Aging Well in Rural America:

A Collection of Stories from the Heartland

Presented by Tivity Health and Health eVillages

Interested in learning more about these organizations and how they are helping the aging population in rural America? Contact Tivity Health at RuralAge@TivityHealth.com or visit RuralAge.com.

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Introduction from Donato

All of us aspire to enjoy good health, prosperity and the comforts brought by our homes, families and local communities as we grow older.

Yet, the experience of aging can be vastly different depending on where you live – whether that's on the coast of Maine or in the urban heart of Los Angeles. Older Americans living in rural areas often face unique challenges. Caregivers and family sometimes live far away. Traditional transportation options can be sparse and access to healthy food may be limited. The challenges of loneliness and social isolation, which are associated with serious public health risks, may be more pronounced.

The good news is that many people, organizations and communities have recognized these challenges and are mobilizing solutions. Across the United States, there are stories of people who are working to promote healthier living and greater social connectedness among older Americans, examining solutions to address social determinants of health and creating innovative partnerships, particularly for those living in rural areas. Even with the challenges posed by geography, those living in rural America are resilient, resourceful and often have deep roots in the community, making community-based programs and approaches successful.

There are stories of people who are working to promote healthier living and greater social connectedness.

Several years ago, I wrote a book to share my own story of challenges, adversities and triumph. Throughout my book tour I learned that everyone has a story and the power of storytelling can help significantly to create a sense of connectedness at a time when people around the globe increasingly feel on their own. Hence, this collection of stories is designed to empower all of us to join the movement to address aging in rural America, social isolation and loneliness by learning about what others are already doing – and where they're finding success. Through the art of storytelling, our goal is to inspire action and new partnerships to tackle the most significant challenges facing older populations.

Our work here is just beginning. I genuinely believe that, by working together, we can empower our older friends, families and neighbors to live out their dreams in full health and prosperity.

Sincerely,

Donato Tramuto

CEO, Tivity Health

Founder, Health eVillages

Background & Acknowledgments

Several years ago, Tivity Health, in partnership with Health eVillages, launched a national campaign on rural aging to encourage everyone – from the private sector to the public sector – to take meaningful action around improving the health and well-being of older adults living in rural parts of the United States. Since launching this campaign, the focus has morphed from *what's going on* to *what can we do about it*. We've also broadened our focus to better understand how social determinants of health and the public health crisis of social isolation and loneliness, impact older adults.

In 2018, we convened nearly 200 people including public health experts, researchers and leaders from the private and public sectors for the annual Connectivity Summit on Rural Aging. What we heard is that people want to learn by example. And, we were missing a centralized resource that could serve as a "community playbook," offering guidance, program ideas, and proven results that other stakeholders working in this space could replicate.

What we heard is that people want to learn by example.

Nearly a year later, we are proud to unveil one such resource with our newest publication: **Aging Well in Rural America: A Collection of Stories from the Heartland**. This collection of stories offers more than a dozen examples of what various people and organizations are doing to promote healthier aging and social connectivity.

The development and production of this collaborative project would not have been possible without the help of our staff and partners on rural aging. Tivity Health thanks in particular the Rural Aging Advisory Council, which represents leading businesses, organizations and experts who are leading our national campaign on rural aging and social isolation. Special acknowledgment to Caroline Young, NashvilleHealth for chairing this effort. Caroline is a member of the Rural Aging Advisory Council and was instrumental in outreach for the stories and in supporting the development of this effort. We also want to acknowledge Justine Page, Ken Currey, Steve Phillips, Kimberly Janicak and Dominic Portalla, who spent countless hours working on this project, organizing the compilation of stories and production of this publication.

AARP Livable Communities

America's historic downtown renewal

Livingston, Tennessee, has been a leader in downtown revitalization for more than a decade. The historic courthouse square, rich outdoor recreation, and Americana music heritage serve as the primary amenities and economic engines for tourism in the community. Livingston leaders saw the construction of a new downtown park and event space as an opportunity to connect and grow assets to improve residents' quality of life. In 2007, the city was selected as a Tennessee Courthouse Square Revitalization Act pilot project community.

The Livingston Downtown Revitalization Committee (DRC) led the Courthouse Square Revitalization program. Through this program, the committee has made strategic investments to establish the courthouse square as a vibrant home to many events that leverage the county's Americana music assets. Livingston was selected to participate in the Tennessee Department of Economic & Community Development Tennessee Downtowns program in 2016.

