact with prescription drugs. For example, St. John's Wort interacts with Theophylline, a bronchodilator, says Dr. Lee. "The herb could possibly compromise the effects of this drug in asthma patients," she says.
- **Managing cost.** Drugs are expensive, and Medicare does not cover prescription medication. De la Fuente estimates that drugs can cost an older patient about $300-400 a month. Some go to fill a prescription, find out the cost, and leave. "They're faced with: Do I buy medicine or do I buy food?" President Clinton has proposed a prescription drug benefit for all Medicare recipients, with extra benefits for those with lower incomes. The benefit would include a monthly premium and cover half of all prescription drug costs over the next few years up to a ceiling of $5,000. There are also more than 20 bills on Medicare/prescription drug coverage before the Senate and House of Representatives, according to the American Association of Retired Persons.
- **Understanding side effects.** Some new side effects unexpectedly surface for older people because clinical drug trials have, until recently, focused on middle aged people. De la Fuente says it's also important to note that symptoms such as memory loss, forgetfulness, and falling are sometimes side effects of drugs. "But people don't ask because they assume those problems are part of aging."

Resources for elderly taking medications

- *Medicines: Use Them Safely*, National Institute on Aging (NIA), 1-800-225-2225, http://www.aoa.gov
- *Talking with Your Doctor, A Guide for Older People*, NIA, 1-800-225-2225, http://www.aoa.gov
- *Prescription Medications and You*, Agency for Healthcare Research and Quality, http://www.ahrq.gov
- *"Your Medicine Cabinet Needs an Annual Checkup, Too,"* FDA Consumer magazine, March-April 2000, http://www.fda.gov. ~

Healthy People 2010: Objectives for Older Adults

In January 2000, Health and Human Services Secretary Donna E. Shalala and Surgeon General David Satcher launched the new goals and objectives for Healthy People 2010 (HP2010), a national initiative that aims to improve the health of all Americans and eliminate disparities in health.

With guidance from the Administration on Aging, HHS came up with several focus areas for the elderly population. Reducing the prevalence and overall number of people who suffer from diseases such as arthritis, osteoporosis, cancer, diabetes, and kidney diseases are primary HP2010 focus areas, reflecting the increasing concerns for the nation's elderly.

Also included in HP2010 is a goal to reduce the overall rate of diabetes and prevent its associated health problems. Strategies to do this include: increasing formal diabetes education for people with diabetes from 40 percent to 60 percent; increasing the number of annual dilated eye examinations, annual foot examinations, and dental examinations for people with diabetes; increasing the proportion of adults with diabetes who take aspirin at least 15 times per month in an effort to reduce the likelihood of heart attack or stroke; and increasing performance of blood glucose self-monitoring to at least once daily.

Some other age-specific goals include: increasing the number of older persons receiving pneumonia and influenza vaccinations and colorectal cancer screenings. Increasing access to long -term care services and eliminating problems associated with medications for patients over 65 are also included in HP2010, along with increasing daily physical activity and cardiovascular health.

For more information on HP2010 goals and objectives, call (800) 367-4725, or go to http://www.health.gov/healthypeople.~

As You Age, Breast Cancer Risk Rises

By Barbara C. Good, PhD

The risk of breast cancer increases with age. But more than one-third of women 65 and older are less concerned about getting the disease than they were when they were younger, according to a recently released national telephone survey by the National Cancer Institute (NCI) and the Health Care Financing Administration (HCFA).

By age 30, one in 2,525 women has developed breast cancer. By age 40, the number has risen to one in 217 women. By age 50, one in 50; by age 60, 1 in 24 women; by age 70, one in 14; and by age 80, one in 10 women has developed breast cancer.

Factors that increase a woman's risk of developing breast cancer are: aging, having family history of the disease; having a child after age 30, menstruating early, and having a history of breast conditions like lobular carcinoma in situ or atypical hyperplasia. But most women who develop breast cancer possess none of the known risk factors.

Although most older women have had at least one mammogram in their lifetime, many don't get them according to schedule. The American Cancer Society and the American College of Radiology recommend one mammogram per year for women age 40 and over who are not "at risk." Earlier or more frequent mammograms may be recommended for some women who are at higher risk. More outreach on preventive measures, including the fact that Medicare covers the cost of mammograms, is needed. The NCI survey showed that minority women are nearly twice as likely as whites to be unaware of this benefit.

Sponsored by NCI, the National Surgical Adjuvant Breast and Bowel Project (NSABP) conducts research on prevention and treatment. Last year, the NSABP completed a study of more than 13,000 healthy women, showing that the drug tamoxifen, which has been used to treat breast cancer, can also be used as a preventive agent to lower the risk of developing the disease.

The NSABP recently began a second "prevention" trial called The Study of Tamoxifen and Raloxifene (STAR). This study of 22,000 women will compare the now-proven benefits of tamoxifen with the promising effects of the drug raloxifene for lowering risk. To be eligible, women must be postmenopausal, at least 35 years old, and at high risk as determined by a computerized calculation.

