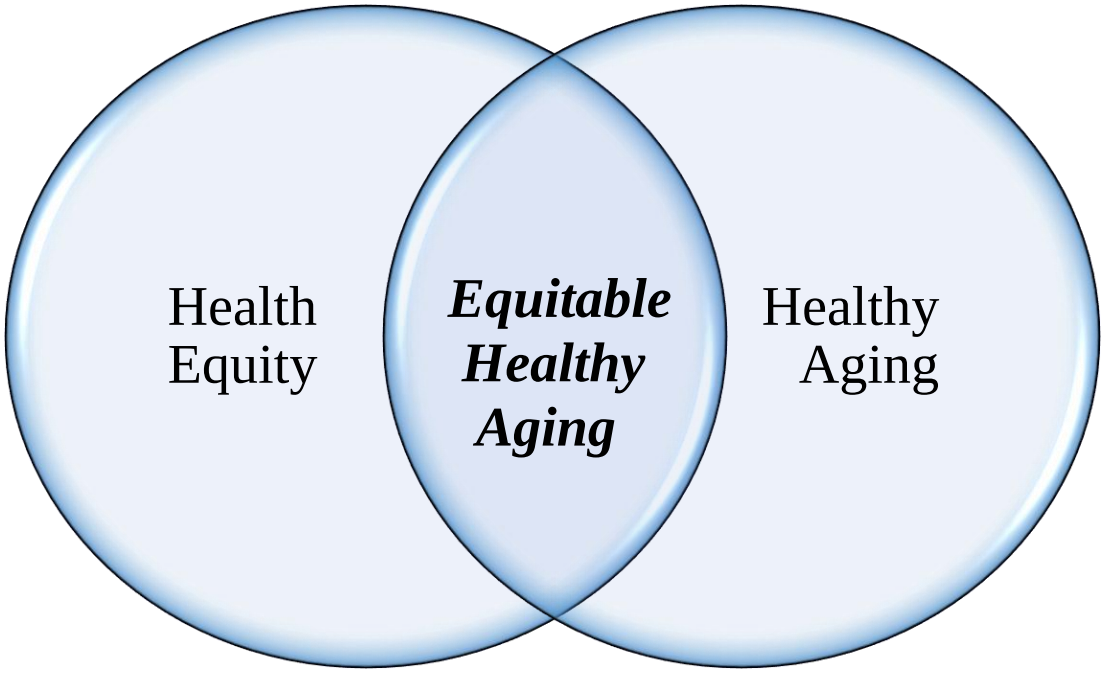
Equitable Healthy Aging in Public Health Toolkit Report:

A Guide for Community Health Improvement Practice



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Contents

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

The Equitable Healthy Aging in Public Health Toolkit Report aims to increase the capacity of public health departments to enhance equitable health and wellbeing of older adults and promote healthy aging across the life course in community health improvement practice.

Equitable healthy aging means that everyone has a fair and just opportunity to optimize health and wellbeing at all life stages and abilities across the life course. Equitable healthy aging is achieved when every person has the opportunity to attain their full health potential to age well and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstance.

Achieving equitable healthy aging in public health practice requires recognizing the unique and cumulative factors that shape health and wellbeing in later life. This requires actions to advance accessible, inclusive, empirically-informed and culturally-relevant policies, systems and environments that enable healthy aging. This also means dismantling systemic and structural barriers that result in health inequities exacerbated in later life.

This report provides equitable healthy aging considerations in alignment with Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 – the nationally-accredited planning and implementation model that guides community health improvement practice across the United States. With an emphasis on health equity, community engagement and root causes of health inequities, local public health practice is uniquely positioned to advance equitable healthy aging across the diversity of our nation's communities – small and large, urban, suburban and rural – where we are born, live, work, play *and* age.

The toolkit begins by framing and defining the scope of equitable healthy aging vis-à-vis the roles and opportunities for public health. Foundational principles and frameworks are presented to bound practice along with core models including the age-friendly public health system and age-friendly communities. The final section of the report identifies explicit considerations for departments of health to enhance equitable healthy aging across the phases and steps of MAPP 2.0. Because MAPP 2.0 is in stages of evolution (2021-2023) this report should be viewed within the context of additional NACCHO guidance. Embedded throughout, the report provides links to a range of helpful resources that provide expanded information to more fully understand content of interest.

The toolkit report was sponsored by AARP and developed by the University of South Florida's College of Public Health and School of Aging Studies in consultation with the Trust for America's Health and the National Association of City and County Health Officials. The toolkit report content was piloted with the Florida Department of Health Community Health Improvement professionals.

I. Introduction

- *This section introduces the intersecting topics of health equity and healthy aging in public health practice and the Toolkit.*
- *It addresses **WHY** equitable healthy aging is a public health imperative as well as **HOW** to navigate the Toolkit.*

A. Purpose and Intended Audience

The purpose of the Equitable Healthy Aging in Public Health Toolkit Report is to provide local and state health departments with guidance on advancing equitable healthy aging in community health improvement (CHI) practice. The overarching aim of the toolkit is to increase the capacity of public health to enhance the equitable health and wellbeing of older adults and promote healthy aging across the life course.

IMPORTANT NOTE

This report aims to supplement forthcoming guidance on CHI practice in alignment with *Mobilizing for Action through Planning and Partnerships* (MAPP). MAPP 2.0 is in stages of evolution and subject to revision with implemented changes occurring 2021 – 2023 per the *National Association of County and City Health Officials* (NACCHO).

B. Organization and Content

The toolkit is designed to equip health departments and public health professionals with a primer on equitable healthy aging in CHI practice. Though the content is presented sequentially, readers should feel free to reference the modules based on a variety of factors including level of professional knowledge as well as organizational needs.

The toolkit is structured across three sections as noted in Table 1. Each section provides a brief overview of the topic and elucidates key concepts. Empirically-informed content is provided throughout to illustrate practice strategies where applicable. References and e-resource links and key points are highlighted to provide readers with expanded sources to more fully understand content of interest. Because concepts pertaining to health equity and healthy aging are multifaceted and still evolving, readers are encouraged to reflect upon and consider learnings from multiple lens:

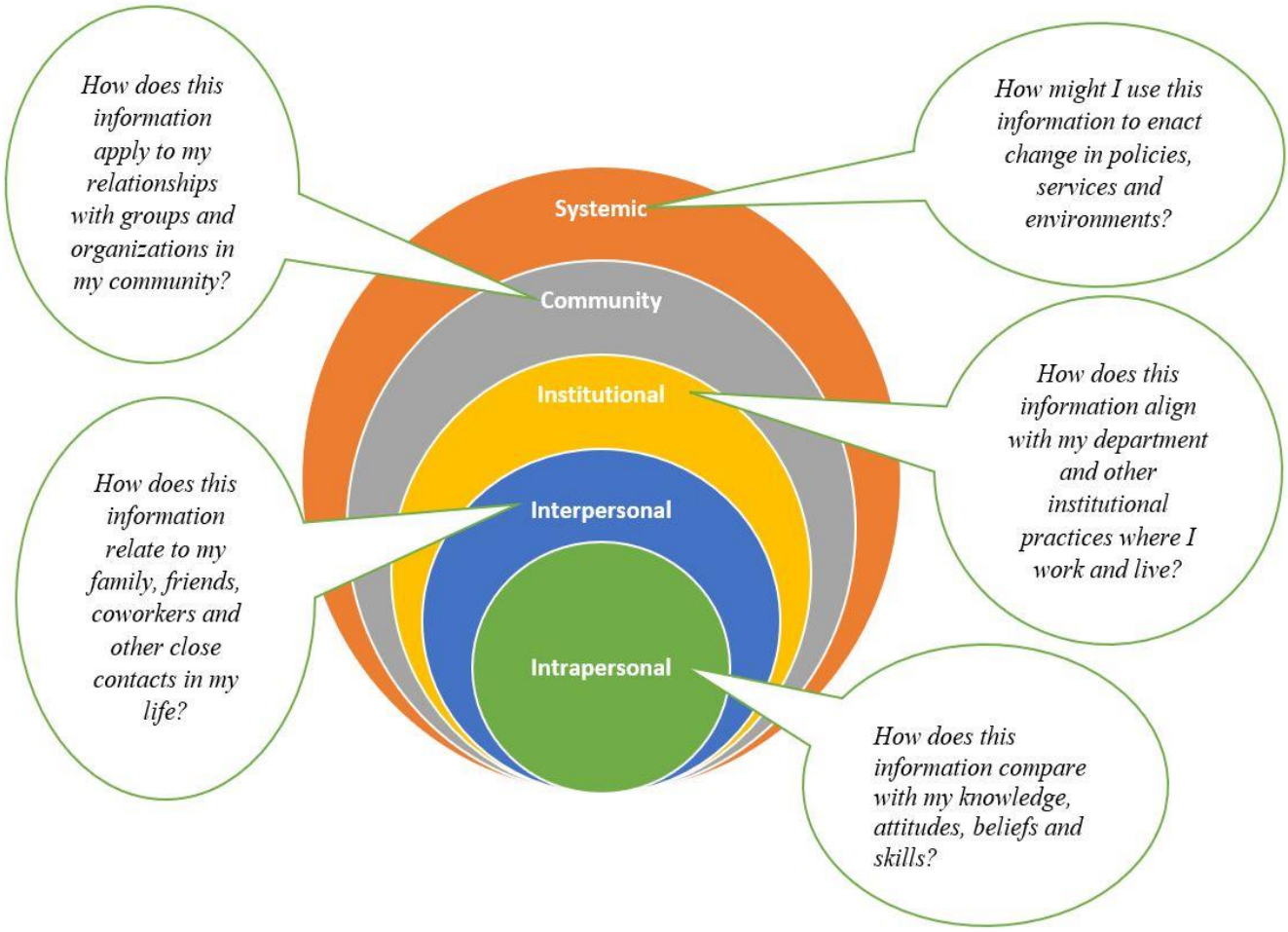

Figure 1. 1 Reflective Considerations by Multiple Lens

Table 1. 1 Toolkit Sections and Overview

Sections	Overview
Foundational Equitable Healthy Aging Public Health Principles	Presents overarching concepts and foundational principles to guide public health practice on equitable healthy aging.
Age-Friendly Public Health Frameworks	Introduces the Age-Friendly Public Health System and Age-Friendly Community frameworks to bound practice on equitable healthy aging in CHI practice.
Advancing Equitable Healthy Aging in Community Health Improvement Practice	Identifies practice considerations to propel equitable healthy aging across phases and steps in MAPP 2.0 CHI processes.

C. Toolkit Development and Methodology

This toolkit was commissioned by AARP Thought Leadership on Health Longevity and prepared by the College of Public Health and the School of Aging Studies at the University of South Florida. The toolkit was developed in advisory partnership with the NACCHO and the Trust for America's Health (TFAH). With foremost consideration of MAPP 2.0 across all phases, the following methods and activities were conducted:

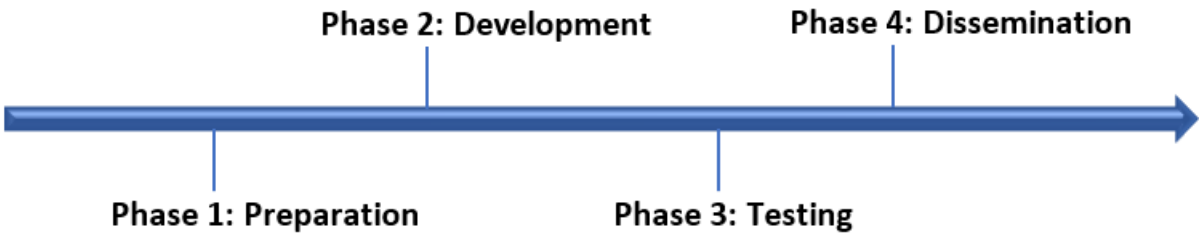

Table 1. 2 Toolkit Development by Phase, Methods and Activities

Phase	Methods and Activities
Preparation	An environmental scan was conducted to ascertain core public health terms and frameworks as well as contemporary and promising processes and practices relevant to health equity and healthy aging. Research using following key words was conducted to identify local, state, national and international public health improvement processes: *public health *community health assessment *community health improvement planning *health equity *health disparities *healthy aging *healthy longevity. Public health sources include (see list of acronyms in appendix): APHA, ASTHO, CDC, NACCHO, NAM, PHAB, RWJF, TFAH, UN SDG, US DHHS, US Office of the Surgeon General, WHO.
Development	Content for the toolkit was vetted and guided by advisory input of members from AARP, NACCHO, TFAH and the USF College of Public Health and School of Aging Studies. A synthesis of findings was compiled to apply an equitable healthy aging lens to public health practice per MAPP 2.0 framework.
Testing	Pilot testing of the toolkit was conducted across the state Florida Department of Health local health department professionals in community health improvement practice (n=104) with 74% response rate. The 34-item survey solicited professionals' input on content (knowledge and interest of Health Equity and Healthy Aging considerations per MAPP 2.0 processes) and format of the toolkit. Formative findings were incorporated into the toolkit.
Dissemination	The toolkit is available free of charge on the following websites: TFAH Age-Friendly Public Health System Resource Page and the USF College of Public Health and School of Aging Studies. Outreach promotion of the toolkit will occur via partner channels including e-distribution lists and other educational offerings via public health and aging webinars, conferences and journal articles.

D. Scope of Equitable Healthy Aging in Public Health Practice

Health in older age reflects a lifetime of cumulative advantage and disadvantage, underscoring the imperative to address both the current cohort of older adults as well ensure equitable healthy aging trajectories for all people across the life course.

Public health practice is uniquely positioned to foster equitable healthy aging in the United States. Public health aims to protect and promote the health of all people in all communities at all life stages, including older adults. To achieve optimal health for all, this requires actively promoting policies, systems, environments and services that enable healthy aging, and removing obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression that result in health inequities exacerbated in later life.

Population aging has escalated the need for public health action to foster equitable healthy aging. As more Americans are reaching age 65 and older [1] than ever before, our health in extended longevity is greatly impacted by normative physiological changes in aging as well as age-related pathologies such as heart disease and cancer – the nation's top causes of morbidity and mortality.[2] Among persons age 65 and older, 80% have at least one chronic condition [3] and 68% have two or more. Chronic conditions curtail our activities of daily living and can impact our ability to live independently - which is highly valued among older Americans. Chronic conditions also enact a heavy toll on our health care system as well - accounting for 90% of total US health care expenditures.[4] Public health interventions aimed at reducing risks of disease, ensuring early diagnosis and management of chronic conditions as well as preventing further decline can reduce the health care burden and costs of chronic conditions.[5]

"Never has there been such a spotlight on older adults, and we can use this moment to redefine what it means to experience healthy aging in the United States." [6]

Vice Admiral Vivek H. Murthy, MD, MBA
U.S. Surgeon General

"[The] Decade of Healthy Ageing (2020-2030) sends a clear signal that it is only by working as one… that we will be able to not only add years to life, but also life to years." [7]

Dr Tedros Adhanom Ghebreyesus
Director-General of the World Health Organization

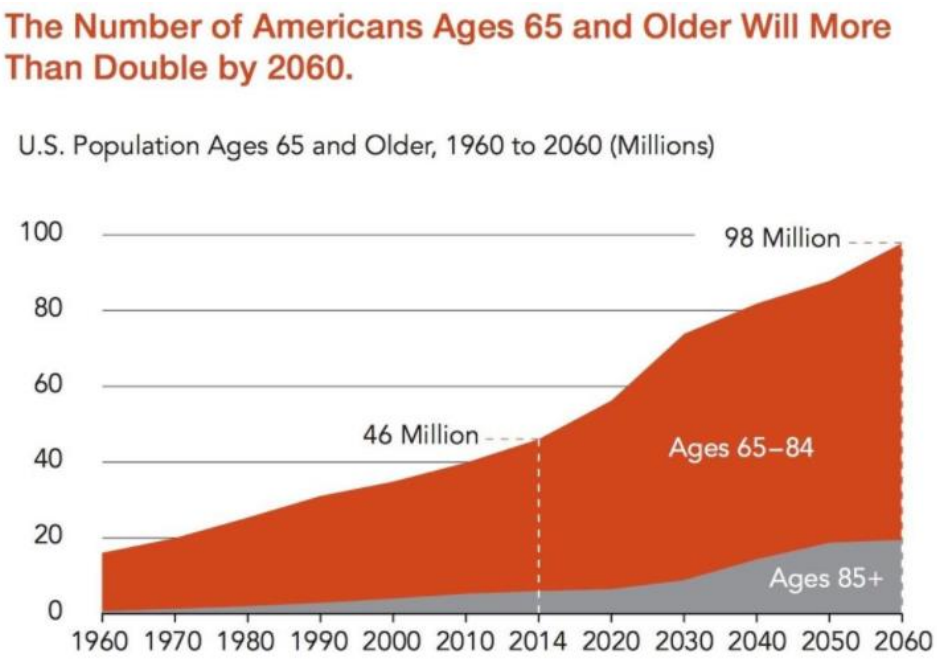

Figure 1. 2 Past, Current and Projected Population Increases among Persons Age 65+ [8]

Epidemiological data reflect wide variations in the distribution and determinants of chronic disease leading to health disparities among older adults.[9] For example, compared to white persons age 65 and older, there is a disproportionately greater prevalence [10] of hypertension and diabetes among non-Hispanic Black people (68% vs. 55% for hypertension and 34% vs. 18% for diabetes) and Hispanic people also have higher levels of diabetes (33%) than non-Hispanic White people.

Mounting research suggests that our life expectancy as well as our health in later age results largely from the environments we inhabit across our lives. For example, life expectancy can differ [11] by 20 years or more based on zip codes located just a few miles apart - and neighborhoods with lower socioeconomic conditions have also been linked to residents spending a greater portion of remaining life with disabilities.[12] Similar differences across population subgroups and geographic areas can also be found for many precursors to chronic disease [13] such as obesity. Higher levels of chronic disease burden accumulated [14] in earlier life is further attributed to increasing multimorbidity's in later life, particularly among Black and Hispanic people.