Central Park, located just off the historic courthouse square, is now bringing more people to downtown Livingston to shop, eat and play. In August of 2017, the city hosted a Solar Eclipse event that brought thousands of visitors to Central Park. New community events at Central Park include tai chi classes, a new walking activity "Walk Livingston," two movies per month, "Live in Livingston" music performances and the community's biggest event "Fall-O-Ween in Livingston."

The Livingston Central Park has increased the number and size of community events that show immediate positive economic impact.

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AARP Livable Communities ***supports the efforts of neighborhoods, towns, cities and rural areas to provide safe, walkable streets, age-friendly housing and transportation options, access to needed services, and opportunities for residents of all ages to participate in community life.***

American Heart Association

Gardening in the heart of Arkansas

People often associate rural America with rolling farmlands and a plethora of access to fresh fruits and vegetables. Unfortunately, many rural communities face a very different reality. In fact, 2.4 million rural households struggle with hunger. Small towns, given their potentially remote locations and limited populations, are often many miles from the nearest accessible grocery store.

Altheimer, Arkansas, is no exception. With less than 1,000 residents and no full-service grocery store, it is considered a food desert. Of its population, more than 65 percent are seniors living below the federal poverty line with limited access to reliable transportation. This community of dedicated seniors is committed to making Altheimer a better place to live. They are starting with an approach that has been a part of their community for many generations: farming.

2.4 million rural households face hunger.

The community is working together with the American Heart Association (AHA) and the Ben J. Altheimer Foundation, the family after whom the town is named, to address food access issues and increase community connectivity. Their first initiative is a community garden project.

The AHA worked with leaders to develop a plan and secure help from the University of Arkansas at Pine Bluff's small farm and garden program. Future steps will include connecting with the schools, offering educational cooking classes, and creating a more sustainable model by working with the town's corner stores to offer healthier options.

With the support of more than 22 million passionate supporters ***and volunteers, key partners and a global network, AHA delivers lifesaving information and programs into clinical facilities, businesses, schools and homes in over 80 countries.***

Blue Zones Project – Albert Lea, MN

Creating a better future today

In 2008, Albert Lea, Minnesota, was suffering in the face of economic downturn. Businesses had closed downtown, and the city was plagued by high smoking rates and low activity levels. Local leaders were determined to transform the situation and teamed up with Blue Zones, LLC in 2009 to become the first Blue Zones Project. The first nine months of initiatives were born out of a partnership between Blue Zones Vitality Project and AARP, sponsored by the United Health Foundation.

"The Blue Zones Project initiative allowed our community to look at ourselves in a different light and build a better future by learning from our past," says Vern Rasmussen, Jr., Mayor of Albert Lea.

Thanks to progressive tobacco policies, residents saw a 35 percent decline in smokers between 2010 and 2016 based on Well-Being Index data. This reduction equates to an $8.6 million annual saving in health care costs for Albert Lea employers.

The addition of more than nine miles of new sidewalks and three miles of bike lanes led to a 40 percent increase in active transportation since 2014. More than a dozen businesses relocated downtown, with more than $2.5 million invested in building permits since 2013. This investment created a 25 percent increase in property value in the downtown area, adding $1 million to the tax base.

Freeborn County jumped to 34th place in the Minnesota County Health Rankings (previously 68 out of 87 counties).

*Using secrets discovered in the original blue zones, **community transformation programs help lower health care costs, improve productivity and boost national recognition as great places to live, work and play.***

Blue Zones Project - Dodge County, WI - Moai

Making transformation a reality

After several preventable risks for serious health problems were identified in Wisconsin's Dodge and Jefferson Counties, the Beaver Dam Community Hospital formed a coalition of local leaders to explore solutions. In three years, Dodge county has seen a decrease in smoking and an increase in the number of residents who feel active and productive daily. Leaders have changed food policy and offerings in restaurants, grocery stores, schools, and workplaces. The addition of the Rotary Riverwalk Park has encouraged outdoor activity, healthy connections, and more community investment.

One of Dodge County's goals is to create a community where residents can – and want to – age in place. Like many other rural communities across the country, the population has begun to decline, with young professionals moving away in search of career opportunities.

Leaders have changed food policy and offerings in restaurants, grocery stores, schools, and workplaces.

To make transformation a reality, Dodge County leaders and Blue Zones Project experts identified key opportunities for impact through community design improvements, tobacco and alcohol policy initiatives. This provides more opportunities for residents to connect and build social networks through walking and healthy potluck groups.