For information on breast cancer and mammography screening, or to locate a participating STAR near you, contact NCI's Cancer Information Service at 1-800-4-CANCER; http://www.nci.gov. Or, visit NSAPB's Web site at: http://www.nsabp.pitt.edu.

Dr. Good is medical editor for NSABP.~

OAA, Dept. of Labor Helps Seniors Stay Employed

There are approximately 17.3 million people ages 55 and over in the workforce, an increase of two million since 1996, according to the Bureau of Labor Statistics. With the baby-boomer population growing, the number of older workers will increase significantly.

Age discrimination and outdated skills can limit choices for elderly people who seek work. To help curb these barriers, the U.S. Department of Labor (DOL), through the Older Americans Act, offers a Senior Community Service Employment Program (SCSEP) for those 55 and older. The program also promotes part-time jobs in community services for jobless, low-income persons.

Program participants can work up to 25 hours per week in community service assignments at places such as senior citizen centers, schools or hospitals, programs for people with disabilities, fire prevention programs, or in areas such as beautification and restoration projects and economic development. Job training is provided in four employment areas, including home health, bank telling, information technology, and construction. Almost 80 percent of SCSEP participants are over 60 years of age; two-thirds are women, and more than 30 percent are minority group members, according to DOL.

To learn more about SCSEP, call your state office for aging, or call (202) 219-8211.~

Minorities More Likely to Rely on Medicare

By Houkje Ross

Minorities are far more likely to depend solely on the traditional Medicare program for their health insurance, according to a 1999 Kaiser Family Foundation (KFF) report, *Key Facts: Race, Ethnicity and Medical Care.* Almost 25 percent of African Americans and Hispanics/Latinos have no supplemental coverage, compared to 10 percent of all whites. Two-thirds of all white beneficiaries have Medigap or employer-sponsored retirement benefits, compared to only one third of African Americans and one fourth of Latinos, according to the report.

Minority dependence on Medicare can be attributed to higher poverty rates and lower incomes in African American, Hispanic, and American Indian/Alaskan Native (AI/AN) populations. This can create huge financial burdens and tough decisions for beneficiaries who must pay out-of-pocket costs for services not covered under Medicare.

"One woman told me she was taking her medication only every other day, instead of every day as prescribed," says Tricia Neuman, director of Medicare Policy Project at KFF. "She could not afford to pay her bills otherwise."

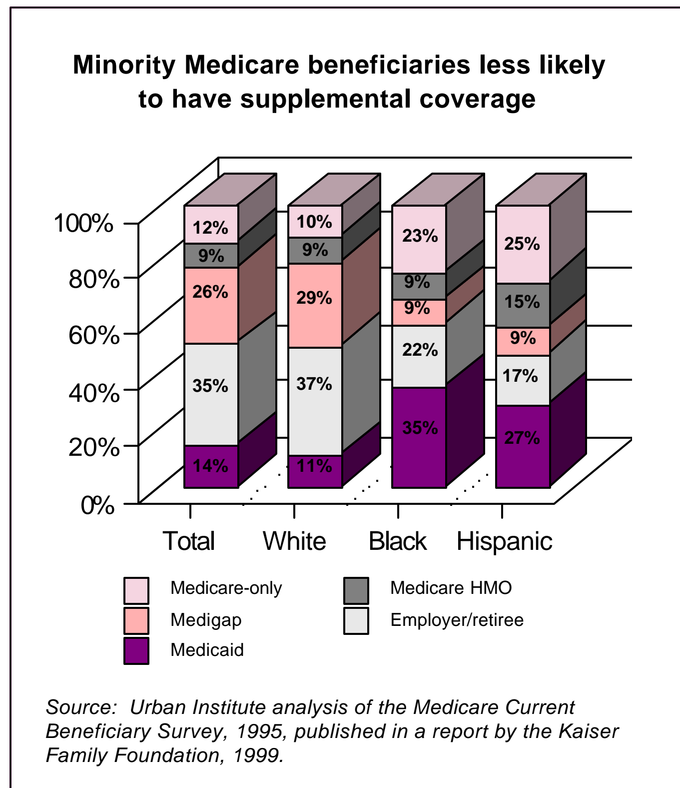
Minority Americans account for 16 percent of the nation's elderly population. Generally, racial and ethnic minorities suffer from illness more often and are more likely to live in poverty. So limited access to health care and financial burdens are more likely, according to KFF.

More than half of the minority Medicare population is African American. Latinos are the next largest group. Asian Americans and Pacific Islanders and AI/ANs represent less than two percent. Bill Benson, of the National Indian Council on Aging, says services such as having Medicare certified providers rarely exist where AI/ANs live.

The study also found that African American and Latino beneficiaries are likelier than whites to have serious health problems and long term needs. More than 40 percent of Latinos and African Americans perceive their health as fair or poor compared to 26 percent for whites.

More than 1 in 6 African Americans and Latinos have limitations in functional status compared to 1 in 10 whites. Minority beneficiaries are also more likely than whites to have cognitive impairments such as dementia.