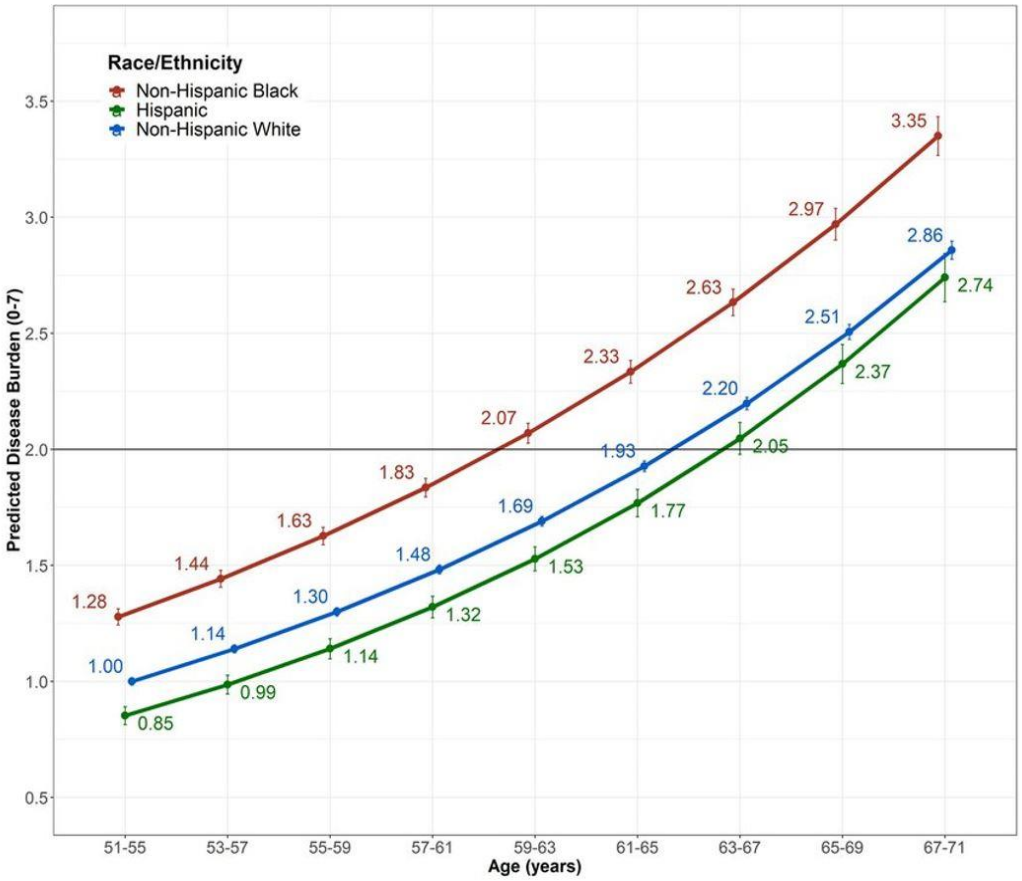

Figure 1. 3 Non-Hispanic Black, White and Hispanic trajectories of chronic disease accumulation over time (Health & Retirement Survey 1998 – 2014)[15]

There is increasing evidence that health in later life culminates from experiences across the life course at the intersection of multiple characteristics such as age, race, ethnicity and socio-economic position. This can begin with prenatal influences [16] and other factors continuing throughout childhood and midlife, ultimately shaping health throughout one's lifetime. The cumulative health impact of poverty and structural racism in particular account for greater vulnerabilities and health inequities at later ages.[17] Compared to risk factors such as health status, health insurance and health behaviors, financial factors such as income account for the bulk of disparities in mortality [18] by 40% among Hispanic Americans and more than 50% among Black Americans in midlife. And decreased life expectancy [19] resulting from the pandemic (i.e., 1.5 years reduction overall), has caused even greater declines among Black and Hispanic persons (e.g., 2.9 and 3.7 years respectively) which is attributed to structural inequities experienced across the life course.

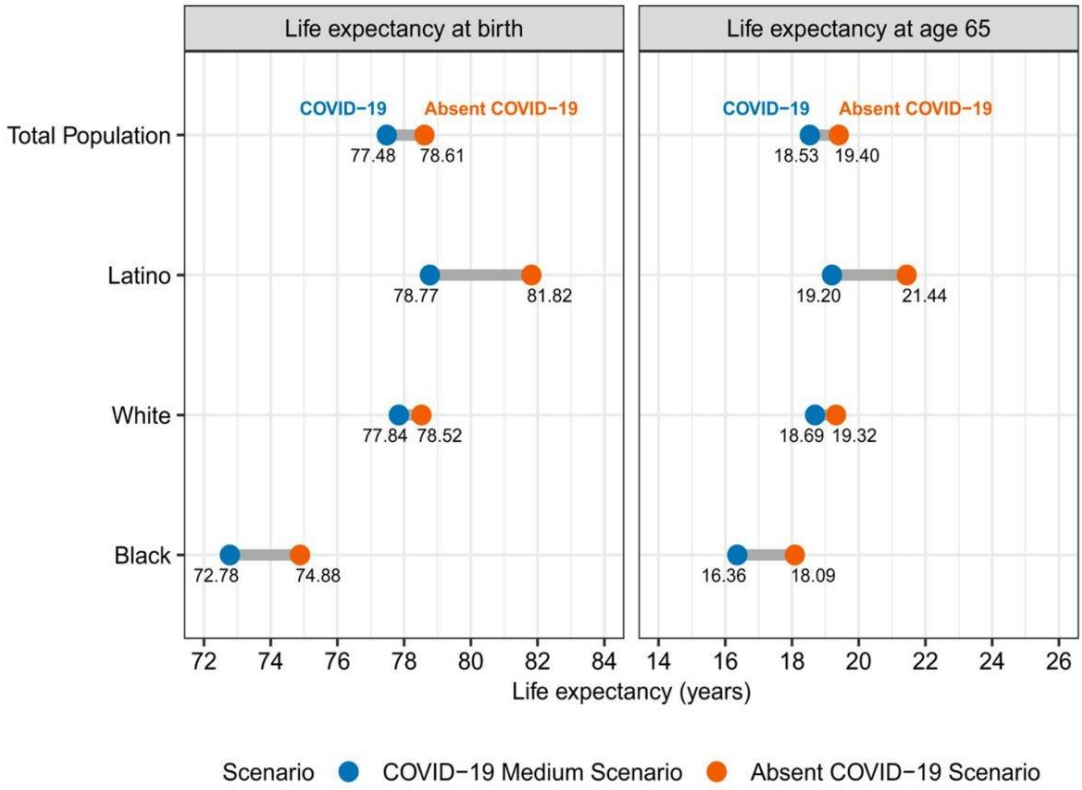

Figure 1. 4 Life Expectancy at Birth and Age 65 by COVID by Black, White, Latino and Total Population [20]

Healthy aging calls for optimizing mental and social wellbeing and functioning in the environment where people live. This directs attention to such pressing issues as Alzheimer's Disease and other dementias disproportionately afflicting [21] Black and Hispanic persons– despite mounting evidence regarding the prevention of dementia and promotion of brain health across the life course.[22] In addition to vast disparities in the incidence and prevalence of chronic health conditions among persons based on intersecting social positions culminating in later life, there are also population disparities in preventable injuries [23] due to falls (for example, by age, gender, ethnicity, education and income) and pedestrian accidents and fatalities[24] among other indicators. The nation's twindemics of loneliness and social isolation [25] – both of which are associated with increased morbidity and mortality – underscore the importance of connectedness with others at all life stages. Social wellbeing also extends to the health of informal and formal caregivers across the continuum [26] of settings of which older persons are differentially impacted by race, socio-economic position and other factors including the geography where people reside.

While public health efforts are in large part responsible for extending our longevity to date, public health is now poised to promote longer and healthier lives for all Americans. Public health professionals represent a critical force in promoting equitable healthy aging by leveraging skills and capacities in disease prevention and health promotion across the life course as well as attend to the unique needs among the diverse cohorts of older adults today – and in the years to come. Advancing equitable healthy aging will yield innumerable benefits beyond individual health, impacting families as well as all sectors and industries in American society.

E. Key Terms Defined

Several key terms are referenced throughout the toolkit. The following terms are defined here to provide a common source of understanding as usage and meaning may vary implicitly or in other applications. To the greatest extent possible, terms used throughout the toolkit are explicated by MAPP 2.0 (NACCHO) and other leading public health authorities and are subject to updated definitions based on new knowledge.

Ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age.[27]

Equitable Healthy Aging means that everyone has a fair and just opportunity to optimize health and wellbeing at all life stages and abilities across the life course. Equitable healthy aging is achieved when every person has the opportunity to attain his or her full health potential to age well and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstance.

Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity.[28]

Health Disparities are preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities. Health disparities exist in all age groups, including older adults.[29]

Health Equity is a state in which all people and populations have the opportunity to achieve optimal health. Optimal health means not only moving beyond the lack of disease or infirmity, but represents a state of complete physical, mental, and social well-being and is essential for individuals to reach their full individual capacities and participate in society. [30]

Health Inequities are the preventable and unjust differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age.[31]

Healthy Aging is the process of maintaining and promoting physical, mental (cognitive and emotional), spiritual, meaningful social engagement and social wellbeing and function as people age.[32]

Intersectionality is a theoretical framework that posits that multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism).[33]

Policy, Systems & Environment (PSE) refers to longer-term, sustainable change designed to impact health where and how we live, work, play and age. Policy change includes organizational or legislative changes such as institutionalizing new rules or procedures. Systems change involves macro level and structural entities such as organizational and community norms and cultural practices. Environmental change addresses our natural, built and social surroundings such as housing and programming.

Prevention refers to three main interventions: 1) Primary prevention consists of strategies that seek to prevent the occurrence of disease or injury, generally through reducing exposure or risk factor levels; 2) Secondary prevention consists of strategies that seek to identify and control disease processes in their early stages before signs and symptoms develop (screening and treatment); and 3) Tertiary prevention consists of strategies that prevent disability by restoring individuals to their optimal level of functioning after a disease or injury is established.[34]

Root Causes of Health Inequity can be organized in two clusters: 1) Structural inequities (operating via intrapersonal, interpersonal, institutional, community and systemic mechanisms) that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender expression, and other dimensions of individual and group identity and 2) The unequal allocation of power and resources—including goods, services, and societal attention—which manifests itself in unequal social, economic, and environmental conditions (i.e. determinants of health).[35]

Social Determinants of Health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks. SDOH are grouped into five domains: 1) economic stability; 2) education access and quality; 3) health care access and quality; 4) neighborhood and built environment; and 5) social and community context.[36]

Structural Racism refers to macro-level conditions such as residential segregation and institutional policies that limit opportunities, resources, power, and well-being of individuals and populations based on race/ethnicity and other statuses such as gender and social class. Achieving health equity for all in the U.S. will require dismantling this country's historical legacy of structural racism.[37]

II. Foundational Equitable Healthy Aging Public Health Principles

- *This section presents overarching concepts and foundational principles on health equity and healthy aging in public health.*
- *It addresses **WHAT** equitable healthy aging means, **WHY** it is important for public health and **HOW** it can be operationalized in practice.*

A. Equitable Healthy Aging

Equitable healthy aging means that everyone has a fair and just opportunity to optimize health and wellbeing ***at all life stages and abilities across the life course***. Equitable healthy aging is achieved when every person has the opportunity to attain his or her ***full health potential to age well*** and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstance.

Achieving equitable healthy aging in community health improvement practice aligns with the three pillars of the 10 Essential Public Health Services: assessment, assurance and policy development. Specific to healthy aging, public health professionals must acknowledge the unique and cumulative factors that shape health and wellbeing in later life. Awareness of disparate life cycle circumstances informs actions to advance accessible, inclusive, empirically-informed and culturally-relevant policies, systems and environments that impact health trajectories as people age. Consistent with the equity focus of the revised essential public health services and MAPP 2.0, this also means addressing structural root causes of inequities that shape the determinants of health in order to optimize longevity for all people across the life course.

Foundational principles that guide equitable healthy aging in public health practice require an integrative approach, melding multiple core constructs:

Figure 2. 1 Collage of Equitable Healthy Aging Constructs

B. Up, Mid and Downstream Causes of Health Inequities and Disparities

Health inequities are the systematic differences in opportunities to achieve optimal health leading to unjust and preventable health outcomes across groups. [27] This includes ***downstream*** differences in disease and death between different populations *including older adults* (e.g., disparities), arising from the ***midstream*** social determinants of health (SDOH) [32] or conditions in which people are born, grow, live, work, play, worship *and age* – and attributed to further ***upstream*** root causes associated with imbalances in power and systems of oppression (e.g., systemic racism). Health disparities are driven by social and economic inequities.

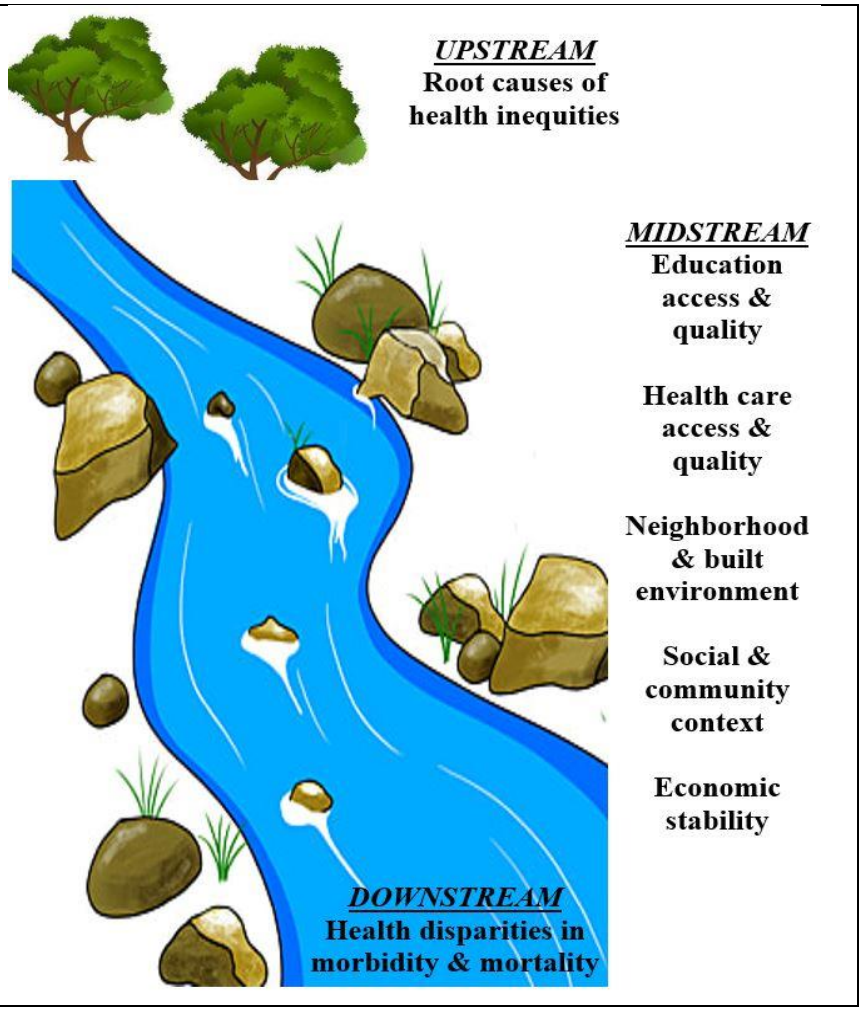

Figure 2. 2 Stream Illustration of Health Inequities

"Rising economic inequality, the lingering impact of the Great Recession, and escalating rates of obesity and opioid addiction, among other factors, may contribute to even greater disparities between the haves and the have-nots in future cohorts of older adults."[38]

Deborah Carr, Golden Years? Social Inequality in Later Life (2019)

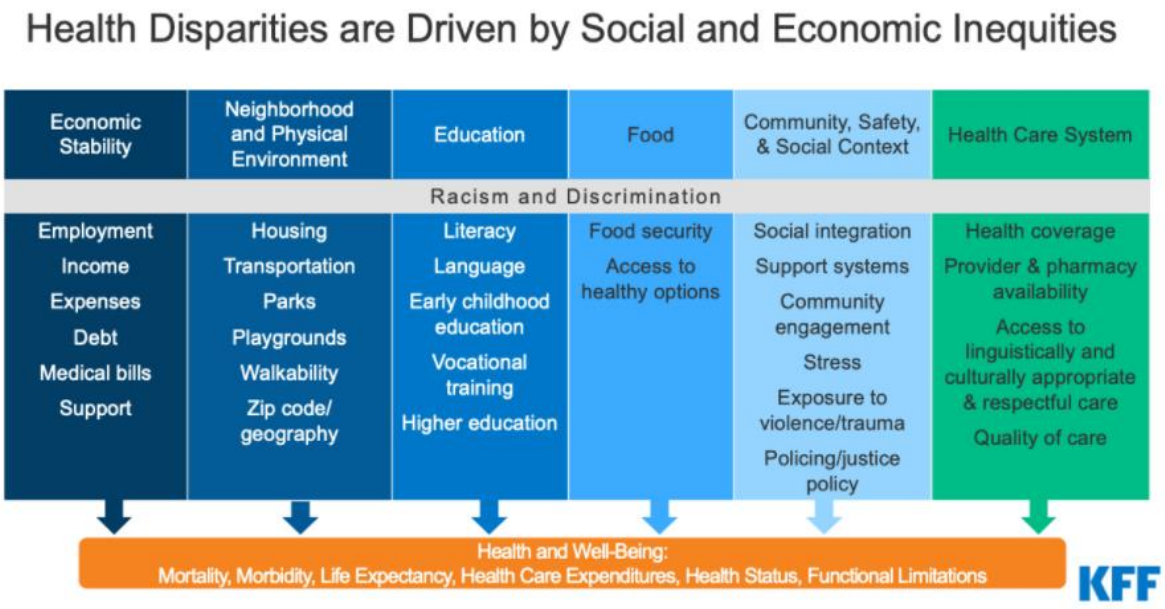

Figure 2. 3 How Social and Economic Inequities Impact SDOH and Health Disparities [39]

**********PRACTICE CONSIDERATIONS**********

- Differentiate pathways and trajectories to identify root causes underlying individual, group and overall inequalities across the diversity of the population.
- Recognize interactions within the environment as social determinants of health that accumulate throughout life, contributing to strengths and vulnerabilities at all ages.