According to Well-Being Index data, residents of Dodge County who are aware of and engaged in the Blue Zones Project have significantly higher well-being than those who are not engaged. Additional well-being shifts for those engaged in the Project include reductions in smoking rates, obesity rates, high blood pressure and high cholesterol, as well as increases in fresh produce consumption and those who feel active and productive daily.

*Using secrets discovered in the original blue zones, **community transformation programs help lower health care costs, improve productivity and boost national recognition as great places to live, work and play.***

California Health Collaborative

Creating hope for aging in place

The California Health Collaborative (CHC) is involved in over 50 programs that target mental health, nutrition, diabetes, smoking cessation, early detection of breast and cervical cancer and much more. CHC serves 54 of the 58 California counties. The variety of public health services offered by the Collaborative are a testament to the power of partnerships in caring for the underserved.

The Collaborative successfully reaches out to where people live, work, learn, eat, spend their leisure time, and receive their health care. In doing so, they have created a far-flung, multi-tiered network that addresses a host of health care challenges.

The variety of public health services offered by the Collaborative are a testament to the power of partnerships.

Ms. Brown is a participant in California Health Collaborative's Multipurpose Senior Services Program (MSSP), a state and federally funded Waiver program that serves low-income seniors in both the rural and urban communities of Placer, Sacramento, Yolo and Yuba counties. Ms. B, 81, lives with her daughter and has been an MSSP participant for 1.25 years. Upon enrollment, she exhibited significant cognitive impairment with a Short Portable Mental Status Questionnaire of 9 out of 10, as well as indicating depression with a Geriatric Depression Scale score of 7 out of 15.

As a participant in the Multipurpose Senior Services Program, Ms. Brown's daughter received alarms to signal when she would attempt to leave her bed. A door alarm was also installed, allowing her daughter to respond quickly, creating a safer environment for Ms. Brown and her daughter.

*The Collaborative addresses the needs of the underserved, **especially those who have limited access to resources affecting their well-being, and face barriers related to culture, language, income, education, gender, geography or immigration status.***

CareMore - Lyft

Lyfting experiences one ride at a time

In 2015, Lyft, the transportation network, partnered with CareMore Health, an integrated health plan and care delivery system, to explore ways to improve the patient experience and reduce costs through access to reliable, on-demand transportation.

Due to limited access to reliable transportation, millions of Americans are not able to access the health care they need each year. Transportation barriers primarily affect the elderly and chronically ill populations, for whom access to ambulatory care is necessary.

In 2016, CareMore launched a two-month long pilot program to assess the impact of adding Lyft for curb-to-curb (C2C) transportation. The pilot offered Lyft rides to 75,000 Medicare Advantage enrollees across California, Nevada, Arizona and Virginia. Within three months of the pilot launch, half of all C2C rides were Lyft-based. By the end of 2017, Lyft was providing 91 percent of all C2C rides accessed by CareMore members.

Due to limited access to reliable transportation, millions of Americans are not able to access the health care they need each year.

The encouraging early results from partnering with Lyft prompted CareMore to expand its partnership across all its Medicare Advantage markets nationwide.

Through the collaboration with Lyft, CareMore is helping thousands of patients across their entire system enjoy better experiences getting to their medical appointments. With the addition of Lyft for CareMore members who need C2C transportation, patient experience has improved, wait times have reduced and efficiency of Non-Emergency Medical Transportation benefits has increased significantly.

CareMore is a health care delivery system built on compassion ***and fueled by innovation, treating patients and families with the care and dignity they deserve. Lyft aims to provide safe, reliable and affordable transportation that lowers barriers to care for those in need.***

Eastern Band of Cherokee Indians

Investing in Cherokee's aging population

The Cherokee Indian Hospital is the primary care institution for more than 13,000 enrolled Cherokee Indians, with more than 35,000 primary care visits per year and 13,000 ER admissions.[1] Over the past five years, the Eastern Band of Cherokee Indians (EBCI) has invested more than $50 million into their health services – focusing on access and quality of care. These investments have centered primarily on the aging population.

The Eastern Band of Cherokee has implemented several programs including geriatric, nutritional, wellness and prevention programs to improve the overall health of the aging population. Access to care in rural western North Carolina has been a major concern for the Cherokee, where they have added rural health care centers.

The Home Health program provides nursing care for homebound patients including skilled nursing, physical, occupational and speech therapy programs. Caring for the Caregiver offers support for family members who are looking after Tribal elders. This program works with the families and looks at short-term respite care based on the individual needs of each family. The Department of Health and Human Services provided the Tsali Care Nursing Facility, a 60-bed facility that is equipped to deliver quality nursing care for Cherokee senior citizens.