For a copy of the KFF report, call 1-800- 656-4533; or access it at: http://www.kff.org.~



Source: Urban Institute analysis of the Medicare Current Beneficiary Survey, 1995, published in a report by the Kaiser Family Foundation, 1999.

Medicare Beneficiaries Can Receive Medicaid Supplements

Many Medicare beneficiaries struggle to pay health care costs not covered by Medicare. There are programs that can help pay out-of-pocket medical expenses. The Health Care Financing Administration (HCFA) developed an outreach kit, *Savings for Medicare Beneficiaries,* to educate outreach workers and beneficiaries about cost saving programs available through Medicaid. Medicaid is a jointly funded federal and state health insurance program for people with low incomes.

Developed in 1965 as Title XVIII of the Social Security Act, Medicare is the nation's health insurance program for people age 65 and over. But gaps in coverage exist. The most controversial is the lack of coverage for most prescription drugs. This can be especially costly for the elderly, many of whom are on fixed incomes.

Most people don't know that those covered under Medicare may be eligible to apply for financial coverage through Medicaid. "A lot of Medicare beneficiaries are either unaware of the cost savings programs—which can put up to $546 back into their pockets—or they don't think they qualify," says Debby Higgins, health insurance specialist for HCFA.

The American Association of Retired Persons (AARP) reports that about half of poor Medicare beneficiaries who are also eligible for Medicaid—approximately 1.5 million people—do not receive this supplementary assistance. These beneficiaries will spend about half of their income on out-of-pocket costs for health care, according to the AARP.

continued on page 9...

Meals on Wheels Helps Elders Maintain Good Nutrition

By Houkje Ross

The nutrition needs of older Americans are complex, says Jean Lloyd, a nutrition specialist for the Administration on Aging (AoA). For example, older adults often don't get enough daily nutrients or fluids, which can affect the way medications work, Lloyd says. Vitamin A and D are extremely important.

There are also critical differences in nutrition needs across the spectrum of the aging population. For example, an 85 year-old is more likely to have problems with diminished appetite than a 60 year-old, Lloyd explains. This can mean not feeling hungry and not eating at a time when nutrients are becoming more important.

"It's a good way for elders to find out about their community programs, to find a job, get physical activity, or find a volunteer opportunity."

Other reasons for not getting enough nutrients may include not being able to get to the grocery store or not being able to cook due to illness. Struggling to pay the costs of medications, dentures, or a hearing aid may mean cutting back on groceries. The challenge is that becoming older often means having to pay more attention to what you eat, Lloyd says.

To ensure that elders receive at least one nutritious, appetizing, and culturally appropriate meal a day, the Older Americans Act mandates funding for a national nutrition program called the Elderly Nutrition Program, also known as Meals on Wheels.

AoA administers grants to state and community programs on aging, which then provide nutrition services such as meals or nutrition education. AoA also provides funds to tribal organizations to serve American Indian elders.

Through Meals on Wheels, seniors can receive meals at home or in a group setting such as a senior center. The program serves more than three million elders aged 60 and over. All those 60 and over are eligible, but the program targets those in greatest need.

Older adults often contribute funds and volunteer their time, says Lloyd. Volunteers at the community level, funding from private or state sources, and the U.S. Department of Agriculture help support the program.

Between 80 and 90 percent of those participating in Meals on Wheels have incomes below 200 percent of the poverty level, according to AoA. A large percent of those served by the program are minorities, Lloyd says.

Nearly four times as many Meals on Wheels participants are low-income minorities, compared with the overall population aged 60 and older.

An added benefit of the program is that it keeps elders connected to the community, says Lloyd. More than twice as many program participants live alone compared with the overall elderly population (60 percent versus 25 percent), according to AoA.

When asked what they like most about the program, 77 percent of those who receive meals in a group setting and 70 percent of those who receive meals at home mentioned interacting with the other participants, according to an AoA report.

"It's a good way for elders to find out about other community programs, to find a job, get physical activity, or find a volunteer opportunity, Lloyd says.

For more information on the program, call AoA's Eldercare Locator at (800) 677-1116, or browse AoA's Web site at: http://www.aoa.gov.~

Medicare...*from page 8*

HCFA sent approximately 6,500 outreach kits to federal agencies, community based organizations, advocacy groups, health care providers, and others. The kits included brochures, posters, an article, and public service announcements to help workers promote cost-saving programs to beneficiaries.

For more information about the outreach kit, contact: Debby Higgins, HCFA, (410) 786-3764, or visit HCFAs Web site at: http://www.hcfa.gov/Medicaid/dehmpg.htm.~

Immunizations: Not Just for the Young

By Jennifer Brooks

Most people think of children when they hear the word "immunization." But for adults, especially those 65 years and older, getting immunized against certain diseases is just as important and can prevent thousands of deaths each year.

Influenza and pneumonia are the fifth leading cause of death among the elder population, according to the Centers for Disease Control and Prevention (CDC). Some 20,000 deaths nationwide are attributed to influenza each year; 80 percent of those cases are among people over age 65. Additionally, 40,000 people, mostly elderly, die from pneumococcal infection.