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Resource	Description
Government Alliance on Race and Equity: Racial Equity Tools	Collection of webinar materials, issue papers, and examples on creating and implementing racial equity plans in the policies, programs, and budgets in local and regional government.
Justice in Aging: Strategic Initiative to Advance Equity Framework	Framework for incorporating and implementing programming that advances equity for older adults who are people of color, women, people with disabilities, limited English proficient, immigrants, and/or part of the LGBTQ+ community.
Race Forward: What is Race Equity?	Definitions, comparisons, and examples of race equity, race-related terminology, diversity and inclusion concepts.

C. Intersectionality and Health Equity across the Life Course

Intersectionality is a framework that elucidates how people are adversely affected by multiple social categories such as race, ethnicity, socioeconomic status *and age,* which intersect at the micro level of individual experience and reflect interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism, classism, ableism *and ageism,* etc.). [27] The framework is particularly useful to better understand the complexity of prejudice, discrimination and cumulative disadvantage experienced by sub-groups of older adults.

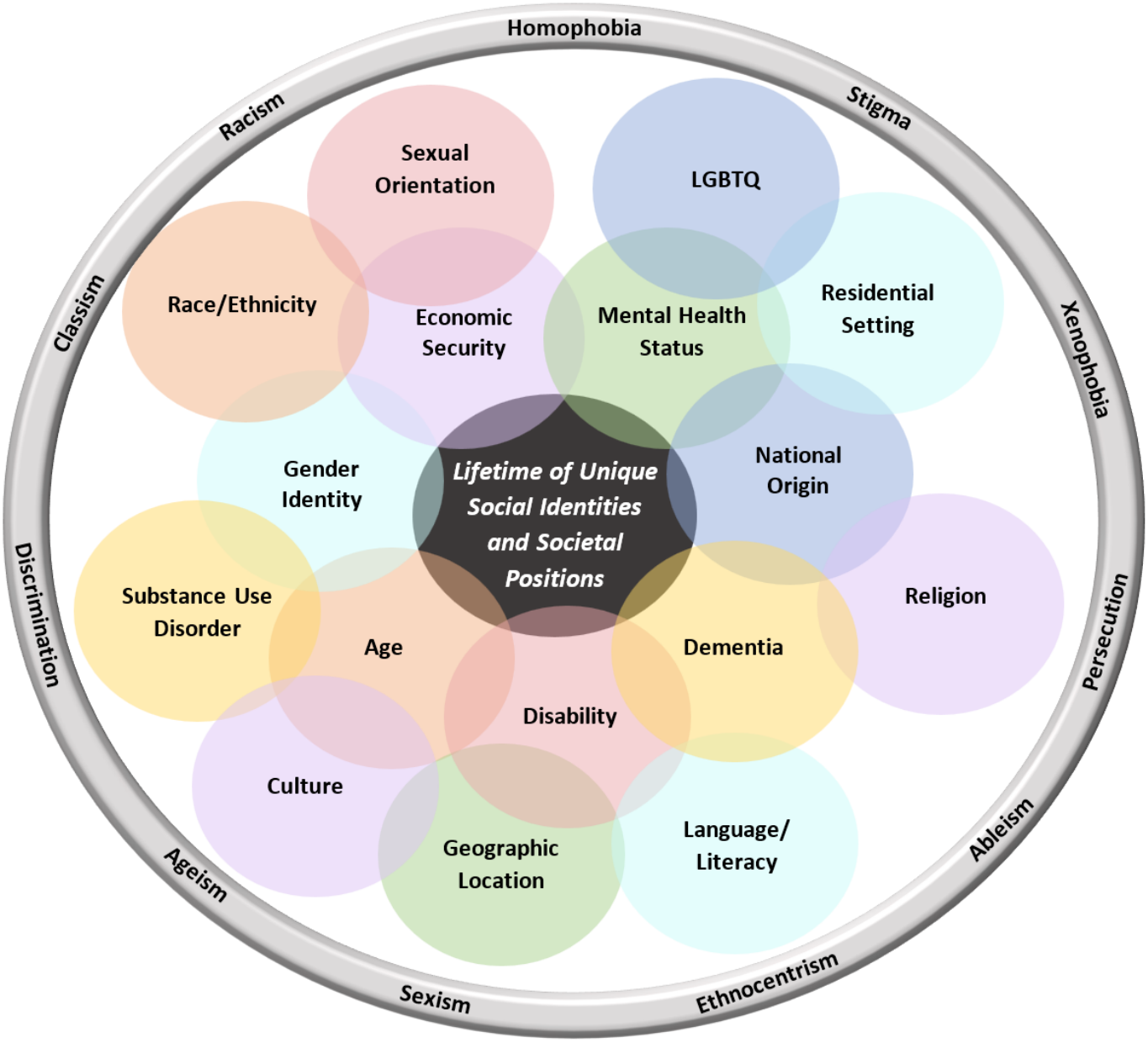

Figure 2. 4 Intersectionality by Lifetime of Unique Social Identities and Societal Positions

Intersecting social identities compound health inequities in older age due to structuring differential access to opportunities for health across the life course.[40] That is, social identities based on age, race, socio-economic position and more *influence the trajectory of healthy aging at every life stage*, resulting in multiple and *cumulative lifetime experiences in later life*. For example, many older Americans are privileged to experience good health as a result of healthy birth and attainment of developmental childhood milestones and subsequent successes and accomplishments in school, work and other life pursuits, in large part due to societal structures designed to help people grow, succeed and prosper. However, many older adults, across a range of social positions, *face constrained choices and blocked opportunities due to structural inequities which shape deleterious life circumstances impacting health from conception throughout the end of life – leading to vast disparities in health and life expectancy.*

Though once considered a disease of old age, Type II diabetes is no longer viewed as 'adult-onset.' For more information on the research linking diabetes to earlier life stages and conditions associated with social identities and societal positions

Though dementia rates have fallen among the oldest cohorts, declining cognitive functioning among early and mid-Baby Boomers is attributed to: lower household wealth, lower likelihood of marriage, higher levels of loneliness, depression and psychiatric problems and more cardiovascular risk factors such as obesity, inactivity, etc.

For more information on the intersection of healthy aging and heath equity, see the WHO Ageing and Life Course team conceptual model identifying factors that contribute to levels and distribution of health in older age

FACTS on Aging and Diverse Older Adults [41]
❖ LGBT older adults who are also racial and ethnic minorities will often face the highest levels of disparities and discrimination, due to encountering racism, as well as anti-LGBT bias and possible violence due to transphobia, biphobia, and homophobia.
❖ American Indian/Alaska Natives (AI/AN) include many distinct populations, representing 574 federally recognized tribes, approximately 60 state-recognized tribes, and many who identify as AI/AN culturally, but are not members of an identified tribe.
❖ Many Black immigrants are from English-speaking countries; however, many immigrants experience language barriers and low-literacy levels particularly when it comes to using preventative health care services.
❖ Half of the Hispanic population read English at an 8th grade level or lower. This creates a barrier when most health information is written in an 11th to 12th grade level or higher.
❖ Nearly 60% of Asian Americans and 25% of Native Hawaiians and Pacific Islanders are limited English proficient (LEP). More than 2 out of 3 Chinese, Korean, Vietnamese, Laotian, Hmong, Fijian, Marshallese, Nepalese, Taiwanese, Bangladeshi, and Burmese older adults are LEP.

Resource	Description
Diverse Elders Coalition	DEC advocates for policies and programs that improve aging for racially and ethnically diverse people; American Indians and Alaska Natives; and lesbian, gay, bisexual and/or transgender (LGBT) people.
Institute for Social Policy and Understanding - American Muslims and Aging	Needs assessment conducted to develop a more informed understanding of older American Muslims' needs, gather preliminary insight on their aging experience, and explore the role American Muslim communities can play in serving needs.
National Resource Center on LGBT Aging	Practice guides for strategies that increase inclusiveness and feelings of safety among diverse and LGBTQ+ older adults.
MHP Salud	National nonprofit organization that provides programs for Latino communities about peer health education, increase access to health resources, and bring community members closer.
National Asian Pacific Center on Aging	Organization that preserves and promotes the dignity, well-being, and quality of life of Asian Americans, Pacific Islanders, and diverse communities during older adulthood.
National Caucus and Center on Black Aging, Inc.	The only national organization devoted to minority and low-income aging that provides employment, health and wellness, and affordable housing assistance.
National Hispanic Council on Aging	The leading national organization working to improve the lives of Hispanic older adults, their families, and their caregivers.
National Indian Council on Aging, Inc.	Advocates for improved comprehensive health, social services, and economic wellbeing for American Indian and Alaska Native older adult.
Opportunity Agenda: 10 Tips for Putting Intersectionality into Practice	Tips for implementing intersectionality into practice to help individuals and communities who face multiple and intersecting forms of discrimination.
Rural Health Information Hub	Guide includes information about home-based services and community support available to support aging in place and independent living and discusses challenges for people receiving/providing services in rural communities.
Southeast Asia Resource Action Center	National civil rights organization that empowers Cambodian, Laotian, and Vietnamese American communities to create a socially just and equitable society.

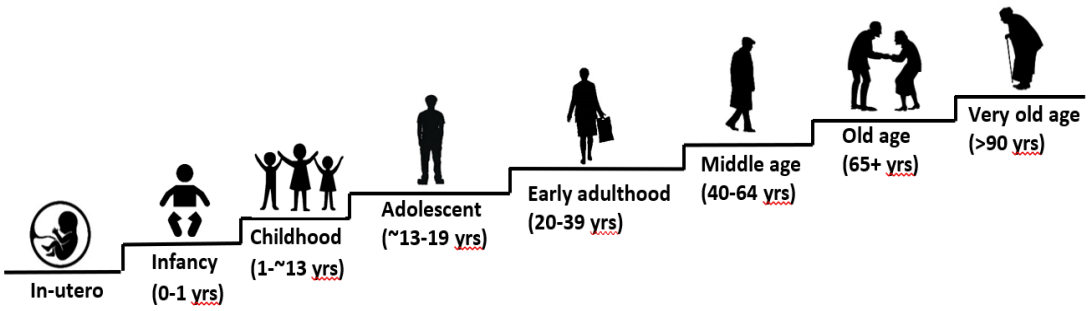

Figure 2. 5 Stages across the Life Course

A life course perspective helps explain how socially patterned physical, environmental, and socioeconomic exposures at different stages of human development shape health within and across generations, contributing to the etiology of health disparities.[42] Across the stages of development, a life course perspective identifies how exposures to risk factors during sensitive life stages shift health trajectories. Exposure to risks at any age can be offset by a variety of resources and assets available to individuals, resulting across the continuum from resilient adaptation to heightened vulnerability. A structural life course lens further reveals how unique social identities and societal positions within environments can disproportionately allocate risk factors and resources, resulting in altered health trajectories.

As a distinct stage of life, old age is widely recognized as beginning at the chronological age of 65 and continuing throughout the end of life. However biological age is only loosely associated with health in later life and health in older age is not random. [43] Only a small proportion is due to genetic inheritance and most due to ongoing interactions between the broader characteristics of individuals and the environments they inhabit. Personal characteristics such as gender, ethnicity, occupation, educational attainment and wealth contribute to social positions that impact access to resources. The environments in which older adults reside further influence health including the home and location where people live, transportation options and health and long-term care systems. Interactions throughout the environment and across the life course consequently contribute to the vast diversity of health in older ages. While some people age as physically fit as athletes, two out of three will require support to meet daily needs in old age.

**********PRACTICE CONSIDERATIONS**********

- Recognize that differences in older adults' health and illness experiences reflect accumulated inequalities across peoples' lives.
- Challenge perspectives on aging and counter ageism via intrapersonal, interpersonal, organizational, community and systemic lens.
- Promoting health in old age is a human right which requires comprehensive attention to the social determinants of health.
- Protect those who are most vulnerable

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D. Social Justice and Healthy Aging

Healthy aging is a human right. Public health efforts that support healthy aging include a United Nation (UN) Resolution on Principles for Older Persons which identifies fundamental human rights in the areas of independence, societal participation, care, self-fulfillment and dignity.[44] Seven of the 17 UN Sustainable Development Goals pertain to healthy aging, including social protection in old age, access to care, lifelong learning, gender equality, employment parity, reduction of inequalities and discrimination in later life and building of inclusive and accessible cities and communities. The 73rd World Health Assembly adopted, and the World Health Organization deployed 2020-2030 as the Decade of Healthy Aging,[45] which aims to improve the lives of older people and their families and communities in four action areas: creation and expansion of age-friendly environments, combatting ageism, promotion of integrated care from prevention through the end of life, and ensuring the continuum of long-term care.

Building upon the fundamental concepts of dignity, independence and wellbeing in old age, as well as illustrating the central role of the social determinants of health, the Older American's Act of 1965 decreed ten entitlements (as amended through P.L. 116-131).

Table 2. 1 Older American's Act Title I Objectives

1. An **adequate income in retirement** in accordance with the American standard of living.
2. The **best possible physical and mental health** (including access to person-centered, trauma informed services as appropriate) which science can make available and without regard to economic status.
3. **Obtaining and maintaining suitable housing**, independently selected, designed and located with reference to special needs and available at costs which older citizens can afford.
4. **Full restorative services** for those who require institutional care, and a comprehensive array of community-based, long-term care services adequate to appropriately sustain older people in their communities and in their homes, including support to family members and other persons providing voluntary care to older individuals needing long-term care services.
5. **Opportunity for employment** with no discriminatory personnel practices because of age.
6. Retirement in health, honor, dignity—after years of contribution to the economy.
7. **Participating in and contributing to meaningful activity** within the widest range of civic, cultural, educational and training and recreational opportunities.
8. **Efficient community services**, including access to low-cost transportation, which provide a choice in supported living arrangements and social assistance in a coordinated manner, and which are readily available when needed, with emphasis on maintaining a continuum of care for vulnerable older individuals.
9. **Immediate benefit from proven research knowledge which can sustain and improve health and happiness.**
10. **Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives**, full participation in the planning and operation of community-based services and programs provided for their benefit, and protection against abuse, neglect, and exploitation.

Resource	Description
Generations: Navigating the Patchwork of Civil Rights Protections for Older Adults	Overview of U.S. civil rights laws and their applicability to older adults.
Older Adults Equity Collaborative: Resource Library	Includes resources for the aging services network, providers serving diverse communities and populations, and diverse older adults and family caregivers themselves.

E. Healthy Aging – An Evolving Paradigm

Though life expectancy varies by population, demographic aging has added more years to life, enabling people to redefine living at older ages. Dependent on health and abilities, opportunities from increased longevity allow people to be and do what they have reason to value:

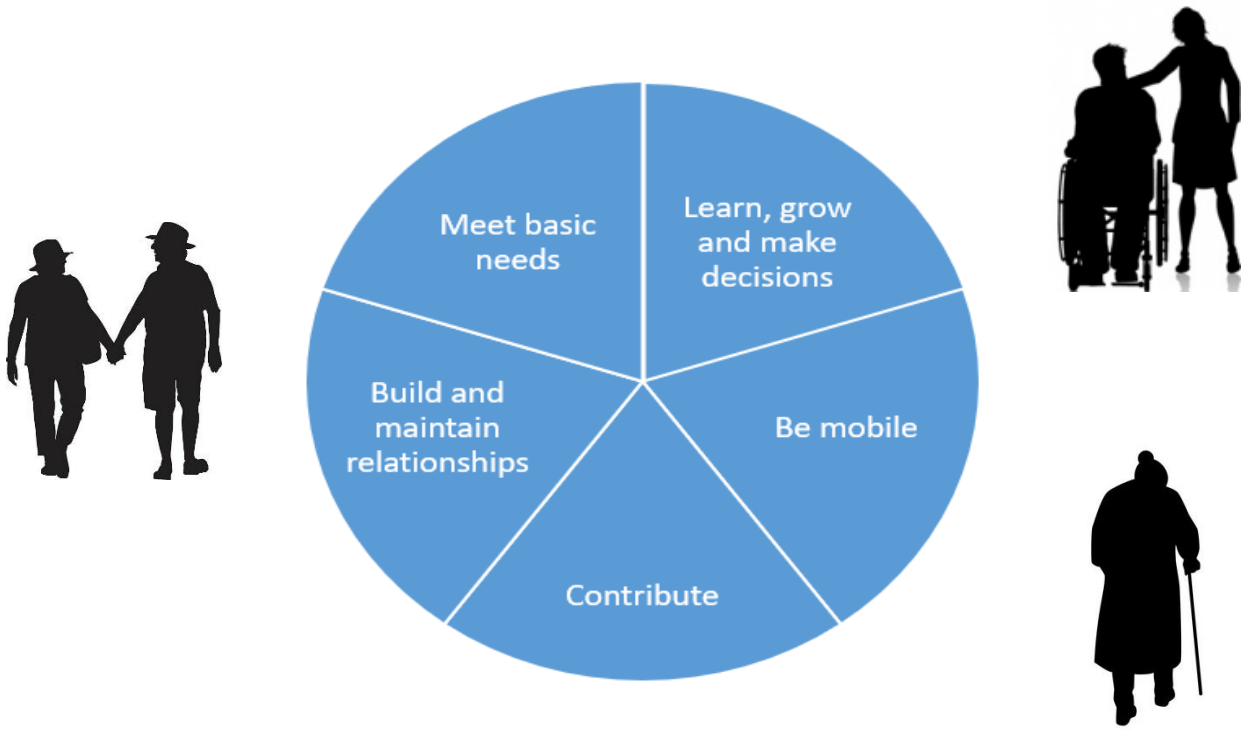

Figure 2. 6 Valued Abilities in Healthy Aging [46]

Public health authorities have recognized our increasing longevity by defining healthy aging upon the long-standing conception of health [47] – with updated knowledge as understandings are continuing to evolve.