Caring for the Caregiver offers support for family members who are caring for Tribal elders.

The Eastern Band of Cherokee's food distribution program, administered through the Public Health and Human Services Department, in conjunction with the US Department of Agriculture, is designed to provide nutritious food to eligible citizens, including the aging and disabled population, to assist with supplementing the families' food needs for the month.

With an emphasis on Cherokee history, arts, crafts ***and the unique healing aspects of Cherokee culture, CIHA addresses the health and wellness needs of the Tribe—and does so to the highest national standards of health care.***

1. http://cherokeehospital.org/

Louisiana Sheriffs' Association

Filling the gaps of elder care

Sheriffs across the country have initiated many community outreach programs that provide senior citizen assistance to "fill the gaps" and meet the needs of our aging population in rural communities.

Louisiana led the way in 1989, when St. Martin Parish Sheriff Charles Fusilier created the "The Right Information and Direction," or Triad Program. Triad is a partnership among three groups: senior citizens, law enforcement and the community. The focus of the Triad Program is to reduce crime against senior citizens and the crime-related fears older adults often experience by keeping them informed. By the early 2000s, with the backing of the American Association of Retired Persons (AARP), International Association of Chiefs of Police (IACP) and the National Sheriffs' Association (NSA), more than 800 counties and parishes signed Triad agreements. Currently, Triad programs are active in 47 states.

Through programs such as Triad, our elderly population can feel safer and more involved in the rural communities in which they live.

Whether it is through hosting community events, helping the elderly in their homes or providing meals for seniors in need, Louisiana's sheriffs are proud to "fill the gaps" to assist the aging population. However, this is only possible with the help of other partners within each community who are willing to help bridge the gap. Through programs such as Triad, the elderly population can feel safer and more involved in the rural communities in which they live.

*The Louisiana Sheriffs' Association's purpose is to maintain the powers of the sheriff **as peace officer, ensure the delivery of first-rate services by sponsoring legislation to promote the administration of criminal justice and serve as a clearinghouse for information.***

Lutheran Services in America

Collaborating to improve rural America

Lutheran Services in America is advancing solutions that support the healthy, independent aging of America's seniors, particularly those struggling with limited resources in rural, isolated settings. In 2015, the organization, along with Lutheran Social Service of Minnesota and Lutheran Social Services of North Dakota, launched its ongoing Great Plains Senior Services Collaborative.

The Collaborative has successfully improved the health and quality of life of over 1,550 low-income, vulnerable seniors in over 70 communities throughout Minnesota and North Dakota and has been expanded to include Montana. Its efforts have led to some of the highest-need older adults receiving services that contribute to improved quality of life and having the freedom to choose where to live.

Efforts have led to some of the highest-need older adults receiving services that contribute to improved quality of life.

The Collaborative's services directly relate to social determinants of health - a key area of focus for Lutheran Services in America and its national network. Its services range from aiding with transportation to medical appointments and coordinating visits to friends and families, to assisting people struggling with dementia, visiting as a needed companion and even helping with challenging household tasks.

Jeff, a Vietnam veteran who has struggled with post-traumatic stress, has cared for his wife, Sheila, since her Alzheimer's diagnosis at age 56. He says the stress of caring for his wife is the hardest thing he's ever had to face. "Day by day, you are faced with tremendous loss," he said. Through Remote Caregiver's respite care and counseling using the program's user-friendly technology, Jeff sees great improvement.

Lutheran Services in America is a nationwide network of 300 health care and human services organizations that work with one in 50 Americans each year. It is deeply embedded in the fabric of communities nationwide and works to transform the lives of people and communities.

Margaret Mary Health

Transitioning volume to value

Margaret Mary Health was founded in 1932 in the rural community of Batesville, Indiana, with only 7,000 people. After a sustained effort to understand the population's specific health needs, the hospital was formed by the community through support and firsthand input. Their main mission is to improve the overall health of the communities they serve.

Over time, Margaret Mary Health began to recognize an ongoing problem in hospital systems throughout the nation: hospitals were getting paid to do things for patients (such as perform surgeries, prescribe treatment and provide other necessary services), but not to keep them healthy after the fact. As a result, Margaret Mary Health made the commitment to focus on helping keep people in the community healthy, especially the elderly and isolated, beyond simply providing clean water and vaccines.

Margaret Mary Health is determined to be the one long-lasting hospital that is dedicated to helping their patients stay healthy and happy in the long-term.