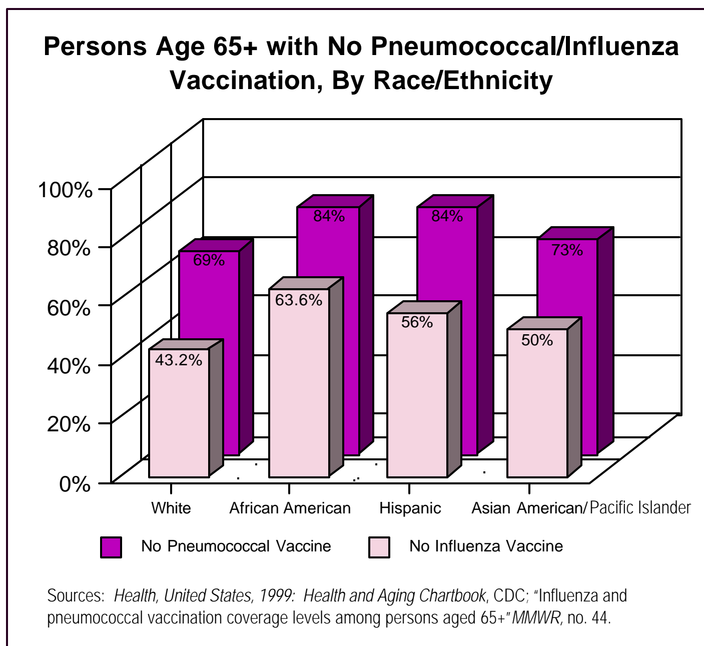
Why Vaccines are Important

More commonly known as "the flu," influenza is a highly contagious viral infection of the respiratory tract—nose, throat, and lungs. But unlike other respiratory infections like the common cold, the flu often causes more severe illness such as fever and extreme fatigue. According to CDC, younger and generally healthy people who get the flu recover within two weeks, but elderly people who come down with it are more likely to develop severe conditions such as pneumonia.

Likewise, bacterial pneumococcal infection can have a devastating impact on the elderly. Pneumococcal bacteria can invade the blood stream (bacteremia) or brain (meningitis), causing serious complications and even death.

Both the influenza and pneumococcal (PPV) vaccines are safe and effective. Experts recommend getting a yearly flu shot before the flu season begins—by mid-November. This gives the body time to build the proper defense before the flu season is in full swing. CDC reports that most people experience minimal side effects, such as low-grade fever.

One dose—which is all one needs to be immunized against pneumococcal infection for a lifetime—protects against 23 different types of bacteria that cause over 90 percent of all pneumococcal disease cases, according to the CDC.



Sources: *Health, United States, 1999: Health and Aging Chartbook*, CDC; "Influenza and pneumococcal vaccination coverage levels among persons aged 65+" *MMWR*, no. 44.

Who should get immunized?

The attack rate of invasive pneumococcal infection begins to increase at about age 55 and rises even more sharply at age 65. African Americans and American Indians are more likely to have underlying high-risk conditions such as diabetes and heart disease, and they are more susceptible to invasive pneumococcal infection, according to the CDC. Thus, all persons over age 50, particularly African Americans and American Indians, should be assessed for high-risk conditions that indicate the need for pneumococcal vaccine. And everyone age 65 and older not previously immunized should receive the vaccine.

People over age 65 should also immunize themselves against other diseases such as tetanus (lockjaw) and diphtheria (bacterial disease affecting the throat and windpipe). A simple booster shot every 10 years protects against these dangerous diseases. In addition, people at risk for measles, mumps, rubella, and hepatitis B should also get vaccinated. Contact your physician to find out if you are at risk for these diseases.

Disparities in immunization rates

The nation's Healthy People 2000 goal of increasing influenza vaccine rates among persons at high risk for complications by 60 percent, was met by all 50 states and the District of Columbia. However, no state reached the target for pneumococcal vaccination, according to 1997 data from the Behavioral Risk Factor Surveillance System.

"Too few African American adults are immunized," says Yvonné M. Fuller, maternal and child health director of the National Medical Association (NMA). Despite increasing influenza and pneumococcal

continued on page 11...

Immunizations...*from page 10*

vaccination levels over the past 10 years in all racial and ethnic groups age 65 and over, "immunization rates among African Americans remained significantly below Healthy People 2000 objectives," Fuller says. Pneumococcal vaccination levels were especially low among African Americans.

In June 1999, the NMA convened the Adult Immunization Consensus Panel to look at these disparities. The panel found that a major barrier to immunizations was a general lack of awareness because the provider failed to recommend it. "Also, many people are scared of needles or misperceive side effects, such as thinking the flu shot can cause someone to get the flu," Fuller says.

Jeanette C. Takamura, PhD, Assistant Secretary for Aging and head of the Administration on Aging (AoA), identified fear of immunization based upon medical experiments conducted in the past as one of several barriers to immunization.

Another barrier is cost. "Many elderly people have the misperception that they will have to pay for these immunizations, when in reality they are covered by Medicare," said Dr. Takamura. According to the Health Care Financing Administration (HCFA), Medicare will cover the cost for one influenza vaccination per flu season and for one dose of the PPV vaccine.