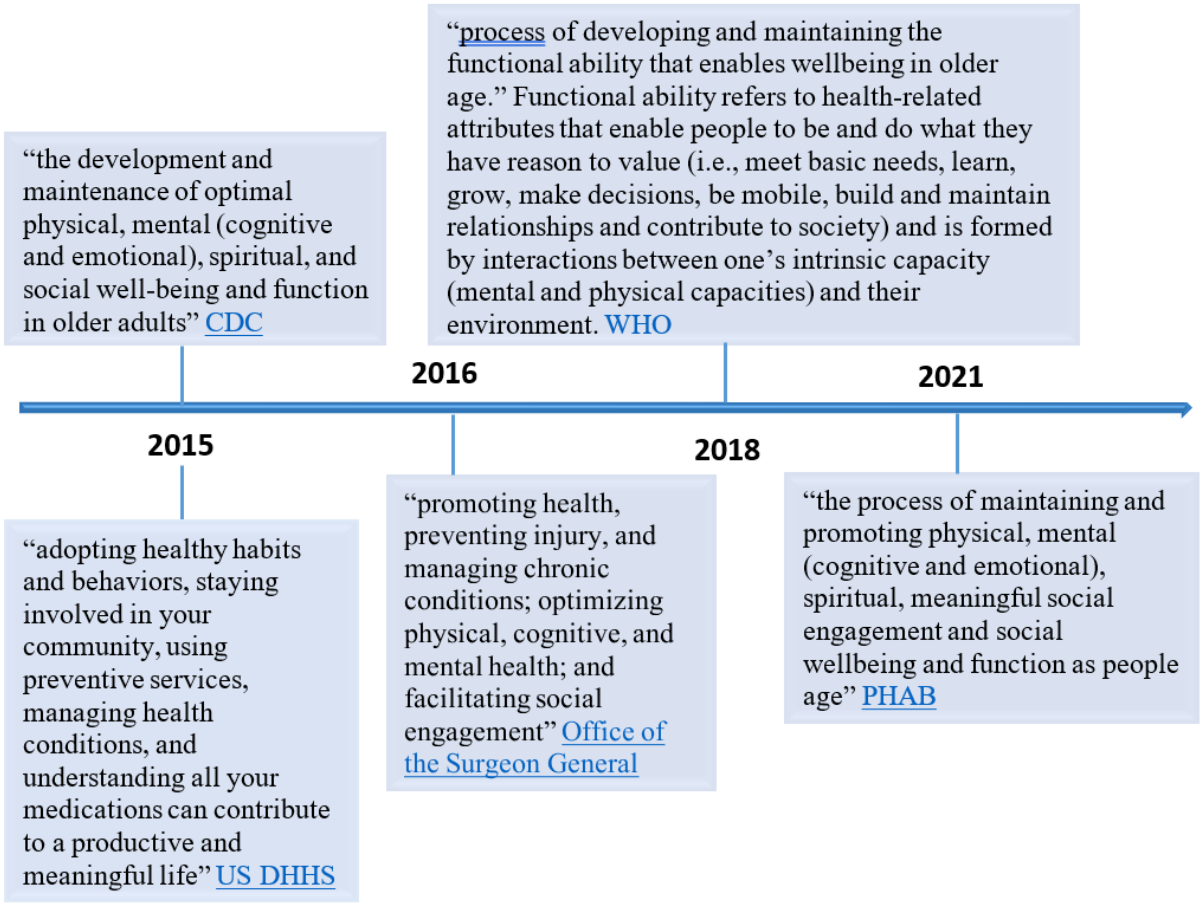

Figure 2. 7 Timeline of Healthy Aging Definitions in Public Health

Contemporaneous understandings on healthy aging are particularly useful to guide practice. Across the western world, aging is viewed primarily via a negative lens and ageism is pervasive throughout society. Consequently, shifting perceptions on healthy aging begins with an intrapersonal lens and continues in application to policies, systems and environments encountered in public health practice. See the Frameworks Institute Reframing Aging to counter ageism via effective communication strategies.

Table 2. 2 Practice Considerations by Healthy Aging Constructs

Construct	Practice Consideration
Autonomy	Acknowledge independence and dignity of selfhood in life/ lifestyle decisions
Connected	Realize opportunities to participate fully in society (e.g., activities, relationships, mobility, digital access, etc.)
Continuum	View aging as continuous process along with changing needs (not defined by chronological age)
Diversity	Appreciate array of health status and circumstances
Ecological	Situate person in interactive context of home and community
Functional	Optimize mobility in meeting needs and activities of daily living based on abilities and preferences
Holistic	Address multidimensional aspects of being (i.e., mental, social, physical, spiritual, etc.)
Positive	Include strengths-based and growth-oriented opportunities to learn, grow and contribute
Resilient	Recognize adaptive abilities and capacities
Subjective	Focus attention on person-centered lived experience, values, desires, preferences and goals

Resource	Description
Reframing Aging Initiative	Long-term social change endeavor designed to improve the public's understanding of what aging means to avoid ageism and guide our nation's approach of ensuring supportive aging policies.
WHO Global Campaign to Combat Ageism Toolkit	Toolkit includes necessary resources to learn about ageism, initiate conversations about this important topic in communities, organize events to raise awareness, and spread the word through social media.

Note. Launched with Public Health England, the 'free to use' age-positive icons can be accessed via the Centre for Ageing Better.

F. Public Health Frameworks on Equitable Healthy Aging

Several leading public health frameworks address equitable healthy aging. The National Prevention Strategy [48]– a joint effort between the Office of the Surgeon General, the CDC and the US DHHS represents the nation's most prominent public health framework on healthy aging. The plan outlines four strategic directions as the foundation for a prevention-oriented society which include: 1) Healthy and Safe Community Environments; 2) Clinical and Community Preventive Services; 3) Empowered People; 4) Elimination of Health Disparities. Healthy aging actions to advance the National Prevention Strategy include multiple equitable aims to promote safe and accessible physical environments and social inclusion efforts as well as address health disparities.

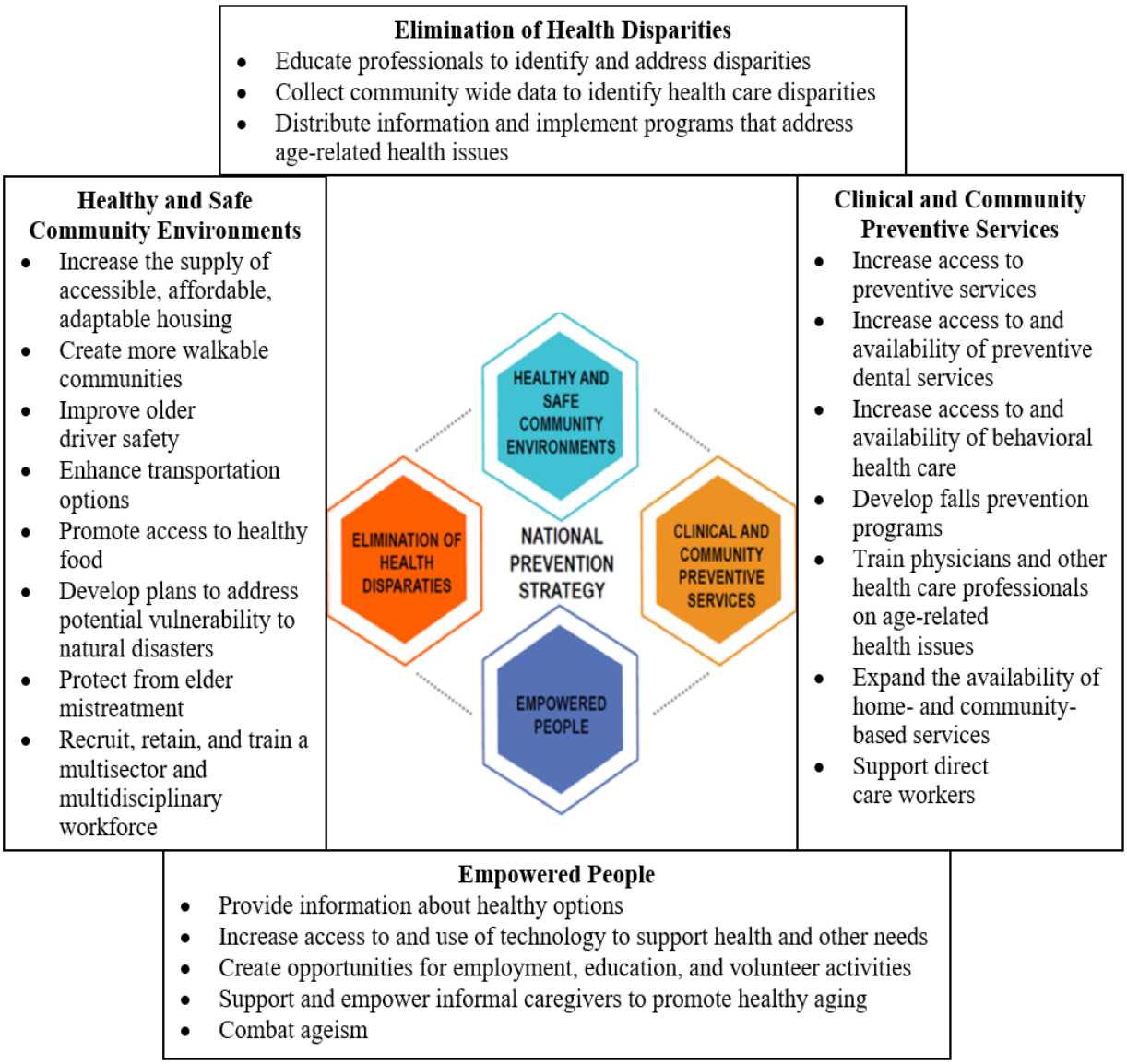

Figure 2. 8 National Prevention Strategy Goals and Objectives

Healthy People 2030 [49] provides a mechanism through which the nation ensures that all people achieve their health potential across the lifespan. The decade-long effort uses data-driven measures that address health conditions, behaviors, populations, settings and systems and social determinants of health across 355 indicators, of which 20 are specific to older adults [50] (e.g., fall-related deaths). Leading Health Indicators in both Healthy People 2020 and 2030 were selected and organized by a Life Stages conceptual framework. The life span approach was intentionally designed to address both individual and societal determinants impacting public health and disparities from infancy through old age for strategic action aimed at promoting health for all Americans.

The WHO outlines a public health framework for healthy aging [51] that identifies opportunities across the life course to optimize trajectories of functional ability which is defined as health-related attributes (or intrinsic capacities) in interactive context of the environment that enable people to be and do what they have reason to value. The framework identifies subpopulations by three levels of capacity and integrates health services, long-term care and the environment in supporting capacity-enhancing behavior across all levels as well as removing barriers to participation, compensation for loss of capacity and ensuring a dignified later life.

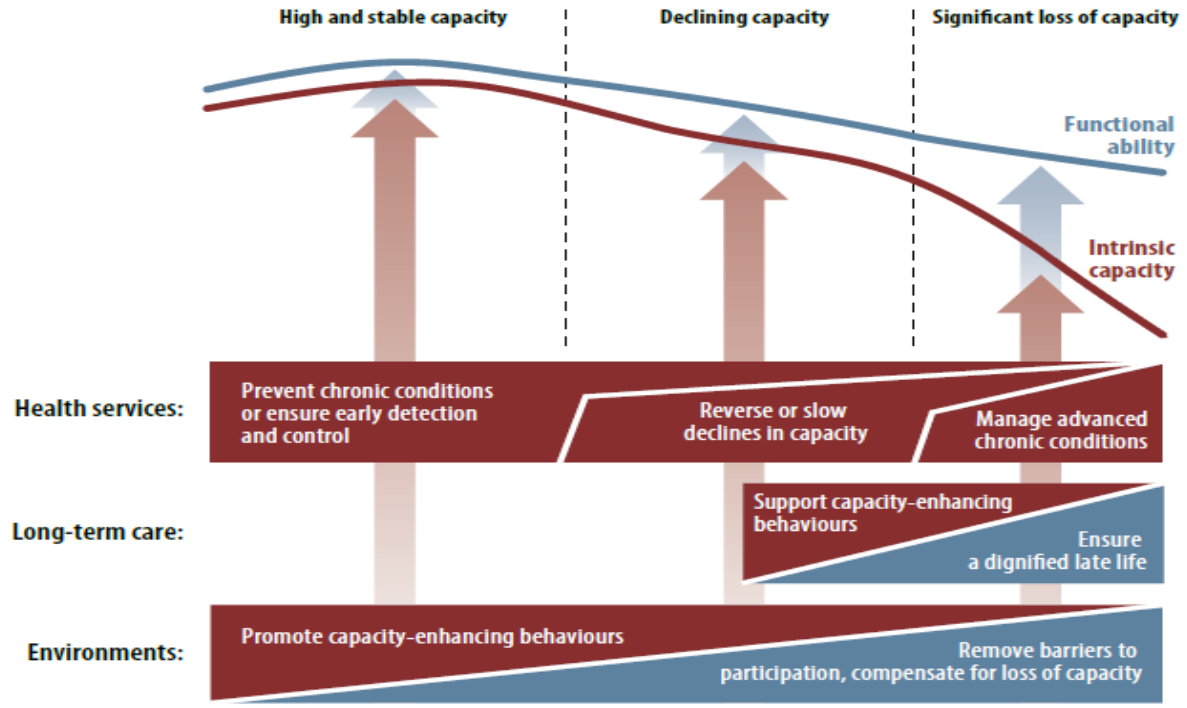

Figure 2. 9 Public Health Framework for Healthy Ageing: Opportunities for Public Health Action Across the Life Course [52]

The WHO has advanced an actionable Strategy on Health and Ageing based on the principles of human rights, equity, equality and non-discrimination (on the basis of age), gender equality, and intergenerational solidarity to ensure that everyone can live a long and healthy life.

Table 2. 3 WHO Priority Areas Action Strategies for Healthy Ageing

Priority Area	Actions
Align health systems to the needs of older populations	• Orient health systems around intrinsic capacity and functional ability • Develop and ensure affordable access to quality older person-centered and integrated clinical care • Ensure a sustainable and appropriately trained, deployed, and managed health workforce
Develop age-friendly environments	• Foster older people's autonomy • Enable older people's engagement • Promote multisectoral action
Strengthen long-term care	• Establish and continually improve a sustainable and equitable long-term-care system • Build the long-term care workforce and support informal caregivers • Ensure the quality of person-centered and integrated long-term care
Improve measurement, monitoring, and research	• Agree on ways to measure, analyze, describe, and monitor Healthy Ageing • Strengthen research capacities and incentives for innovation • Build and synthesize evidence on Healthy Ageing

************************PRACTICE CONSIDERATIONS**********************

- Focus on optimizing a person's trajectory across the life course by promoting a high level of ability and capacity early and delaying declines as much as possible
- Recognize that people with declining trajectories have the right to treatment and other forms of care and social support with dignity and respect of culture, values and preferences
- Employ a spectrum of actions/preventive interventions across the life course to build and maintain physical and mental capacities
- To achieve sustainable change, orient actions toward policies, systems and environments (PSE)

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Resource	Description
Blueprint for Changemakers: Achieving Health Equity Through Law & Policy	Outlines strategies to address fundamental drivers of health inequities including local policy solutions, incorporate health in all policies, and engage diverse community members in the policy process.
JustLead Washington: Systems Thinking and the Iceberg Model	(Adapted by the Shriver Center on Poverty Law) Model approach for both unpacking events involving inequity and goals for achieving a system that advances equity.