Margaret Mary Health implemented the transition from "volume to value" in order to provide better health care coverage by understanding issues such as social isolation and loneliness.

The ongoing question for Margaret Mary Health remains, "What can we do to help the people in our community feel their best all while addressing social isolation?" To answer this, the community hospital is working with local churches, clubs and city centers to implement programs to keep residents involved and eradicate social isolation. Margaret Mary Health is determined to be the one long-lasting hospital that is dedicated to helping their patients stay healthy and happy in the long term.

Margaret Mary Health improves the health of its communities ***by being the best health care provider for the communities where people choose to go for services, where physicians choose to practice, and where team members choose to work.***

Mercy Community Healthcare

Finding faith and health in rural Tennessee

Mercy Community Healthcare is now in its 20th year of operation and provides health care services to more than 10,000 people in four counties of central Tennessee, regardless of ability to pay.

Over the past two decades, Mercy has added critical services to their offerings, including mental health and social services, chronic care management, pediatric and adult primary care and care coordination. Mercy also maintains a strong footprint in rural areas of Tennessee, often being the insurer of last resort.

Wanda M. lived in a small rural area in Appalachia and cared for her terminally-ill husband for months. Years earlier, Wanda was diagnosed with atrial fibrillation, a condition that can lead to blood clots, stroke, heart failure, and other heart-related complications. Her prescriptions included blood thinning medication and oxycodone, which led to addiction.

Mercy also maintains a strong footprint in rural areas of Tennessee, often being the insurer of last resort.

Her quiet battle with addiction empowered her to recommit to her faith, and when she was forced to move from Florida back to Tennessee, she adjusted more quickly. Thanks to the excellent care she was given at Mercy, and the opportunities and activities available at her new home, the Brookdale Senior Living Center, Wanda's well-being has improved. She is very active as the garden club president and is a hostess for new residents coming into Brookdale.

Mercy Community Healthcare reflects the love and compassion ***of Jesus Christ by providing excellent health care to all and support for their families, regardless of ability to pay. Mercy provides compassionate, convenient and comprehensive services.***

Motion Picture & Television Fund

Social connection a phone call away

Motion Picture & Television Fund's (MPTF) Daily Call Sheet (DCS) is all about creating social connections, addressing social isolation and loneliness affecting industry members, and creating a model for broader impact. The concept is simple: MPTF trains volunteers and matches them with industry members who are isolated and are suffering through loneliness through social telephone conversations. DCS participants live in locations across the U.S., including rural areas where geography and limited transportation options compound feelings of isolation triggered by health and aging challenges.

To expand the reach of this work, MPTF now trains other non-profit organizations in identifying and addressing social isolation and loneliness. With this, MPTF guides organizations in developing and deploying programs that directly address the unique needs of those they serve.

Over half the volunteers report that making the calls helps reduce their own sense of loneliness and isolation.

Participants, isolated due to caregiving duties, treatment facilities or other circumstances, may go many days without speaking to anyone. These recipients describe the calls as a "lifeline" that "lifts their spirits." Of the recipients, 97 percent indicate that they would like to continue receiving calls and would recommend this for others. Over half the volunteers report that making the calls helps reduce their own sense of loneliness and isolation.

Phillip, a 77-year-old retired prop manager, lives in a rehab facility in Ohio where he receives cancer treatments. He moved back to Ohio to be closer to family but found himself very isolated and feeling lonely. He reports, "I am so happy to have been connected to the Daily Call Sheet program. There were times I was so lonely, I thought I was dying. I truly look forward to Lisa's calls and can't thank MPTF enough for creating this program!"

*MPTF supports the entertainment community in living and aging well, **with dignity and purpose, and in helping each other in times of need, through a broad range of innovative programs and services across the lifespan - from childcare through end of life care.***

National Council on Aging

Mastering aging as a joyful experience

Founded in 1950, National Council on Aging (NCOA) is a national advocate for every person's right to age well. Working with a nationwide network of partners, as well as directly with individuals, NCOA focuses on improving the health and economic security of all older adults, and has surpassed its 2020 goal of improving the lives of 10 million older adults with its next goal of improving the lives of 40 million by 2030.

NCOA delivered Aging Mastery® in 39 rural communities in Wisconsin, Minnesota and Washington. Aging Mastery is an innovative, fun approach to living that helps individuals take key steps toward making positive changes in their lives. In a three-year span, more than 4,000 individuals either participated in Aging Mastery Program® (AMP) classes or received the in-home Aging Mastery Starter Kit. The lead state agencies were Greater Wisconsin Area Agency Resources, Inc. (GWAAR), Washington Association of Area Agencies on Aging (W4A) and Minnesota Recreation and Parks Association (MRPA).