Raising Public Awareness

"People are more likely to listen to their physicians about getting immunizations," said Linda Horsch, communications and outreach specialist for HCFA Region VI. "That is why we collaborated with NMA to encourage doctors to talk about immunizations with their patients." The HCFA grant allows NMA to conduct 11 education programs for physicians and health professionals who work with minorities and underserved populations.

The program, "Immunizations: A Family Affair," is presented in a dinner symposium-style format that offers interactive training sessions for attendees at no cost for Continuing Medical Education Credits (CME) or for meeting materials. Launched in February 2000 in Houston, TX, sessions will take place throughout the year in Atlanta, GA, Chicago, IL, Charlotte, NC, Dallas, TX, Gary, IN, Louisville, KY, Memphis, TN, Miami, FL, Newark, NJ, and New Orleans, LA.

AoA's national aging network of state and area agencies on aging is also very active in immunization outreach. The AoA is also a partner in the HHS Eliminating Health Disparities Among Minority Elders Initiative.

The National Coalition for Adult Immunization (NCAI) has information ranging from immunization fact sheets, publications, and immunization schedules, to contact information. NCAI's Web site links to the National Foundation for Infectious Diseases, and has a clickable map of state contacts for adult immunizations, plus regional project directors, program managers, and public health advisors for the CDC National Immunization Program.

For more information, v*isit NCAI's Web site:* http://www.nfid.org *or call (301) 656-0003. For the NIA Age Page: Shots for Safety, visit:* http://www.aoa.gov. *For physicians and health professionals interested in participating in NMA's interactive training sessions, contact Yvonné Fuller at (202) 347-1895.*~

Recognizing and Treating Depression in Older Adults

By Houkje Ross

You don't give a damn about yourself, anybody, or anything. Your aches and pains intensify. Any pride you took in your hair or how you looked disappears. This is how 70-year-old Hikmah Gardiner, an African American, describes depression.

Gardiner, who has struggled with depression since she was 10, is the division director of mental health services at the Mental Health Association of South Eastern Pennsylvania. She also works as a peer supporter at the association, which serves predominantly African American and Hispanic patients.

A large reason older people become depressed is the loss and grieving they experience, says Gardiner. "They lose their spouses of 60 years, their children die before they do, or their grandchild gets shot in the street. There is tremendous loss," says Gardiner.

Barriers to Diagnosis and Treatment

More than two million of the 34 million Americans age 65 and older suffer from some form of depression, according to the National Institute of Mental Health (NIMH), National Institutes of Health. But statistics from NIMH also show that over 50 percent of the time, physicians miss or misdiagnose depression in older adults. Recognizing and treating depression in older adults is complicated, says Marion Becker, PhD, associate professor in the Department of Mental Health at the Florida Mental Health Institute of the University of South Florida.

Older people are more likely to suffer more than one illness at a time, requiring multiple diagnoses and medications, says Dr. Becker. Symptoms from diseases like dementia, delirium, Parkinson's disease, or stroke, may overlap, mimic, or distort symptoms of depression, according to the American Association for Geriatric Psychiatry. These disorders make it easy to overlook treating depression in the elderly. Studies also show that doctors spend less time with patients the older they get, Becker adds.

Depression occurs at higher than average rates in heart attack and cancer patients, persons with diabetes, and post-stroke patients, according to NIMH. These are all diseases that are more prevalent in the elderly. "Chronic illness, which often afflict the elderly, goes hand in hand with depression," Dr. Becker says.

Common medications used to treat illnesses found in the elderly can cause depression. African American elderly, who have a higher incidence of hypertension, may suffer from depression as a result of their medication, says Dr. Becker.

Another factor that plays into the increased rate of depression in the elderly is a reluctance to tell a provider about psychological symptoms, according to the Surgeon General's Report on Mental Health. "As a rule, no matter what color they are, older people don't come forth as quickly as the younger ones do," says Gardiner.

They are afraid to tell anyone because of fears of having to go to a nursing home and the stigma associated with mental illness, says Gardiner "Some older folks were taught to be quiet and sit in the corner," she adds. Living in a society that does not encourage anyone, regardless of age, to talk about mental illness makes things more complicated. The public needs to learn about mental illness, and especially how it affects older adults, says Gardiner. "We need to start talking about depression."

Gardiner agrees and adds that some primary care physicians are not trained in how to treat mental illness. Some prescribe drugs to treat mental illnesses, but may not have the knowledge of a mental health specialist, says Gardiner. Doctors are also sometimes guilty of glossing over depressive symptoms in older adults as, "Oh, she's just getting old," says Gardiner. "It's not normal to be depressed, at any age," she says.

Family members need to take their elders directly to a service provider, suggests Gardiner. Don't assume they will go on their own, says Gardiner. "They'll come up with all sorts of excuses: *'These doctors are crazy,' 'I'm ashamed,' 'I feel fine.'* The ideal situation is for elders to see a private therapist, who can give an adequate evaluation," says Gardiner. If they don't have the means to do that, then their local mental health center can be a good resource.