III. Age-Friendly Public Health Frameworks

- *This section introduces the Age-Friendly Public Health System and Age-Friendly Community frameworks to bound public health practice on health equity and healthy aging.*
- *It addresses **WHAT** core components and indicators comprise the age-friendly practices, **HOW** the aligned movements are continuing to evolve and **WHY** it is important for public health. professionals.*

A. Age-Friendly Public Health System Framework

1. C's of Practice

The Age-Friendly Public Health System Framework, [53] developed by the Trust for America's Health (TFAH), identifies six important public health practices in alignment with the core equity-focused functions of the Ten Essential Public Health Practices:

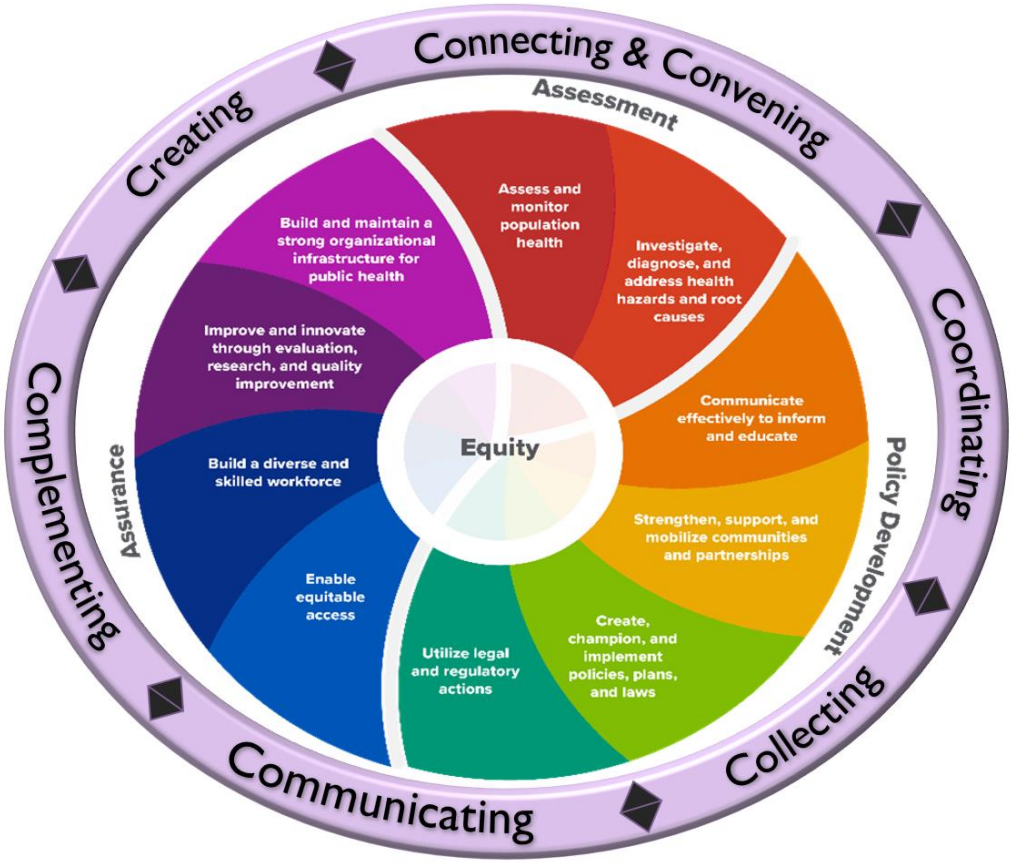


Figure 3. 1 Ten Essential Public Health Services by Six C's of Age-Friendly Public Health System Practice

Table 3. 1 Importance of Age-Friendly Public Health System Practice

Practice	***Why this matters for public health practice***
Connecting and convening multi-sector stakeholders to address the health and social needs of older adults through collective impact approaches focused on the social determinants of health.	Addressing the range of needs to support healthy aging in the community involves a vast yet fragmented system of providers – *public health practice adds a preventive and community-wide focus on improvements that impact entire populations.*
Coordinating existing supports and services to help older adults, families, and caregivers navigate and access services and supports, avoid duplication, and promote an integrated system of care.	Navigating the continuum of community-based supports to age in community can be complex and inefficient – *public health practice assures programmatic inclusion by addressing barriers to effective community offerings as well as promoting preventive health services for all persons.*
Collecting, analyzing and translating relevant and robust data on older adults to identify the needs and assets of a community and inform the development of interventions through community-wide assessment.	Synthesizing information across a variety of sources is necessary to understand the status and opportunities to improve healthy aging in community – *public health practice assesses and monitors health risk factors across the entire community, particularly targeting efforts for at-risk and older populations.*
Communicating important public health information to promote and support older adult health and well-being, including conducting and disseminating research findings, and emerging and best practices to support healthy aging.	Disseminating empirically-informed learnings can enhance healthy aging across the community – *public health practice promotes healthy behaviors among individuals of all ages as well as informs the establishment of safe and healthy living environments and services.*
Complementing existing health promotion programs to ensure they are adequately meeting the needs of older adults.	Aligning community health within the broader health care system can more effectively address healthy aging across the life course - *as the scope of public health addresses diseases from acute to chronic, prevention from primary to tertiary, outreach from broad-based to targeted, environmental conditions from safe to hazardous, and emergency responses from rare to catastrophic events and specifically addresses older adults as well.*
Creating* and leading policy, systems, and environmental changes to improve older adult health and well-being.	Impacting healthy aging across the life course requires strategizing efforts regarding the determinants of health and underlying root causes of health inequities – *public health practice assures an ecological lens, attending to community power structures and levers for change across the community.*

Note: The sixth C was added in 2022 – see evolution section below for more detail.

2. Age-Friendly Public Health System Evolution

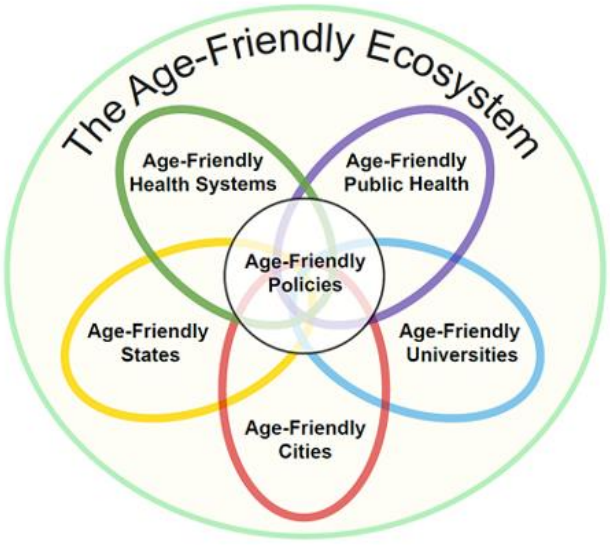
The Age-Friendly Public Health System began by TFAH to advance a model for Public Health's role in healthy aging. In 2018, a Florida Department of Health Pilot was conducted with 37 county health departments participating in a 'Learning and Action Network.' The teams collected and analyzed data to identify and prioritize the health needs of older adults and created partnerships in collaboration with other organizations that serve older adults. In 2021 the pilot was expanded to included nine more Florida counties and three other states including: Michigan, Mississippi and Washington.

The Public Health Accrediting Board (PHAB) commissioned a Healthy Aging Paper and Think Tank Summary [54] and Tip Sheet [55] to encourage health departments to include initiatives and strategies focused on healthy aging and the creation of an Age-Friendly Public Health System into their work on accreditation and reaccreditation (Version 2022). In 2021, the Think Tank convening of public health authorities and leaders across the nation added a sixth 'C' (Creating) to TFAH's initial five 'C' framework.

To support Age-Friendly Public Health System practice, TFAH hosts a website for the growing network including a forum for professionals as well as helpful resources, relevant events and a range of topics such as ageism and caregiving. TFAH also launched a recognition program for state and local health departments to incentivize making healthy aging a core public health function.

To advance the practice framework, TFAH has partnered with the U.S. Department of Health and Human Services to help facilitate collaboration among state public health and aging services leaders leading to several efforts including Healthy Aging Symposium Summits, [56] held in 2018 and 2021.

TFAH is working to strategically align the AFPHS initiative with other components of the Age-Friendly Ecosystem including the Age-Friendly Health Systems, an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement, in partnership with the American Hospital Association, and the Catholic Health Association of the United States.



Age-Friendly Health Systems

Age-Friendly PUBLIC HEALTH SYSTEMS

3. Key Indicators

Evaluation of the Age-Friendly Public Health System Framework is ongoing. A logic model was developed to guide the project's development. The Florida Pilot yielded evidence of core process measures by practice. Key indicators are listed in the following Table:

Table 3. 2 Key Indicators by Age-Friendly Public Health System Practice

Practice	Indicator
Connecting and convening	• Engage at least one new aging sector or other community partner in its efforts to expand public health's role in aging. • Enhance at least one existing relationship with an aging sector partner. • Create or joined a multi-sector coalition, committee or council that addresses healthy aging.
Coordinating	• Review and strengthen Emergency Preparedness plan to ensure it addresses needs of older adults • Implement at least one new education program or health service targeted at older adults.
Collecting	• Collect, analyze and disseminate data from the Aging in Florida profile (DOH). • Review and strengthened community health assessment to ensure it addresses older adult health needs. • Identify a priority around older adult health in community health improvement plan. • Conduct an environmental scan to identify community programs that address older adults. • Establish a mechanism for ongoing input of older adult residents into health planning and policy development.
Communicating	• Develop messaging or communication strategy to engage additional partners and/or improve visibility of health aging programs/services. • Increase awareness of existing services and facilitate referrals to improve access.
Complementing	• Implement at least one new education program or service targeted at older adults.
Creating	• Engage in or lead policy, systems and/or environmental change to improve older adult health and wellbeing.

B. Age-Friendly Community Framework

1. Domains of Livability

The Age-Friendly Community Framework, developed by the World Health Organization (WHO), identifies eight 'domains of livability'– representing built, social and service aspects of community life that can enable or impede wellbeing among older adults.

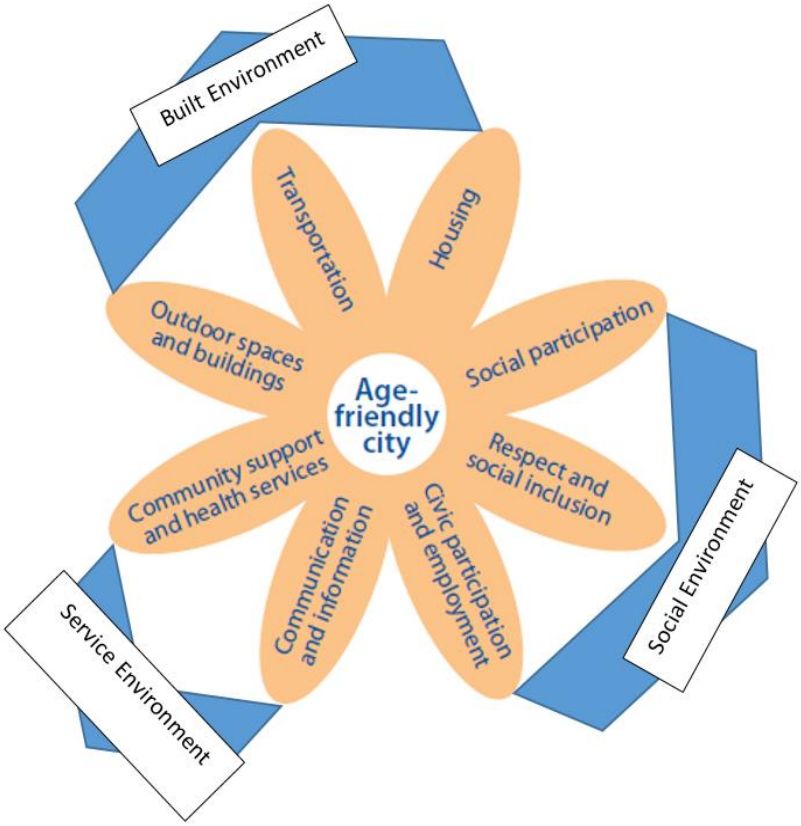


Figure 3. 2 Age-Friendly Community Clustered Domains of Livability

More than nine out of 10 adults age 65 and older reside in community settings[57] and the vast majority prefer to 'age in place' in their own homes – and communities – for as long as possible. Age-friendly domains of livability support healthy aging[58] by enabling opportunities to age safely in a place that is right, continuing to develop personally, and to be included and contribute to their communities while retaining their autonomy and health.

Table 3. 3 Importance of Domains of Livability for Healthy Aging

Domain of Livability	***Why this matters for healthy aging***
Built Environment	
Housing	Affordable and accessible housing options and supportive services for home maintenance and help to manage daily living activities enable people of all ages, life circumstances and abilities to age in place which is *associated with greater life satisfaction and self-esteem.*[59,60]
Outdoor Spaces & Buildings	Safe and accessible facilities for recreation, shopping and services and well-maintained walkways, parking areas, public restrooms and public parks enable people of all ages and abilities to participate more fully in community life outside of the home which is *associated with improved physical, mental and social wellbeing.*[61]
Transportation	Mobility options that offer reliable and affordable transportation choices as well as safe pedestrian, cycling and roadway design and signage address changing abilities to drive which can *prevent transportation-related injuries, enhance accessibility to needed services and desired activities as well as promote activity among older adults.* [62]
Social Environment	
Civic Participation & Employment	Options for life-long training, paid work and volunteering post-retirement can *provide for meaningful opportunities to more fully participate in social, civic and economic life.*[63]
Respect & Social Inclusion	Community experiences that provide reverent treatment and interactions, intergenerational activities and engagement of people of all ages, abilities and socio-cultural positions can *enhance dignity and wellbeing among older adults.*[64]
Social Participation	Affordable and accessible opportunities across a range of social activities with peers and younger people can *counter isolation and contribute to social, mental, physical and spiritual wellbeing.* [65]
Service Environment	
Communication & Information	Access to information about community activities and needed services via multiple formats (including digital and outreach to home) and adapted for variable sensory and other abilities can *enhance health literacy, help navigate the continuum of care options and boost self-efficacy* in an increasingly complex and technological world.[66]
Community Support & Health Services	Available services ranging from the promotion of wellness, emergency, and end-of-life planning, from home to specialized acute and long-term inpatient and institutional settings, as well as programs for caregivers and other informal supports can *ensure comprehensive and integrative care options that best meet older adults' needs and preferences.*[67]

2. Age-Friendly Community Evolution

The origins of the global Age-Friendly Community movement can be traced to the 1991 United Nations Principles for Older Adults Resolution based on principles of Independence, Participation, Care, Self-fulfilment, and Dignity. In 2002, the concept was further developed as a local response to encourage active ageing policy [68] by optimizing opportunities for health, participation and security in order to enhance quality of life as people age. In 2007, the WHO published the age-friendly guide [69] which outlined eight core community features (aka 'domains of livability') based on research with more than 2,200 older adults, caregivers and service providers in 33 cities and 22 countries to identify ways in which cities could become age-friendlier places for persons to age.

In 2010, the WHO established the Global Network for Age-friendly Cities and Communities to connect cities, communities and organizations worldwide with the common vision of making their community a great place to grow old in. The network focuses on amplifying action at the local level to promote healthy and active ageing. To facilitate efforts, the WHO created a website which lists worldwide members along with age-friendly practices and resources to inspire, connect and support the global effort.

In 2012, the AARP Network of Age-Friendly States and Communities was established as a national, independent affiliate of the global movement. Aligned with their overarching Livable Communities effort and related teams, AARP hosts a website and extensive support for the age-friendly network, including resources, an interactive map and a members-only portal.

A series of reports by the WHO has further propelled the age-friendly community movement. In 2015, the World Report on Ageing and Health [70] outlined how age-friendly communities foster healthy ageing around the concept of functional ability (defined as composite of mental and physical capacities in context of one's environment). Also in 2015, 15 of the 17 adopted United Nations *Sustainable Development Goals* pertain to aging. In 2016, the creation of age-friendly environments is listed as one of five Global Strategies on Ageing and Health [71] and the development of the Global Network for Age-friendly Cities and Communities is identified as one of the WHO's Ten Priorities for the Decade of Action on Healthy Ageing [72] 2020 – 2030.

3. Key Indicators

Evaluation is a requisite component of age-friendly community participation in the global network. As a condition of membership, communities commit to a five-year cycle of continuous improvement [73] which culminates in a report of progress. However, there is considerable latitude regarding evaluative foci, as age-friendliness is a complex, dynamic, and multi-dimensional concept which is highly context dependent with that does not easily lend itself to standardization of measurement. [74] Consequently, there is flexibility of reported content, processes and formats based on local needs, capabilities and approaches.

Increasing focus on the need to demonstrate AFC progress led to the development of indicators. In 2015, after conducting literature reviews, expert consultations, several rounds of peer review and a pilot study spanning more than 50 communities across 15 countries, the WHO released a guide to measure the age-friendliness of cities using a common framework of 41 indicators. The key principles reflected in the core indicators are equity, accessibility and inclusiveness. Though not prescriptive, the guide provides an overview on identifying feasible indicators, data sources and methodological approaches including the necessity of obtaining input from older adults to contribute to a more holistic and accurate assessment. [71]

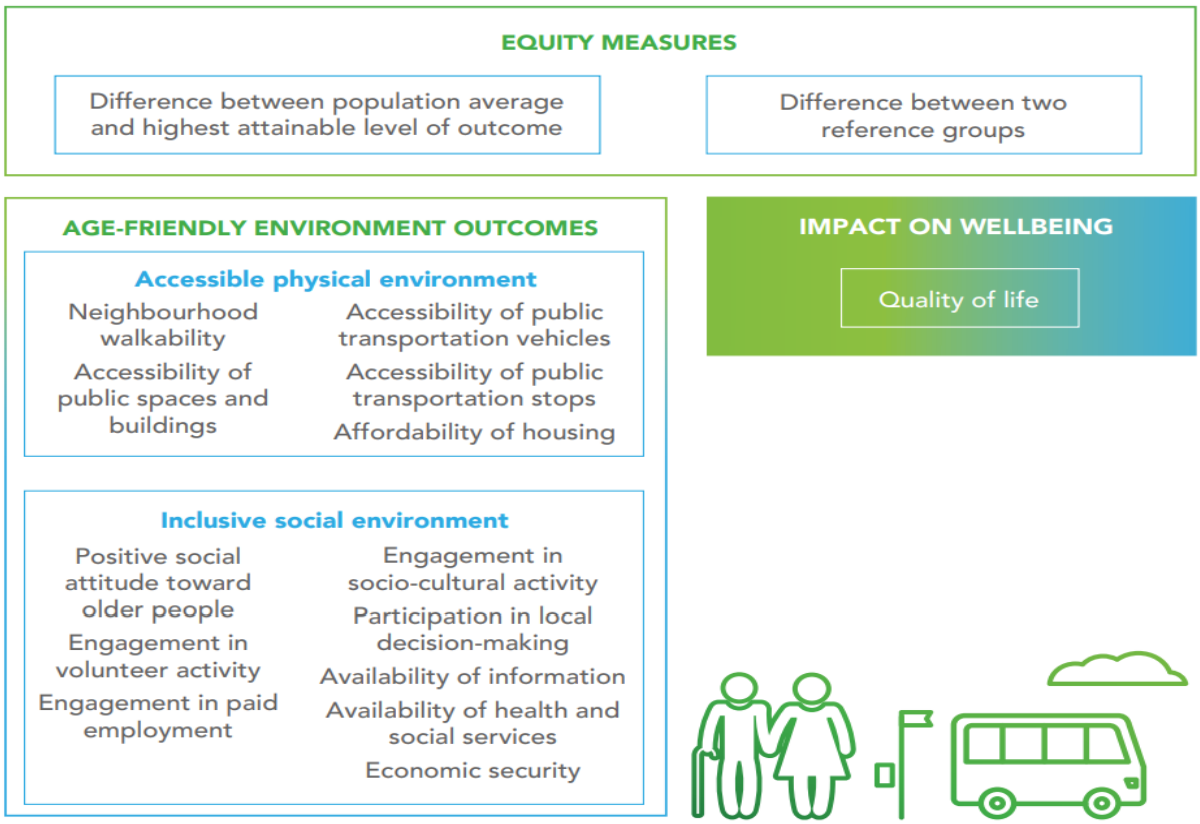


Figure 3. 3 Core indicators of Age-Friendly Cities[75]

AARP has created several resources to evaluate age-friendly community progress, including a step-by-step evaluation guide based on logic modeling [76] and the Livability Index which uses 60 objective indicators across seven categories to create scores aligned with the domains of livability.