Founded in 1950, National Council on Aging (NCOA) a national advocate for every person's right to age well.

Behavior change is a key metric for the AMP classes: 91 percent of participants reported that the classes improved the way they managed their health and 94 percent stated that AMP improved their quality of life. AMP participants most enjoyed its social component and the opportunity to meet new people. Participants often cited steps they took toward increasing gratitude and improving relationships.

Aging Mastery has transformed lives. As one participant said: "As a result of the Aging Mastery Program, I am now more aware of all aspects of aging. I take the time to recognize that small changes can make a big difference and actually make aging a joyful experience."

In addition, the program has transformed communities and NCOA has committed to growing the program over the next three years in additional rural areas in Wisconsin, Minnesota and Washington while focusing overall on improving the economic security and health of all older adults.

NCOA is a respected national leader and trusted partner ***to help people 60+ meet the challenges of aging. NCOA partners with non-profit organizations, government and business to provide innovative community programs and services, online help and advocacy.***

Penn State Intergenerational Program

Bridging the gap between generations

The Penn State Intergenerational Program, an arm of the Penn State Extension, includes a broad base of scholars and practitioners who are interested in studying and employing diverse approaches to growing older across different age groups. They emphasize the development of new models and curricular resources that enrich people's lives and help address vital social and community issues.

Included in the 4-H Youth Development Program is the Generation Celebration Project.

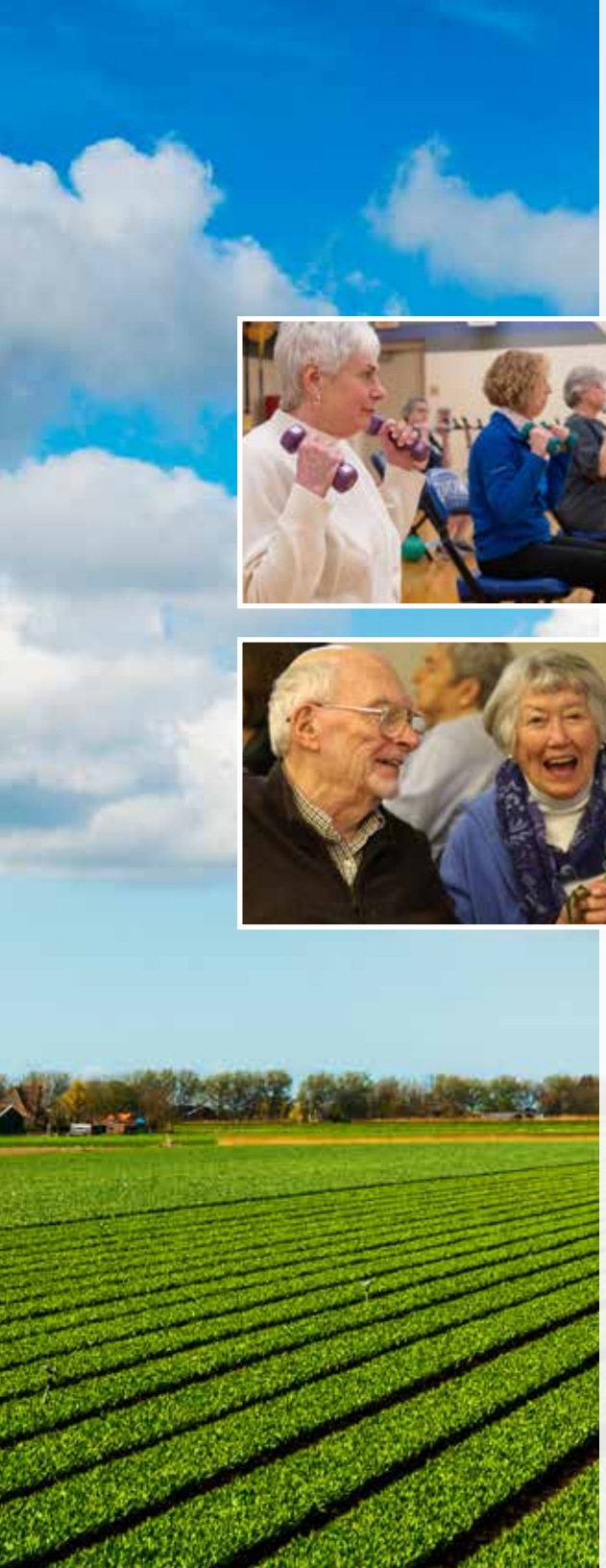
One of their flagship programs, identified as FRIDGE (Food Related Intergenerational Discussion Group Experiences), is designed to help families communicate better about food, learn about nutrition and work collectively to achieve personal healthy-eating goals.