To learn more about mental illness in the elderly, contact the Administration on Aging (202-619-7501) or the National Institute of Mental Health (301-443-4513). Both HHS agencies provide information on identifying and treating depression in the elderly. (See resources on page 14 for mailing and Internet addresses.)~

Common Diseases Among the Elderly

Diabetes Mellitus

Diabetes is increasing in prevalence and incidence, particularly among the elderly, according to the University of Texas Center on Aging. Approximately 6.3 million people (18.4 percent) age 65 years and older are diagnosed with diabetes. Only 8.2 percent of people between the ages of 20 and 64 have diagnosed diabetes, according to the National Institutes of Health. Although the number of persons with undiagnosed diabetes has declined, due to new screening guidelines, there are still more than 5 million people undiagnosed with the disease.

Diabetes occurs more frequently in American Indians and Alaskan Natives (AI/AN), who are 2.8 times more likely to get the disease than whites. Tribes in the Albuquerque, NM, Phoenix and Tucson, AZ areas have some of the highest rates of diabetes in the world, according to the Indian Health Service. Hispanics and African Americans are also at greater risk for the disease than whites. The disease affects the body's ability to produce or respond to insulin, a hormone that allows blood glucose (blood sugar) to enter cells and be used for energy.

Complications of diabetes can include heart disease, stroke, high blood pressure, blindness, kidney disease, gum disease, and amputations. People with diabetes are more likely to die of pneumonia or influenza than people who do not have diabetes.

Though this chronic disease has no cure, it can be controlled through medication, diet, and exercise. Patient education is critical. The American Diabetes Association (ADA) has a project called *Awakening the Spirit*, which delivers critical messages to AI/AN communities. The program focuses on the importance of choosing a healthy lifestyle for oneself and generations that follow.

For more information on diabetes or Awakening the Spirit program, contact ADA, (800) 342-2383, or http://www.diabetes.org. NIH and the Centers for Disease Control and Prevention have collaborated on the National Diabetes Education Program, (800) 438-5383. Or contact the National Diabetes Information Clearinghouse at (301) 654-3327.

Cardiovascular disease

Cardiovascular diseases—the leading cause of death in the U.S. for all races—include stroke and heart disease. Contributing factors include: hypertension or high blood pressure, obesity, advancing age, smoking, high cholesterol levels, high alcohol consumption, physical inactivity, and diabetes.

Hypertension, which is very common in African Americans, is the most common reversible risk factor for cardiovascular disease. The National Heart, Lung and Blood Institute (NHLBI), National Institutes of Health, offers seven brochures aimed at educating African Americans about the importance of getting cholesterol levels checked, preventing hypertension, eating less salt, losing weight, increasing physical activity, and avoiding the dangers of smoking.

NHLBI also has an initiative for Latinos called Salúd para su Corazón (For the Health of Your Heart), which raises awareness of the risk factors of cardiovascular disease, and promotes healthy lifestyles.

Contact the NHLBI Information Center at (301) 592-8573 for more about the initiative or publications on cardiovascular diseases.

Glaucoma

African Americans over the age of 40 are more likely to develop glaucoma, a disease that can lead to damage of the eye's optic nerve and result in blindness. The disease is also known as the 'silent thief of sight' because it sometimes strikes without obvious symptoms. It often goes unnoticed until vision loss has already occurred.

If symptoms occur, they include: intense pain, red eye(s), swollen or cloudy cornea(s), halos around lights, recurrent blurry vision, and morning headaches, according to the Glaucoma Foundation.

African Americans over age 65 or those with a family history of glaucoma should have an exam every year, says May Khadem, MD, director of eye programs at Health for Humanity, a non-profit health development organization in Gencoe, IL. African Americans ages of 40 and 65 should get tested every two years; for those ages 20-39, testing should be done every three to five years.

To detect glaucoma, an ophthalmologist typically performs the following tests: visual acuity, visual field, pupil dilation, and tonometry or the "air puff" test. Although glaucoma is not curable, it can be treated and controlled. Early diagnosis is important to protect vision.

For more information, contact: The National Eye Institute, NIH, (301) 496-5248; http://www.nei.nih.gov.

Alzheimer's disease

Approximately 25 percent of all elderly individuals in the U.S. suffer signs or symptoms of dementia, reports the Journal of Geriatric Psychiatry. Alzheimer's disease is one of the most common forms of dementia. The National Institute on Aging, NIH estimates that approximately 4 million persons –almost 11 percent of the population over 65— have Alzheimer's disease. Those with the disease experience a loss of memory and gradually lose their capacity to reason, communicate, and carry out tasks of daily life.

Health care professionals, family members, and the elderly need to know that Alzheimer's disease is not a normal part of aging, says Melanie Starns, community care specialist and project officer for the Administration on Aging's (AoA) Alzheimer's Disease Demonstration Grant Program. Other diseases like depression, metabolic changes seen in the elderly, and some medication interactions can all mimic Alzheimer's.