IV. Advancing Equitable Healthy Aging in Community Health Improvement Practice

- *This section identifies actionable efforts to promote equitable healthy aging in community health improvement practice.*
- *It addresses **WHAT** practical actions can be undertaken by core planning phases, **HOW** community-capacity can be enhanced and **WHY** it is important for public health professionals.*

Community Health Improvement (CHI) practice to advance equitable healthy aging requires in-depth work with communities to more fully engage and better understand the community story on aging well – addressing both the quantity and quality of years lived. This includes leveraging opportunities to optimize health and wellbeing at all life stages and abilities across the life course. It also includes facilitating strategic collaboration in planning and alignment of missions, goals, resources and reach of cross-sectoral partners in moving upstream to improve equitable healthy aging across the community and in the measurement of improved health and wellbeing.

This section identifies strategies and helpful resources to advance equitable healthy aging across three main phases of CHI practice as identified by MAPP 2.0. As learnings continue to evolve, content pertaining to health equity and healthy aging and are subject to updates. Likewise, progression of MAPP 2.0 processes are further subject to continued refinement and guidance per NACCHO.

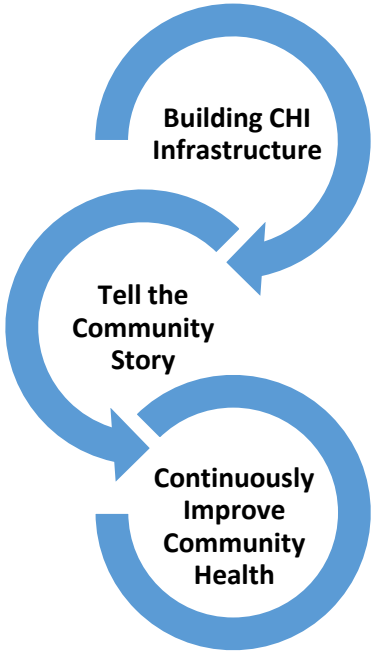


Figure 4. 1 Three Phases of Community Health Improvement Practice

A. Building a CHI Infrastructure

Building a CHI infrastructure to advance equitable healthy aging requires strategic internal and external capacity-building. Health department infrastructure to advance equitable healthy aging includes workforce, policy, programmatic and intentional partnering considerations. This phase of CHI work establishes CHI leadership, strengthens community and partnership engagement, and improves CHI processes and outcomes.

Figure 4. 2 Health Department Infrastructure Considerations to Advance Equitable Healthy Aging

Workforce
➢ Dedicate funding for healthy aging staff positions or shared positions with other agencies who are responsible for embedding age-friendly public health system practices throughout the entire organization and explicate inclusion of equitable healthy aging in performance expectations.
➢ Require that health equity staff positions explicitly address older adult life stage, subpopulations, intersectionality and the tenets of healthy aging across the life course.
➢ Educate health departments to build capacity for monitoring resource allocation to ensure available resources to advance healthy aging.
➢ Create ongoing learning opportunities for staff on age-related conditions, syndromes and evidence-based practices that incorporates trajectories and disparities on such topics as: aging-in-place, Alzheimer's disease and related dementias, brain health, care coordination, caregiving, chronic disease management, climate -related events, depression, elder abuse, falls, geriatric mental health assessment, isolation, resilience and emergency preparedness, substance abuse, and suicides.
➢ Initiate educational campaign among staff to counter ageism and other stigmas associated with age and intersecting social positions and identities.
➢ Build equitable healthy aging core competencies and capacities of staff to promote the health department's work toward an age-friendly public health system.
➢ Include information about structural ageism, oppression, and intersectionality as part of education and promotion about the social determinants of health and healthy aging.

Policies
➢ Include healthy aging language within the health department's health and racial equity approach to organizational processes and procedures.
➢ Apply equitable healthy aging practices within the health department's support of staff such as policies on caregiving responsibilities for older adults.
➢ As departments develop a culture of QI and performance measurement, encourage equitable healthy aging as one of the main goals and to include equitable healthy aging performance measures into public facing dashboards.
➢ Make equitable healthy aging a core function and consider AFPHS Recognition Program to reflect a health department's commitment and promote status.
➢ Develop a transparent process for responding to internal/external requests for health department statements, testimonies, letters, etc. on policy related to equitable healthy aging.
➢ Develop, adopt, and implement policies, plans, practices, and tools that explicitly address and champion healthy aging and age-friendly public health actions at the root causes of inequities and disparities and use appropriate life course language in documents created
➢ Include healthy aging population health outcomes across population subgroups outcomes for tracking and monitoring health status.
➢ Incorporate healthy aging into the health department's SDOH framework and health equity strategies to assess state and local policies that support age friendly communities.
➢ Ensure that surveillance and data sources from other state agencies and divisions providing emergency response include populations across the life span with attention to subgroup needs and preferences.
➢ Incorporate goals, language, and data about healthy aging and the social and economic conditions necessary for health into city/county/state's plans, budgets, assessments, and other strategic documents
➢ Use age-related data to inform the development of programs, services, and innovations aimed at creating an age-friendly public health system.
➢ Develop a clear policy, systems, and environmental change agenda that both internally at the health department and externally with stakeholders and the community addresses social determinants of health and aging.

Outreach & Community Partnerships
➢ Work with health care providers to educate their workforce about healthy aging best practices and evidence aimed at eliminating practices that overtly or implicitly discriminate based on social class, language, gender identity, race and ethnicity, disability, etc.
➢ Foster partnerships with schools of public health (or national organizations representing them) to include equitable healthy aging education in curricula and support equitable healthy aging research and fellowship programs.
➢ Encourage and incentivize adoption of equitable healthy aging considerations in relationships with providers such as Medicaid and other purchasers of aging-related services.
➢ Collaborate with local, regional and state government partners on healthy aging policies and programs such as preventive screenings, immunizations, fall prevention, elder abuse, social isolation, and medication and alcohol misuse.
➢ Review and comment on municipal and broader community proposed plans, policies, projects to enhance equitable healthy aging.
➢ Represent equitable healthy aging considerations on policy boards and committees.
➢ Provide outreach education and mobilize community champions on issues pertaining to equitable healthy aging.
➢ Build cross-sector collaboration to hold provider networks and other public health system partners accountable for advancing healthy aging, and foster coordination of existing supports and services to avoid duplication of efforts, identify gaps, and increase access to services and supports.
➢ Adapt communication to ensure effective messaging across diversity of older adult abilities, learning styles and access including vision, hearing and literacy as well as digital media and outreach to place-based older adults and their caregivers.
➢ Consider the need to balance stakeholder organizations that represent the aging populations with community members who are part of the aging population and their caregivers which should extend across the full public health enterprise.
➢ Provide support to communities working on age-friendly community and other similar designations such as Age-Friendly Health Systems.

Programs & Services
➢ Communication plans and strategies with older adults should be adapted to accommodate range of abilities in vision and hearing and cultural competence, health literacy and format including technology-based messaging to demonstrate respect and preferences in communication.
➢ Ensure that laboratory screenings and testing are available, as appropriate, to all ages, across the life span, including aging populations in rural and under-served areas as well as those who are largely place-bound.
➢ Promote the development of caregiver systems that reflect the diversity of caregiver needs and preferences and circumstances to provide relief/respite and aging in place supports that postpone nursing home placement.
➢ Ensure that emergency preparedness planning considers unique conditions associated with vulnerable older adults and home/place bound older adults and their caregivers.
➢ Ensure that any efforts to identify, monitor and mitigate communicable disease outbreaks and environmental health hazards (including the built environment) addresses diversity of the aging population and their caregivers.
➢ Driven by the commitment to health equity, intentionally include people experiencing age-related inequities in all stages of program and policy development and create meaningful opportunities for community engagement and evaluation.

Resource	Description
A Public Health Framework for Healthy Aging	Developed by Ramsey County Public Health to provide guidance on how to implement a healthy aging public health framework, healthy aging, ageism, and aging well in the community.
Community Forum on Racial Equity in Services for Older Adults in Minnesota	Forum that aimed to build collaboration across different community groups and members about aging and long-term services and supports for the needs of racially/ethnically diverse consumers.
Healthy Aging for All Guide	Guide that includes resources and tools age-and dementia-friendly community stakeholders can use to promote conversations and take action to reduce inequities.
Los Angeles Case Study: Successful Partnership Between Public Health and the Aging Sector	This case study highlights the approach taken by the City and County of Los Angeles to integrate public health and older adult services to support the health and well-being of the state's older adults.
Road Map for Indian Country	Includes culturally appropriate recommendations for American Indian and Alaska Native (AI/AN) community leaders as they develop a broad response to Alzheimer's and other dementias.

1. Establish CHI Leadership Structures

Establishing CHI leadership structures to advance equitable healthy aging builds strategic relationships with new and existing partners. This step requires assessing power to influence change among lead agency, core and steering committee positions to determine the most impactful leadership for strategic upstream and sustainable community health improvement. Assessing community partner's power to advance equitable healthy aging can be determined by its organizational commitment to health equity and healthy aging in five core areas: (1) Strategic priorities; (2) Structures and practices; (3) Specific actions to address determinants of health within its organizational purview; (4) Efforts towards decreasing oppression and discrimination within the organization; and (5) Efforts to enhance equitable healthy aging.

**********PRACTICE CONSIDERATIONS**********

- Invite aging providers and other organizations that focus primarily on the health and wellbeing of older adults – and be sure to also assess for explicit attention to health equity which can be expressed vicariously via such terms as diversity, inclusion and accessibility, among other language.
- Among health and social service and other organizational partners that primarily serve the general population, this can be achieved by assessing for explicit attention to healthy aging which may be expressed by terms such as 'all ages,' and 'for all persons,' or in explicit mention of 'older adults' or other phrasing that signifies the essence of aging well.

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Indicators that heath equity and healthy aging are strategic priorities
➢ Organizational position statement, mission, values or pillars on health equity and healthy aging
➢ Strategic plan addresses issues related to health equity, inclusion and diversity and specifies all ages or older adults.
➢ Demonstrated leadership commitment by aligning health equity and healthy aging goals cross-departmentally rather than in isolated units.
➢ Secured sustainable funding for programs and services that promote health equity and healthy aging – such as non-insured walk-in clinic or financial literacy program.
➢ Being a sanctioned provider of major funding for health of older adults or under purview of other public policies mandated to serve older adults by income or socio-economic status

Indicators that the organization has developed structures and practices to support health equity and healthy aging
➢ Established a governance committee to oversee and manage equity work and healthy aging across the organization
➢ Have mechanisms to involve clients and community in the planning, development of programs, services and community initiatives such as feedback process for clients to report on experiences of discrimination
➢ Population health needs-based, evidence-informed planning and decision-making policies/practices such as routine use of population/community level data sources
➢ Equity-informed monitoring and evaluation practices/policies, and routine use of standardized tools such as high-quality socio-demographic data collection
➢ Dedicated resources to support health equity and healthy aging activities in the workforce, with clients and the community
➢ Data transparencies that demonstrate its own track record impact on health inequities and healthy aging or history of improvements towards change (ex)
➢ Workforce has experience and community regard in serving older adults such as representative of older adult demographics and experience serving diversity of older adults

Indicators of specific actions to address the determinants of health of which the organization can have a direct impact on health equity and healthy aging:
➢ Routine collection and use of disaggregated intersectional data to identify factors that affect health equity as well as where disparities exist such as linking demographic data to health outcomes in screening and chronic disease management
➢ Tailored quality improvement efforts to meet the needs of marginalized populations such as health services designed to consider factors affecting different social groups such as those at risk of poverty and racialized groups
➢ Provide economic and development opportunities for staff at all levels such as recruitment and staff development, and for front-line support staff to contribute all levels toward health equity.
➢ Procure supplies and services from women, minority, and older adult-owned businesses.

Indicators of efforts towards decreasing all forms of organizational discrimination and oppression on include:
➢ Physical accessibility of buildings and design that are welcoming to all such as accessible public transportation, signs that convey clients are trusted and welcome, reflective of clientele served, affordable parking, building easy to navigate, no difference in those served in newer vs. older facilities, continuous service access in the face of disasters and other unforeseen events.
➢ Functional accessibility of programs and services that are welcoming to all such as action to reduce wait times, staff explain things in a way that is easy to understand, staff are easy to talk to or ask questions, services provided in language of choice, client knowledge of how to lodge a suggestion/complaint.
➢ Human resource practices to train all staff and boards around health equity, ageism, anti-oppression, anti-racism and cultural competency.
➢ Organizational policies/structures/norms that reduce implicit bias around age, race, gender identity, sexual orientation, spoken language, disability status, education, employment status in service delivery, client/patient care such as commitment to diversity and reflective and inclusive hiring and promotion and encouragement of healthy workplace behaviors among staff such as health care coaching and annual physical health risk appraisal.

Indicators of developed partnerships with others to improve equitable healthy aging at the societal/ population level
➢ Community partnerships, collaborations or linkages with a broad range of community services, groups or entities relevant to its objectives that also address upstream determinants of healthy aging and health equity
➢ Physical/ environmental practices that contribute to the improvement of the local neighborhood such as walking paths, community spaces, parks, and access to nature or built facilities in underserved communities.
➢ Involved in regional and/or cross-sectoral mechanisms /models/networks to formally support professional planning and implementation of cross-sectoral action for healthy aging and health equity such as convening community planning events.
➢ Routine monitoring of and evaluations performed on partnership activities or programs planning, implementation, progress, outcomes, impact of joint initiatives such as sustained outcomes/shared long-term commitment to achieving better outcomes.
➢ History of trusted relationships and success in meeting broader community needs, that is beyond market share and for greater good.
➢ Record of coordination and alignment with other partners and stakeholders within the community system to improve overall quality, efficiency, and effectiveness of programs, services, and interventions to address inequities.

2. Strengthen Community and Partnership Engagement

Strengthening community and partnership engagement to advance equitable healthy aging occurs throughout CHI practice. Inclusive and intentional multi-sectoral engagement helps build relationships and capacity to sustain healthy aging for persons at all life stages and abilities across the life course.

**********PRACTICE CONSIDERATIONS**********

- It is essential to engage older adults throughout the CHI process: to enhance trust, to honor the authentic voice of older adults and to elevate their essential power in the community's health.
- Older adults represent an important pillar in communities with knowledge and experience that links neighborhood and community culture and provides systemic perspectives on wellbeing across time.
- Providers dedicated to serving the health of older adults offer long-standing expertise and credibility in the community provide an already existing infrastructure of services and supports and relationships with older adults across the community.

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As an overarching approach, the principles of community-based participatory research (CBPR) [77] provide particularly applicable and relevant mindset framing. CBPR was developed to connect research to practice through community engagement and social action to increase health equity and is an especially useful approach to engage communities where members feel marginalized or stigmatized. CBPR has since been successfully applied in communities across a wide variety of health disparities, outcomes and behaviors including diabetes, obesity and exercise.[78] CBPR is an applied collaborative approach that enables community residents to more actively participate in the full spectrum of activities from conception to dissemination with a goal of influencing change in community health, systems, programs or policies.

Principles of Community-based Participatory Action Research
➢ Recognizes community as a unit of identity
➢ Builds on strengths and resources within the community
➢ Facilitates collaborative, equitable involvement of all partners in all research/CHI phases
➢ Integrates knowledge and action for mutual benefit of all partners
➢ Promotes a co-learning and empowering process that attends to social inequalities
➢ Involves a cyclical and iterative process
➢ Addresses health from both positive and ecological perspectives
➢ Disseminates findings and knowledge gained to all partners
➢ Involves a long-term commitment by all partners

Resource	Description
Asset-Based Community Development	Framework to identify and utilize community strengths for solutions to community needs. Emphasizes inclusion of residents traditionally excluded from decision-making.
A Toolkit for Serving Diverse Communities	Toolkit that emphasizes full participation of professionals, their agencies, and partners to work together to serve all diverse populations from different cultures with respect, inclusiveness, and sensitivity.
Collective Impact	Framework focused on multisector collaboration to address complex issues, premised on five core principles: (a) co-constructed common agenda; (b) shared measurement; (c) mutually reinforcing activities; (d) continuous communications; and (e) dedicated backbone infrastructure.
Guidance for Integrating Culturally Diverse Communities into Planning for and Responding to Emergencies: A Toolkit	Toolkit offers a comprehensive framework and specific guidance for engaging communities to inform the integration of issues related to race, ethnicity, culture, language, and trust into preparedness plans, programs, and actions.
Health Equity Toolkit: A Resource Inventory for Health Care Organizations	This toolkit maps the resources and tools that are available to build the capacity around health equity, at the individual user, team, and organizational levels.
National Academies of Medicine Communities in Action	The committee identifies major elements of effective or promising solutions to health inequity including key levers, policies, and engaging stakeholders.
National Aging Network	Describes aging network, the federal government's role, the state's role, aging network at the local level, and community-based care initiatives.
Robert Wood Johnson Foundation's Culture of Health	Working alongside others to build a Culture of Health providing everyone in America a fair and just opportunity for health and well-being with health equity being the main driver.
100 Million People Living Healthier Lives Worldwide | IHI - Institute for Healthcare Improvement	Resources using Community of Solutions framework to shift their cultures, identify root causes of inequity, find new allies, and make progress toward improving health, well-being, and equity in their communities.