Included in the 4-H Youth Development Program is the Generation Celebration Project. The objective is to help young people and older adults enjoy and learn from each other. The project consists of six sessions designed to aid young people and seniors to become more aware of stereotypes towards aging while having fun and getting to know each other.

Community and civic engagement, early childhood and environmental education are a few other key resources offered by the Intergenerational Program. Many revolve around training and development of intergenerational programs for those associated with each group. The Intergenerational Program acts as a guidebook, demonstrating strategies for children, adults and the elderly.

The Penn State Intergenerational Program is pioneering the development of new intergenerational initiatives, research around them and their impact on communities. Their work demonstrates how individuals can adapt to intergenerational lifestyles, build relationships and break through aging stereotypes.

Penn State Extension program develops initiatives and study ***their impact on communities, to provide leadership and resource support for organizations interested in establishing intergenerational programs.***



Saint Joseph's College of Maine

Pioneering rural needs in Maine

Saint Joseph's College of Maine is taking an innovative approach to addressing the needs of its rural aging population. The newly created Institute for Integrative Aging (IIA) is committed to developing a variety of programs and activities geared toward wellness, social engagement and longevity.

Integrative Aging—a term coined by Saint Joseph's College President Jim Dlugos—seeks to advance the concepts of integrative medicine and health care by developing an understanding and approach to aging. Integrative Aging understands the multi-dimensional aspects of aging (physical, emotional, social, intellectual and spiritual) along with societal factors (socio-economic, urban vs. rural issues and cultural identity) that can negatively impact the health of a population.

Saint Joseph's College of Maine is taking an innovative approach to addressing the needs of its rural aging population.

The IIA is partnering with Tivity Health®, to bring SilverSneakers®, a nationwide fitness program focused on seniors, to campus. Three 45-minute classes are offered per week with a focus on stability, muscle building and endurance. "We are working on the activities of daily life: bringing groceries in, getting in and out of the car and improving personal hygiene. We are working on things the senior community needs help with," says Jenna Chase, Associate Director of Health and Wellness programming. More classes are being added due to an increase in demand and interest.

In addition to the physical benefits of the exercise program, strong social connections are forged, which addresses issues of loneliness and social isolation. IIA's commitment to social connectivity and community engagement is evidenced through the development and support of additional social events for older adults, such as Silver Lunches, Ukulele classes and a Silver Ball.

Saint Joseph's College of Maine is an intentional community ***committed to the practice and pursuit of wellness and sustainability, designed to provide new learning opportunities for a changing society while supporting the growth of Maine's emerging economies.***

Texas A&M Center for Population Health and Aging

Lone Star State implements Texercise for seniors

On November 9, 2016, the Texas A&M Center for Population Health and Aging (CPHA) was formally recognized as a Texas A&M Board of Regents Center, building on more than a decade of aging-related research, education and practice projects. With a goal of making healthy aging the "new normal," CPHA provides a centralized hub to address the challenges and opportunities of a rapidly aging world. Building upon evidence-based practices, CPHA activities focus on social, behavioral, economic, policy, environmental and technological innovations that positively affect aging individuals, their families, health care professionals, and communities.

CPHA works with local communities and partners to offer Texercise Select, a lifestyle program developed by Texas Health and Human Services, throughout the state. The Center worked with Amigos del Valle senior citizen centers and a faith-based coalition, Bienestar, to deliver Texercise classes.

CPHA provides a centralized hub to address the challenges and opportunities of a rapidly aging world.

Through public (e.g. Healthy South Texas initiative) and private funding (e.g. Knapp Community Care Foundation), Texercise Select has been implemented in Amigos del Valle senior centers in rural and underserved areas across South Texas such as Donna, Weslaco, La Joya, Mercedes and Elsa. The program provides fitness kits and light equipment to otherwise sedentary, inactive seniors. As a testament to the popularity and success of Texercise Select, many community centers continued to offer the program after its "official" end. That way, older adults living in rural and isolated areas could keep exercising in a safe environment, while also receiving social support for being active.