Since 1998, AoA has provided grants to states that help increase diagnostic and support services to persons with Alzheimer's, families, and caregivers. The program reaches out to the underserved, including minorities, rural residents, and those with low incomes.

For more information on AoA's grant program, call Melanie Starns, (202) 401- 4541. For more information on Alzheimer's, contact the Agency for Healthcare Research and Quality's Publications Clearinghouse at (800) 258-9295 or Alzheimer's Disease Education and Referral, (800) 438-4380.~

Federal Agencies

Administration on Aging
National Aging Information Center
330 Independence Ave., SW Room 4656
Washington, DC 20201
(202) 619-7501
http://www.aoa.dhhs.gov/NAIC

Food and Nutrition Information Center
U.S. Department of Agriculture
National Agriculture Library Building
10301 Baltimore Avenue
Room 304
Beltsville, MD 20705-2351
http://www.nal.usda.gov/fnic/

Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244
(410) 786-3000
http://www.hcfa.gov
http://www.medicare.gov

National Institutes of Health

- National Institute on Aging
  Building 31, Room 5C27
  Bethesda, MD 20892
  (301) 496-1752
  http://www.nih.gov/nia/

- NIA's workgroup on minority aging publishes a newsletter twice a year called *Links: Minority Research and Training*. To get on the mailing list, (301) 496-9265;
  e-mail: palmerne@exmur.nia.nih.gov

- National Institute for Mental Health (NIMH)
  6001 Executive Boulevard
  Room 8184, MSC 9663
  Bethesda, MD 20892-4513
  (301) 443-4513
  http://www.nimh.nih.gov

- Alzheimer's Disease Education and Referral (ADEAR)
  P.O. Box 8250
  Silver Spring, MD 20907-8250
  (800) 438-4380
  http://www.alzheimers.org

- The Geriatric Psychiatry Branch is currently conducting a study on depression in the elderly. For more information, contact: K. Sue Bell,
  (301) 496-5111;
  e-mail: ksbell@codon.nih.gov

- National Diabetes Information Clearinghouse (NDIC)
  National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
  1 Information Way
  Bethesda, MD 20892-3560
  (301) 654-3327
  http://www.niddk.nih.gov

National Organizations

American Association of Retired Persons
(AARP)
601 E Street, NW
Washington, DC 20049
(800) 424-3410
http://www.aarp.org

American Diabetes Association
1701 North Beauregard Street
Alexandria, VA 22311
(800) 342-2383
http://www.diabetes.org

American Cancer Society
National Cancer Information Center
2525 Ridge Point Drive, Suite 100
Austin, TX 78754
(404) 320-3333
http://www.cancer.org

Legislation...*from page 5*

also provides leadership, technical assistance, and support to the National Aging Network and funds the Eldercare Locator.

To assist older American Indians, Alaskan Natives, and Native Hawaiians, the AoA awards funds to 222 tribal organizations representing more than 300 tribes in the U.S. Older persons may enhance their health and serve their communities through employment and volunteer programs made possible through the OAA. Part- or full-time employment for low-income persons 55 years of age or older is available through the Senior Community Service Employment program, a part of the OAA currently administered by the U.S. Department of Labor.

Like other major legislation, the OAA must be reauthorized on a regular basis in order to address the current and future needs and wants of the older persons it serves. The most current reauthorization of the OAA expired in September 1995. Since that time, efforts have been ongoing to reauthorize the Act in both the House and Senate. H.R. 782, a bipartisan bill to reauthorize the OAA in the House was scheduled for Floor consideration on October 4, 1999, but was not finalized. A draft compromise proposal developed by two major aging organizations (National Council on Aging and the National Association of State Units on Aging) has generated attention to the need for the reauthorization of the Act. Congressional members and staff continue to work with the Administration toward reauthorization of the Act before the adjournment of the 106th Congress in the fall of 2000. Almost $1 billion was appropriated for the OAA programs administered by AoA in FY 2000.

For more information, contact the AoA Aging at: (202) 401-4541, or view the AoA Web site at: http://www.aoa.gov. To reach the Eldercare Locator, contact 1-(800) 677-1116.˜

American Heart Association
7272 Greenville Avenue
Dallas, TX 75231
(214) 373-6300
http://www.americanheart.org
(800) 242-8721
Stroke Connection: (800) 553-6321

American Association of Cardiovascular and Pulmonary Rehabilitation
7611 Elmwood Avenue, Suite 201
Middleton, WI 53562
(608) 831-6989
http://www.aacvpr.org

American Lung Association
1740 Broadway, 14th Floor
New York, NY 10019-4374
(212) 315-8700
http://www.lungusa.org/

Arthritis Foundation
1330 West Peachtree Street, NE
Atlanta, GA 30309
(404) 872-7100
http://www.arthritis.org/

Glaucoma Foundation
116 John St. Suite 1605
New York, NY 10038
(800) 452-8266
http://www.glaucoma-foundation.org/info

Meals on Wheels Association of America
1414 Prince Street, Suite 202
Arlington, VA 22201
(703) 548-5558
http://www.projectmeal.org

National Asian Pacific Center on Aging
Melbourne Tower, Suite 914
1511 3rd Avenue
Seattle, WA 98101
(206) 624-1221
http://www.napca.org