3. Assess and Improve CHI Infrastructure, Processes and Outcomes

Equitable healthy aging can be made a priority in this early stage when educating and orienting CHI leadership and developing the CHI mission and vision.

Engage and Orient Leadership Committees
➢ Help new committee members establish baseline understanding of equitable healthy aging by including language about older adult subgroups by health status or other life course identities impacting health at later ages
➢ Help new committee members connect concept of equitable healthy aging to CHI process by identifying community demographics and noting that phases will explicitly include all ages, life course perspective and needs of older adults
➢ As each member contributes their voice, look for alignment of their input and organizational perspectives to the health and wellbeing of older adults, such as connecting or extending implication of a comment to older adult health issues, disparities or experiences.
➢ Create a profile of older adults for new members

Define Community and Develop the CHI Mission
➢ Include older adults as a distinct subset of the population.
➢ Allow leadership to collectively define community and help connect each target population by life stage and trajectory of healthy aging.
➢ Encourage mission statement that identifies purpose and scope of the CHI coalition/collaboration vis-a-vis equitable healthy aging lens.

Develop a Community Vision
➢ Foster a transformational long-range vision which engages partners to clearly see how their contributions can enhance the health and wellbeing of all persons.
➢ Envision a healthy community for people of all life stages and abilities across the life course.

Resource	Description
Community Catalyst: Best Practices for White-Led Organizations to Promote Health Equity and Racial Justice in Health Advocacy	Toolkit containing best practices and examples for consumer health advocates looking to include and respond to racial disparities in their agendas, coalition work, stakeholder engagement, and communications.
Disrupt Disparities: Addressing the Crisis for Rural New Yorkers 50+	This report documents disparities experienced by New Yorkers such as greater social and geographic isolation and provides achievable solutions to promote health equity.
Disrupt Disparities: Challenges and Solutions for 50+ Illinoisans of Color	Report focuses on the issues of economic security, health and digital connectivity for older adults of color in communities and includes outlined first-step policy recommendations that should be taken at the state and local level.
Embracing Maine's Diversity	The Maine Council on Aging launched the Equity and Healthy Aging initiative and is committed to intentionally including the needs of diverse older adults in our advocacy and policy efforts, and in helping our members build stronger relationships with communities of diverse older adults.
Engaging Allies in the Culture of Health Movement: Role of Anchor Institutions	Stakeholder meeting that discussed anchor institution strategies are a key component to advancing health equity and a culture of health in neighboring underserved communities, explored how to shape an anchor institution mission for universities, hospitals, health systems, businesses, non-profit foundations, and municipalities, and shared information and lessons learned to determine future directions.
Equity in Aging: Indiana	Equity and aging webinar event will look at existing financial stability inequities among Central Indiana's older adult population and consider the impact of the COVID-19 pandemic.
Health Equity Toolkit: A Resource Inventory for Health Care Organizations	This toolkit maps the resources and tools that are available to build the capacity around health equity, at the individual user, team, and organizational levels.
Latino Age Wave Colorado	Designed to improve the lives of Latino older adults and their caregiving families so they may thrive in Colorado.
Massachusetts Healthy Aging Collaborative	Equity in Aging is an initiative that raises awareness and builds partnerships to advance inclusive age- and dementia friendly communities. The Massachusetts Healthy Aging Collaborative committee and ongoing webinar series will elevate and highlight work that supports diverse older adults across Massachusetts.
Master Plan for Aging Equity Work Group: California	Equity Work Group (EWG) provides advice for Master Plan Aging recommendations and deliverables through an equity lens to address the diversity in California residents.

B. Tell the Community Story

The community story is conducted through three assessments: Community Context, Community Status and Community Partners. The comprehensive assessments will aim to inform how health is experienced, how community partners and residents work together and how partners impact healthy aging inequities, Learnings from this phase will orient practice towards community ownership and co-design in implementing sustainable improvement in equitable healthy aging. Though focused largely on older adults, the context of healthy aging across the life course reveals concomitant mid (SDOH) and upstream factors (root causes) impacting equitable healthy aging in community.

1. Community Context

Assessing the community context requires collecting qualitative data which provides 'authentic' perspectives and strengths-based learnings by listening to peoples' lived experiences. This provides for deeper understanding and shared exploration of historical, systemic, and structural injustices that create and perpetuate inequities. Many older adult populations have experienced lifelong 'marginalization' due to structural racism and cumulative systemic injustices and discrimination impacting healthy behaviors, environments and access to care across their life course.

***********************PRACTICE CONSIDERATIONS***********************

- Seek input from the diversity of older adults, across socio-demographic and geographic representation and across levels of health status ranging from active and independent and those requiring levels of assistance in meeting daily activities.
- Target geographic areas to engage older adult experiencing the greatest inequities.
- Use Photovoice (photos or videos) to capture aspects of community life and share for further discussion. This is particularly useful when working with people with limited power due to poverty, language barriers, race, class, ethnicity, gender, culture, or other circumstances.
- Reach out to caregivers to obtain ancillary, expanded or corroborative information about community interactions and experiences pertaining to older adults' health and quality of life.

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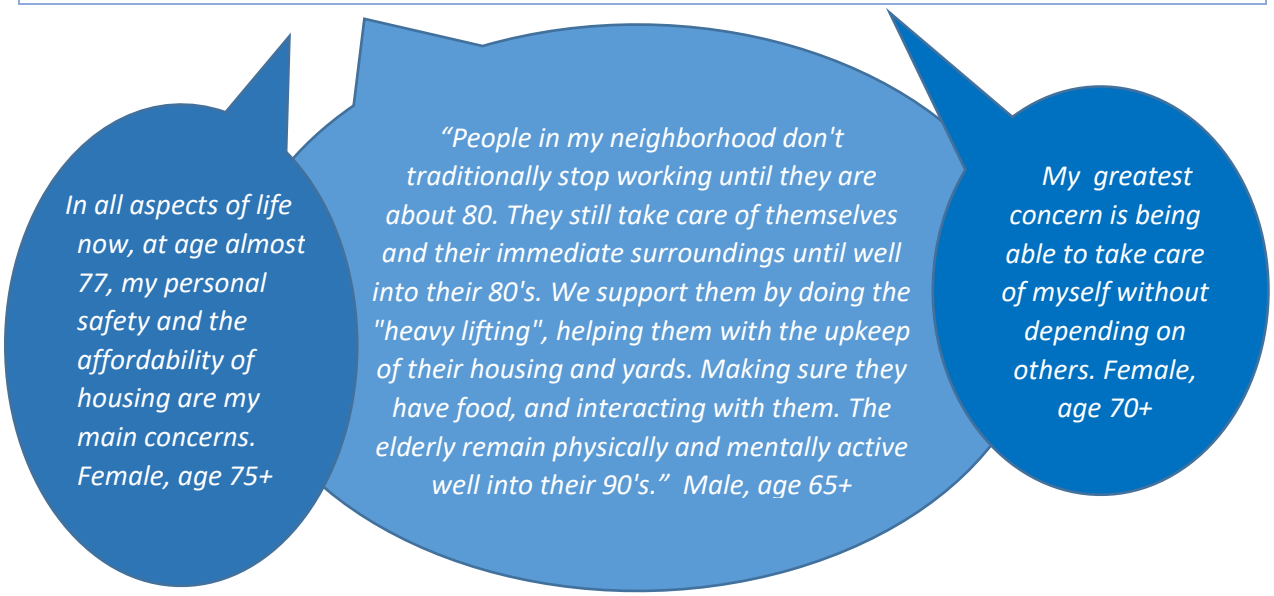
a. Lived Experience

Perceptions
➢ Begin by clarifying term 'community' as interpretations may vary – such as neighborhood, zip code, school district, county wide, sentiment or feeling, etc.
➢ When thinking about daily life in your community, what matters most? (see insights from older adult voice for authentic input what matters most in daily life and health)
➢ Inquire about what healthy aging means – what is needed to be/ enjoy healthy aging?
➢ What do older residents 'think and feel' about their own health and overall community (neighborhood) health – why do they think or feel this way?
➢ Do they feel independent and able to meet their basic needs. If not, why?
➢ Do they feel they have access to personal health care? Explore why or why not
➢ Do they feel they have opportunities to fully participate in community life? Access to activities such as work, recreational or volunteering, etc.
➢ Do older adults feel connected, included, integrated, respected, valued in the community?
➢ How do they describe their relationships with others in the community? Neighbors, mailperson, significant others, etc.
➢ Explore expressions/ feelings such as hopelessness, instability, fear, danger and scarcity AND stability, security, safety, opportunity, comfort and abundance, etc.
➢ Listen for connections between feelings and mental and physical health, chronic disease management, health behaviors and access to health care
➢ To what extent is ageism present? Explore thoughts (stereotypes) and feelings (prejudice) towards self and others and discrimination (actions) based on chronological age – and inquire how ageism experienced in community life



Insights
➢ Is there a 'back story' to better understand topic under discussion – older residents may provide reservoir of past experiences to contextualize issues
➢ What ideas do residents and others have on what can be improved and what might be needed? Inquire and deconstruct the facilitating factors noted
➢ After sharing data on healthy aging and informing how and where data collected and those involved in the process - listen regarding how data is understood, interpretations of intended messaging
➢ Have any other efforts to improve healthy aging have put in place over the years? Helpful or not – what happened?
Culture
➢ How do older residents and other stakeholders view older adults? Inclusive, asset, burden, expendable, etc.
➢ Do neighbors know each other and help others? At home, shopping, yardwork, a ride to a medical appointment, etc.
➢ Are family members nearby? In what ways do they provide support or struggle
➢ Inquire ways in which church or other community sources support healthy aging? Identify any core people, groups or programs involved
➢ How has education (pre-k, k-12, college and lifelong learning) affected healthy aging?
➢ How does their home affect healthy aging? Costs to maintain/ affordability, ability to manage daily needs including accessible features such as single floor design, access to transportation and needed services, etc.
➢ Are there opportunities for safe and accessible recreation and outdoor spaces?
➢ Do older adults think the environment is safe? From crime, toxic waste, access to clean land and water, disasters and emergencies, etc.
➢ Do older adults report access to good health care?
➢ Are health care providers trusted? Competent? Respectful of preferences? Representative of community socio-demographics?
➢ How do older adults view government, non-profits and businesses operating in the community? Trusted? Representative of community socio-demographics?
Priorities
➢ What do older adults and other key stakeholders identify as community's most pressing issues
➢ Explore connections between issues raised – across content areas and all ages

b. Strengths and Assets

Perceptions
➢ What is extent of awareness of community supports to age well? Governmental programs, other organizational, business offerings, etc.
➢ Inquire about stories on community resiliency and community-led efforts to achieve healthy aging – before-during and after experiences such as natural disasters
➢ Ask about what is unique about the community and assets related to healthy aging
➢ Is there a particularly helpful aspect of community that supports healthy aging of which they are especially proud/ appreciative
➢ What community buildings or spaces (like community centers, parks or businesses) feel welcoming, supportive, popular or well-attended by older adults?
➢ What community places or spaces encourage physical activity or other healthy behaviors or bring together people from different ages or backgrounds for a particular purpose ? Why does that matter
➢ Are there any community places or spaces that feel exclusionary? Such as operating hours, physical inaccessibility, etc.
➢ How would they describe their ability to use technology/ electronic / digital access in their world? What barriers exist?
Skills
➢ Are products and technologies available and accessible to support health? Do residents and others have the skills necessary? What are the barriers?
➢ Are caregivers able to support older adults in their homes? What else is needed?
Education
➢ Are older adults engaged in life long education activities?
➢ Are older adults engaged in child care, caring for grandchildren, the local school system?
Job Experience
➢ Are there opportunities for employment, education and volunteer activities? What are facilitators and barriers?

c. Built Environment

➢ Catalog core aging-provider services and resources on healthy aging including reliable and competent workforce
➢ Provide residents with age-friendly checklist to assess community attributes including community walkability
➢ Catalog livable community features including supply of accessible, affordable, adaptable housing, community walkability and pedestrian safety, mobility options and safety, assess to healthy food
➢ Assess emergency preparedness plan for natural disasters and review impact post implementation
➢ Identify extent of elder abuse (all types – financial, self-neglect, etc.)
➢ Identify extent of caregiving needs (financial, work-life balance, emotional support, etc.)

d. Historical Context

➢ How has covid affected health of older adults? Uptake of telehealth, immunization, other health needs, etc.
➢ How have disasters such as hurricanes affected their (and community) health and wellbeing?
➢ Have older adults utilized emergency shelters? What was experienced or subsequently changed?
➢ How has population change, growth and gentrification affected their lives and homes as well as the broader community?
➢ How has employment/ unemployment affected community wellbeing?

e. Structural Racism

**********PRACTICE CONSIDERATIONS**********

- Note that structural racism is a multi-dimensional indicator – referring to macro-level conditions such as residential segregation and institutional policies that limit opportunities, resources, power, and well-being of individuals and populations based on race/ethnicity and other statuses such as gender and social class.
- Consider qualitative data on lived experience in combination with data from the community status assessment on more upstream factors including social determinants of health and root causes.

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➢ How do older adults 'understand/ describe/explain' the economic and racial forces behind the inequities they see or experience?
➢ What level of consciousness do older adults hold of inequities – and to what extent do they think broader community and local organizations, etc. is conscious of forces underlying inequity?
➢ Do older adults talk about systemic oppressions in ways that dig down to root causes and reflect hopefulness, opportunities, or productive action ahead?
➢ Who do older adults think are affected by current structures of oppression? Are these people involved in the conversation?
➢ What are the specific disparities/inequities older adults seek to eliminate through this collective community health improvement focus and action? What barriers stand in the way of achieving more equitable outcomes?
➢ What will an equitable OUTCOME look like for older adults? How will we KNOW we have made progress? When do they expect to see results? What is their timeframe?
➢ Who does and does not have power in this community? What is power based on here?
➢ How safe do older adults feel to share their truths, and for others to speak their truths – and what do they think is needed to foster a culture of safety and relational trust to move forward?
➢ To what extent have older adults been involved in decision-making regarding programs and services to support healthy aging in their community? Has their feedback been provided and acted upon or ignored?

Source: Modified from the National Equity Project [79]

2. Community Status Assessment

Assessing the community status vis-a-vis equitable healthy aging involves collecting quantitative data to obtain baseline measures of health risk factors and outcomes, social determinants of health (SDOH), health inequities and their root causes. This requires the collection and analysis of primary and secondary data sources including age-specific data (if available) based on respective community needs, interests and capabilities. This also requires conducting disaggregated and intersectional analysis by identifying subgroups of older adults and exploring how different indicators (access, quality or outcome) link and intersect to produce multiple and varied inequalities.

***********************PRACTICE CONSIDERATIONS***********************

- Leverage existing data sources including internal partners with aging data, external aging agencies, external organizations mandated to conduct aging assessments regionally or statewide and other community entities that collect data on the aging population.
- Determine # and % of overall population aged 65 and older by age-groups (65–74; 75–84; 85+) and by core socio-demographic characteristics (race, ethnicity, male/female, LGBT, marital status, living alone, English-speaking, income and poverty status).
- Investigate layers of data for comprehensive understanding including: macro (population-level); meso (organizational-level); and micro (client or community member level).
- Longitudinally link disaggregated data and conduct change analysis to compare differences over time.
- Baseline and benchmarking data will depend on community-specific needs, data availability and parameters of data collected such as age-specific vs. all ages and data time frames as well as community-relevant population denominators and rates.
- Inclusion of age-specific data on persons aged 55 or 60 and older may be desirable for planning trajectories.
- Establish transparent data processes that clearly identify what aging-specific data was collected, how and where it was collected and who was involved in the process, how data was interpreted and who and how findings are communicated and received.