The Center for Population Health and Aging is leading a coordinated effort ***to promote research into, and understanding of, successful aging strategies****. Specifically, the Center coalesces several distinct but related aging and health promotion-oriented research programs.*

TN AARP - SMiles

Neighbors driving neighbors

Thanks to a team of 136 adult volunteers, 217 non-driving older adults in rural Blount County, Tennessee, now can make their doctor's appointments, go grocery shopping and visit with others.

Mrs. Smith lives in a remote area seven miles from rural Maryville, Tennessee. Until October of 2013, the options for Mrs. Smith were to call a taxi or schedule a ride with the local rural public transportation provider to get to doctors' appointments. For rural transit, she would leave her house at 8 a.m. and could be driven all over the county in a large van before being dropped off for her 10 a.m. appointment. Afterward, a call to the same provider arranges the pickup. Mrs. Smith would be home by 1:30 p.m., a round trip of five and one-half hours at a cost of six dollars.

The cost is still six dollars, but with the new benefits of efficiency, comfort and friendly socialization.

With SMiles, Mrs. Smith calls and schedules a ride, which is posted online through a special secure software program. A volunteer driver, Joy, assigns herself to take Mrs. Smith to the dentist at 10 a.m. next Wednesday. The two of them have a friendly chat during the ride and while waiting at the office. After leaving the dentist, Joy takes her new friend to the store and then drops her back home by 11:30 a.m., helping bring in the groceries. The cost is still six dollars, but with the new benefits of efficiency, comfort and friendly socialization.

SMiles is a senior-friendly, door-through-door transportation service ***for Blount County, Tennessee, residents age 60+ who need rides for essential trips. The service enhances the quality of life and independence of older adults who no longer drive.***

Valley Area Agency on Aging

Combating loneliness with SilverSneakers

The Valley Area Agency on Aging partnered with AARP to complete a Senior Needs Survey in 2016, in which seniors reported skin rashes, hair loss, anxiety, depression, feelings of isolation and loneliness, fatigue and other serious issues. These were all a result off the lead-contaminated water. Lack of transportation to water distribution stations and the inability to access information and assistance also became evident.

In 2017, the Valley Area Agency on Aging and Tivity Health established a formal partnership to collaborate on strategic ways to enhance engagement for low-income seniors in suburban and rural areas of Flint, Michigan. The goal of this effort was to improve their quality of life, and, by extension, to improve their health, independence and wellbeing.

The SilverSneakers classes continue to grow and have become a source of income for the Valley Area Agency on Aging.

Through this partnership, expanded evidence-based classes and SilverSneakers classes were introduced in area sites with a pre- and post-assessment survey to evaluate the impact of the programming on physical and mental health and loneliness. To date, 360 local seniors have participated in a class series, offered at 15 different locations.

The SilverSneakers classes continue to grow and have become a source of income for the Valley Area Agency on Aging. The ability to leverage support is a concept that can be adopted in other rural and suburban areas. The Agency has noted that the ability to be flexible at on-site locations for activity programs is critical for successful outreach, engagement and retention. Leveraging public-private collaboration is a great story for any community!

VAAA provides answers, action and advocacy on care for the elderly ***and disabled adults of Genesee, Lapeer and Shiawassee counties. It enhances lives, empowering choice, sustaining independence and supporting caregivers and families.***

YMCA

Building healthy living in the community

In 2014, the Ashtabula County YMCA in Ohio, conducted a Community Needs Assessment that indicated a large portion of the county was not being supported with physical/social activities and healthy living opportunities, especially for older adults.

With a mission to put Christian principles into practice through programs that build a healthy spirit, mind and body for all, the Ashtabula County YMCA hired its first ever Outreach Director in 2015 and began a Community Outreach program.

Prior to starting senior group exercise classes, Carol, a 79-year-old from Andover, Ohio, was spending most of her time at home alone. In the summertime, her friends were in town and she was significantly more active. However, her friends would leave for Florida every Fall, and she would spend the next eight months in her house, alone and unmotivated.

For the first time without her friends, Carol came out to the YMCA.

After she read about the Andover outreach programs in the newspaper, Carol attended an open house. She had SilverSneakers through her Medicare supplementary insurance but had never had an opportunity to use it. For the first time without her friends, Carol came out to the YMCA.

Carol no longer stays at home while her friends are away. She has made new friends through the YMCA outreach programs and has even started carpooling with them! She has also started attending senior luncheons and other social activities at the local Senior Center.

YMCAs throughout the country work side-by-side with neighbors ***to make sure everyone, regardless of age, income or background, has the opportunity to learn, grow and thrive, by focusing on youth development, healthy living and social responsibility.***