National Association of Area Agencies on Aging
927 15th Street NW 6th Floor
Washington, DC 20005
(202) 296-8130
http://www.n4a.org

National Association of Nutrition and Aging Services Programs
PO Box 9007
Grand Rapids MI 49509-0007
(800) 999-6262
http://www.nanasp.org

National Association of State Units on Aging
1225 I Street NW Suite 725
Washington, DC 20005
(202) 898-2578

National Council on Aging
409 Third Street SW 2nd Floor
Washington, DC 20024
(202) 479-1200
http://www.ncoa.org

National Council of Senior Citizens
8403 Colesville Road, 12th Floor
Silver Spring, MD 20910
(301) 578-8800
http://www.ncscinc.org

National Caucus and Center on Black Aged, Inc.
1424 K Street NW, Suite 500
Washington, DC 20005
(202) 637-8400
http://www.ncba-blackaged.org

National Hispanic Council on Aging
2713 Ontario Road NW
Washington, DC 20009
(202) 265-1288
http://www.nhcoa.org

National Indian Council on Aging
10501 Montgomery Blvd., NE
Albuquerque, NM 87111
(505) 292-2001
http://www.nicoa.org

Older Women's League
666 11th St. NW Suite 700
Washington, DC 20016
(202) 783-6686
http://www.owl-national.org

Reports Available on the Internet

- *A Profile of Older Americans*
  http://www.aoa.gov/aoa/stats/profile/default.htm.
- *America's Social Fabric (AARP)*
  http://research.aarp.org/general/civic_inv_toc.html.
- *Age Characteristics in Rural America*
  from the Rural Policy Research Institute
  http://www.rupri.org/policyres/context/age.html.
- **Center on the Demography of Aging,**
  Johns Hopkins University
  http://www.sph.jhu.edu/Research/Centers/Aging/.
- *Guide to Choosing A Nursing Home – Health Care Financing Administration*
  http://www.medicare.gov/publications/nhguide.pdf (only available in adobe format).
- *Medicare Reform: Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead,* February 29, 2000 GAO Report.
  http://www.gao.gov/new.items/h100103t.pdf.
- *Mental Health: A Report of the Surgeon General*
  http://www.sg.gov/librar/mentalhealth/idex.html.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Public Health and Science
Office of Minority Health Resource Center
P.O. Box 37337
Washington DC 20013-7337

Official Business
Penalty for Private Use $300

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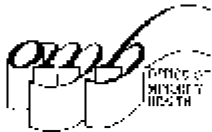
DHHS/OPHS
PERMIT NO. G-280



Closing the Gap

Conferences: Year 2000

May 23-25: Administration on Aging National Symposium II, "Building the Network on Aging Toolkit," at the Drake Hotel in Chicago , IL. For more information, go to: http://www.aoa.gov.

June 7-11: International Conference, *Rural Aging: A Global Challenge*. Charleston, WV. Sponsored by Western Virginia University's Center on Aging. In collaboration with the United Nations Program on Aging, the World Health Organization, and the International Association of Gerontology. Call (304) 293-0628 or visit: http://www.ruralaging.org.

June 26-28: National Association of Nutrition and Aging Services Programs (NANASP) Annual Training Conference, Golden Nugget Hotel, Las Vegas, NV. Will include legislative updates, advocacy efforts, nutrition health outcomes, best practices and more. Contact: Martha Peppones, (425) 290-1264; or e-mail: NANASP@mindspring.com

July 8 –12: National Association of Area Agencies on Aging Annual Conference. Renaissance Cleveland Hotel, Towers City Center. Cleveland, OH. Call (202) 296-8130.

July 9-12: Seventeenth Annual Summer Series on Aging "A New Beginning for a Positive Aging" Lexington, KY. Sponsored by the University of Kentucky's Sanders-Brown Center on Aging. Contact: Mattie Umscheid (606) 257-8301 or visit http://www.rgs.uky.edu/aging/summerseries2000.

July 9-18: World Alzheimer Congress 2000. Sessions include: *Pivitol Research, Bridging Research and Care,* and *Creative Care.* Sponsored by the Alzheimer's Association. Washington Hilton and Towers. Washington, DC. Contact: (312) 335-5813. Or visit: http://www.alzheimer2000.org.

September 14 – 17: Geriatric Care Managers Conference. Sponsored by the National Association of Professional Geriatric Care Managers. Ritz Carlton. Palm Beach, FL. For reservations call (561) 533-6000.

November 12-16: American Public Health Association (APHA). *Eliminating Health Disparities.* Boston, MA. Gerontological health and minority health sessions are planned for this conference. AoA is expected to present on developing culturally competent service programs. Contact: APHA (202) 777-2742, or visit http://www.apha.org.

November 17-21: Annual Scientific Meeting of The Gerontological Society of America. *Linking Research to Policy,Practice, and Education: Lessons Learned, Tasks Ahead.* Washington, DC. Marriot Wardman Park Hotel. Contact: GSA, (202) 842-1275.