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a. Health Outcomes

Morbidity & Mortality
➢ Identify top/ underlying causes of death by age and sex adjusted mortality
➢ Determine prevalence of diseases and conditions by such measures as % Alzheimer's disease and related dementias, heart disease, cancers, chronic obstructive pulmonary disease, diabetes, eye diseases (cataracts, glaucoma), HIV/AIDS, liver and kidney disease, musculoskeletal (arthritis, osteoporosis) and multiple chronic conditions (index ranging from 2+) among other areas reflective of community health status
➢ Establish extent of disabilities by such measures as % with clinically diagnosed deafness or hearing impairment, blindness or visual impairment, or mobility impairment and % with self-reported hearing difficulty, vision difficulty, cognition difficulty, ambulatory difficulty, self-care difficulty, and independent living difficulty
Inpatient Utilization
➢ # inpatient hospital stays and hospital readmissions (as % of admissions) of adults age 65+
➢ # emergency room visits of adults age 65+
➢ # skilled nursing facility stays and skilled nursing home Medicare beds
➢ # hospice use, hospice use as a % of decedents, median hospice days per user, and median hospice payment per hospice user
➢ % of adults age 65+ getting Medicaid long-term services and supports
Injury Surveillance
➢ # of people over age 65 who fell and/or injured in a fall in past year and % with a hip fracture
➢ # and % of traffic injuries and fatalities involving people age 65+, including locations
➢ # and % of pedestrian and cycling injuries and fatalities involving people age 65+, including locations
➢ Injury deaths of persons age 65+ due to intentional and unintentional accidents injuries
Healthcare Utilization
➢ # geriatricians serving community
➢ # of eye doctors and audiologists serving the area per population parameter
➢ # of physician visits, Part D prescription refills, home health visits, durable medical equipment claims among persons age 65+ (Medicare data)

Resource	Description
Aging Integrated Database	AGing, Independence, and Disability (AGID) Program Data Portal is an on-line query system based on ACL-related data files and surveys and includes population characteristics from the Census Bureau.
Alzheimer's Disease and Healthy Aging Data Portal	CDC portal provides access to national and state level data on a range of key indicators of health and well-being for older adults, including: Caregiving, Subjective Cognitive Decline, Screenings and vaccinations and Mental Health.
American Community Survey (ACS)	The American Community Survey (ACS) helps local officials, community leaders, and businesses understand community changes regarding detailed population and housing information.
Behavioral Risk Factor Surveillance System (BRFSS)	The Behavioral Risk Factor Surveillance System (BRFSS) collects state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories.
Caregiving for Family and Friends – A Public Health Issue	Brief addresses and provides statistics about the prevalence of caregivers as well as health characteristics.
Key Indicators of Well-being	Report provides data on older Americans and their families. Divided into six subject areas: population, economics, health status, health risks and behaviors, health care, and environment.
Massachusetts Healthy Aging Data Report	State examples of comprehensive health data for sharing on older adults – including socio-demographic, health behavior, social determinants, etc. to inform partners, government leaders and others.
Aging in Florida Profile	
Master Beneficiary Summary File (MBSF) Base	Includes state and county enrollment information for Medicare Part A/B/C/D, Medicare Advantage (Part C), and the Prescription Drug Program (Part D) plan enrollment information.
U.S. Census	Serves as the nation's leading provider for quality data about the population and economy.
Web-based Injury Statistics Query and Reporting System, WISQARS	CDC's database on fatal and nonfatal injury, violent death, and cost of injury data to learn more about the public health and economic burden associated with unintentional and violence-related injury in the United States.
Wide-ranging ONline Data for Epidemiologic Research, WONDER	CDC WONDER manages nearly 20 collections of public-use data for U.S. births, deaths, cancer diagnoses, tuberculosis cases, vaccinations, environmental exposures, and population estimates, among many other topics. Including multiple causes of death.
100 Million Healthier Lives	Partnered with National Council on Aging to Adult Well-Being Assessment (AWA), an 8-question survey that is a practical and easy-to-use method of measuring an older adult's Quality of Life.

b. Risk Factors

Health Behaviors
➢ % of adults age 65+ getting CDC recommended levels of sleep and physical activity (aerobic and muscle strengthening)
➢ % of adults age 65+ receiving preventive care such as physical exam in the last year, flu shot, pneumonia vaccine, shingles vaccine, women with a mammogram in the last 2 years, colorectal cancer screening, tested for HIV, and who met CDC preventive health screening goals
➢ % of adults age 65+ with clinically diagnosed obesity, self-reported as obese, with high cholesterol and obtained cholesterol screening
➢ % of adults age 65+ who ate five and more servings of fruits and vegetables per day
➢ % of adults age 65+ with dental insurance, with an annual dental exam, with the loss of six and more teeth
➢ % of adults age 65+ reporting fair or poor health status
➢ % of adults age 65+ reporting 14 or more physically unhealthy days in the last month
Behavioral Health
➢ # of older adult deaths (age 65+) related to opioids
➢ % of adults age 65+ with limited activities due to physical, mental or emotional health problem
➢ # of adults age 65+ who are sedentary, inactive or insufficiently active
➢ # of adults age 65+ who engage in heavy or binge drinking
➢ % of adults age 65+ with opioid use disorder, substance use disorder, tobacco use disorder, marijuana use, e-cigarette use, excessive drinking and current smokers
Mental Health
➢ % of adults age 65+ receiving adequate emotional support, life satisfaction, and 14 or more poor mental health days in the last month
➢ % of adults age 65+ reporting depression, anxiety disorder, bipolar disorder, posttraumatic stress disorder, and personality disorder
➢ # and % of adults age 65+ diagnosed with Alzheimer's disease or related dementia
Caregiving
➢ # of caregiver support groups and respite services
➢ % of adults age 65+ who provide care to a family/friends
➢ % of grandparents raising grandchildren and grandparents who live with grandchildren

c. Social Determinants of Health

Food
➢ # of adults age 65+ visiting food banks
➢ % people age 65 and older receiving food benefits (SNAP, Meals on Wheels, etc.)
➢ # of grocery stores and famers markets within a half-mile

Community, Safety & Social Context
➢ # of adult deaths (age 65+) by suicide, firearm fatalities and homicides
➢ # of adults age 65+ victimized by property and violent crime
➢ # of adults age 65+ referred to Adult Protective Services by type of suspected elder abuse
➢ # of adults age 65+ under guardianship
➢ # of volunteering opportunities for adults age 65+ and # volunteering
➢ # of libraries within half a mile and # of programs serving for older adults
➢ # of senior centers and # of participants

Education
➢ # of available, affordable and accessible lifelong learning programs
➢ # of persons age 65+ with limited English proficiency
➢ # health literacy programs serving older adults
➢ # vocational training programs / % older adults participating in vocational training

Economic
➢ Cost of living among single & couple homeowners and renters age 65+
➢ % of people 65 and older who are homeowners or renters spending more than 35% of their income on housing/ % of income devoted to monthly housing costs
➢ Households receiving food stamps/SNAP that have one or more persons age 65+
➢ % of people age 65 and older who were employed, had income below the poverty line, 65+ household income (% < $20,000, % $20,001 – $49,999, % 50,000 – $99,999, % $100,000+) and median household income for community
➢ % of poverty persons age 55-64 and 65+ at increments of poverty level upwards of 500%
➢ # of adults age 65+ receiving Supplemental Social Security Income (SSI) / Medicaid
➢ # of older adults age 65+ employed and unemployed but looking for work

Neighborhood & Physical Environment
➢ # of parks within a half-mile and quality of parks/ Park Score Index
➢ Neighborhood walkability/ Neighborhood Walk Index
➢ Access to public transportation/ Walk Score
➢ % of transit stations and vehicles that are ADA accessible
➢ Motor vehicle ownership among persons age 65+ and # of driving accidents by persons age 65+
➢ Availability of subsidized housing/ # of subsidized housing units per 10,000 people to assisted living sites
➢ % of vacant homes in the community
➢ Average household size (all ages), median house value, % of people 65 and older who own their home, have a mortgage, or stressed about paying mortgage/rent the last month
➢ Accessibility/ % of housing units with zero-step entry
➢ Availability of multi-family housing/ % of housing units that are not single-family detached homes
➢ Water, land and air quality

Resource	Description
Livability Index	The Livability Index scores neighborhoods and communities across the U.S. for services and amenities that impact health.
MA Healthy Aging Collaborative	Provides a comprehensive look at the current activities and resources in place to support populations over 65 years old and those living with dementia and caregivers.
Image: NYC Interactive Map of Aging	Interactive map of aging to visualize local data to address met needs and plan for the future.
Health Equity Tracker	Provides health equity-focused data visualization tool tracking multiple conditions and determinants impacted from COVID-19 and health inequities.
Explore Health Rankings | County Health Rankings & Roadmaps	Aims to Build awareness of the multiple factors that influence health. Provides a reliable, sustainable source of local data and evidence for communities to help them identify opportunities to improve their health.

d. Root Causes

Policies and Practices
➢ Identify policies and laws associated with inequitable health among older persons
➢ Work with partners to identify institutional practices such as allocation methods and eligibility requirements that lead to inequitable health as people age.

Resource	Focal Area
State and local inclusive design laws	Housing accessibility
State and local housing trust funds	Housing affordability
State utility disconnection	Resilience
State foreclosure prevention and protection scorecard	Housing affordability
Local multi-hazard mitigation plans	Disaster resilience
State energy efficiency scorecard	Energy efficiency
State barriers to community broadband	Internet access
Early, absentee, or mail-in state voting laws	Civic engagement
Municipal Equality Index	Equal rights
Municipal LGBT anti-discrimination laws	Equal rights
Complete Streets: Smart Growth America	Safe Streets
State human services transportation coordination	Transportation options for disabled
State volunteer driver policies	Transportation options

e. Health Inequities

**********PRACTICE CONSIDERATIONS**********

- Health Inequities are the preventable and unjust differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age.
- It is important to conduct disaggregated and intersectional analysis by identifying subgroups of older adults and exploring how different indicators (access, quality or outcome) link and intersect by social identities such as race and socioeconomic status, etc. to understand which populations are disproportionately impacted.

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Access, Quality and Outcomes
of preventable hospital stays among older adults
% of uninsured older adults
% with access to primary care providers, hospitals, home health agencies, nursing homes, community health centers, adult day health centers, and hospice agencies
% of older adults dually eligible for Medicare and Medicaid or enrolled in Medicare-managed care.
% of older adults with a regular physician or who did not see a physician when needed due to cost
% of older adults with dental, vision, or hearing needs who were not able to access services and products due to cost
% of older adults stressed about buying food in the last month
% of older adults with no transportation or digital access to see a health care provider
Length of life as measured by premature death (years of potential life lost prior to age 75), life expectancy, and premature age-adjusted mortality)
% of older adults with frequent physical or mental distress
% of older adults with food insecurity
% of older adults with limited access to healthy foods
% of older adults with severe housing cost burden
% of older adults with broadband access
Access to linguistic and culturally appropriate and respectful care

Resource	Description
Disaggregating Data on Race and Ethnicity to Advance a Culture of Health	Report by the RWJF that identifies methods for collecting and analyzing data about race and ethnicity at more detailed levels and government policies that can enable and enhance data disaggregation.
Health Equity Tracker	Aims to give a detailed view of health outcomes by race, ethnicity, sex, socioeconomic status, and other critical factors to help policymakers understand what resources and support affect communities
Intersectionality Toolbox: Resource for Applying Intersectional Lens in Public Health	Applies intersectionality as a lens through which researchers (and other learners) can investigate health issues that bring to light and make visible both individual experiences and how these are created by patterns of power, privilege, and the social structures and policies that contribute to inequality and a lack of health equity.
Robert Wood Johnson Foundation Life Expectancy	The Robert Wood Johnson Foundation (RWJF) explores how life expectancy in America compares with life expectancy in your area, and resources to help everyone have the opportunity to live a healthier life.
Global Partnership for Sustainable Development Data	International repository for Case Studies, Research Methods and Good Practices on Intersectional Approaches to Data.
HHS emPOWER Map 3.0	Displays total number of at-risk electricity-dependent Medicare beneficiaries in a geographic area (i.e., state, territory, county, or ZIP Code), as well as near real-time natural hazard data.
National Equity Atlas	Comprehensive resource for data to track, measure, and make the case for racial equity and inclusive prosperity in America's regions, and states, and nationwide.

3. Community Partners

Community partnerships are critical to advancing equitable healthy aging. Assessment across a variety of attributes (internal and external-focused) will identify partners with the greatest power to enact change, including extent of each partner's engagement, linkage and influence in the community in coordinating, aligning and shaping improvements in programs and services as well as abilities to influence preventive and other upstream conditions that support equitable healthy aging.

Resources
➢ Determine organizational resources to meet diverse needs of older adults across a variety of social identities and positions (e.g., LGBT, socio-economic status, etc.)
Policy
➢ Analyze how internal organizational policies and relevant public policies (such as mandated funding streams) impact health/health inequities among older adults.
Data Capacity
➢ Inventory organization's data capacities to track measures relevant to healthy aging and health inequities among older adults as well as opportunities for transparency and shared measurement with other stakeholders.
Workforce
➢ Assess whether respective workforce is skilled, sufficient, and representative of community demographics to meet needs and address inequities among older adults.
Leadership
➢ Review partners for track record in leading equitable healthy aging efforts as it relates to their mission and participation in broader CHI efforts.
Health Equity Capacity
➢ Assesses each partner's understanding and commitment to equitable health equity and related concept of equitable healthy aging, their role in addressing inequities and analysis of existing interventions across socio-ecological spectrum (i.e., individual, organizational, systemic, and structural level).

C. Continuously Improve Community Health

This phase of CHI practice emphasizes elevating and empowering community-led priorities to achieve equitable healthy aging across a spectrum of actions. It includes establishing CHIP priorities and strengthening strategic partnerships positioned to impact sustainable change. This entails determining focal areas including project-specific and department-wide indicators, data, and priority measures to hold community partners accountable for advancing equitable healthy aging. Implementation actions are deployed within a cycle of continuous quality improvement.

**********PRACTICE CONSIDERATIONS**********

- Strategic efforts attend simultaneously to: the ways groups will work together; how issues are framed; what constitutes success; how work will be allocated and prioritized; and how progress towards the goals, and working together will be tracked.
- Health department or other lead partner oversight provides continuous communication to ensure that committed resources are deployed as agreed upon, such as specific programs serving older adults, planned outreach efforts, or staff assignments.
- While partner activities are differentiated (unique contributions), the coordination of efforts enhances concerted actions to achieve overall goals.
- A spectrum of activities provides for short-term transactional strategies tailored to meet targeted goals as well as longer-term transformational activities impacting mid and upstream factors impacting health inequities.
- Timely communication regarding member activities provides formative feedback to all participants, enabling greater intra-organizational flexibility and responsiveness to better meet targeted benchmarks such as shifting resource allocation within an organization to enhance program delivery to diverse subcommunities.
- Based on partners' commitments to key indicators, tracked disaggregated data via a shared measurement system collects data and measures results consistently across all participants ensuring that efforts remain aligned, and that participants hold each other accountable.
- Shared measurement system provides for assessing progress towards mutually-derived goals and also facilitates inter-organizational opportunities for future progress including additional community development opportunities, such as the use of a previously unknown evidence-based practice or more widespread adoption of successful strategies that were previously limited in scale.
- Moving upstream, Policy, System and Environmental (PSE) change can effectively address the root causes and structural inequities impacting healthy aging in communities.
- PSE change can be most effective when it is data and context-driven and financially sustainable, has clear and accountable implementation, and advances efforts as part of a broader strategic plan.

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POLICY change includes policies at the legislative or organizational level such as institutionalizing new rules or procedures as well as passing laws, ordinances, resolutions, mandates and regulations and can be aimed at governmental levels (federal, state, local and districts such as parks) as well as organizations such as hospitals, health systems and other community institutions such as senior centers.

SYSTEMS change involves changes made to the rules within an organization or efforts to impact the norms and processes operating within a community's milieu including changes focused on people, groups and institutional processes and procedures.

ENVIRONMENTAL change refers to changes made to the physical (built), social (interactional and programmatic) or natural environment.

SPOTLIGHT: Age-Friendly Public Health System Practice

Creating and leading changes in policies, systems, and environments to support equitable healthy aging.

INDICATOR:	EXAMPLES
Engage in or lead policy, systems and/or environmental change to improve older adult health and wellbeing.	**POLICY**
	➢ Change local zoning ordinances to allow for shared housing or accessory dwelling units to provide affordable housing options.
	➢ Promote inclusion of healthcare quality measures that address cognitive assessments, the delivery of care planning to people with diagnosed dementia, and improved outcomes.
	➢ Work with municipal planners to implement better land use and transportation and accessible and affordable mobility options for older adults via complete streets and vision zero policies for safe mobility, particularly in vulnerable geo-locations.
	➢ Establish universal design resolution to support accessible housing features and other home supports that enable people at all economic levels to age-in-place.
	SYSTEMS
	➢ Lead age-friendly, dementia-friendly or integrated age and dementia-friendly community initiatives that promote equity and inclusion.
	➢ Incorporate goals, language, and data about health equity and healthy aging and the social and economic conditions necessary for health into city/county/state's plans, budgets, assessments, and other strategic documents.
	➢ Increase messaging that emphasizes the important role of caregivers in supporting people with dementia and caregivers' health and well-being.
	➢ Lead coalition of community organizations active in disasters (COAD) to promote resilience of older adults by ensuring that emergency preparedness planning responsive to diversity of older adult needs including home/place bound older adults and their caregivers.
	ENVIRONMENT
	➢ Work with urban planners and recreation departments to inform and embed age-friendly park features and healthy aging in parks and socially-connected communities.
	➢ Address culturally and linguistically relevant programming for persons with dementia and their caregivers via screening, intake and outreach to facilitate access and remove barriers for participation and support for at-risk populations such as Fotonovela for Spanish-speaking families
	➢ Work with ADA professionals across government and other organizations to improve the interior and external design of buildings and spaces to accommodate people of all ages and abilities.

Collecting and disseminating data to assess community health status (including inequities) and aging population needs to inform the development of interventions.	
INDICATOR	**EXAMPLES**
Review and strengthen the community health assessment to ensure it addresses older adult health needs.	• Collier County Health Department now includes older adults as a target population within existing health priorities and will leverage community health assessment results to engage partners for Age-Friendly Community efforts. • DeSoto/Highlands County Health Department expanded its community health questionnaire to target older adults and received robust positive response to prioritize older adult health. • Palm Beach County Health Department expanded the community health assessment indicators to include older adult health issues after a data review highlighted the needs of this population.
Establish a mechanism for ongoing input of older adult residents to identify needs and inform the community health assessment process and policy development	• Brevard County Health Department's health educator created an ongoing distribution list curated from multiple health and aging services partners to ensure older adult residents are invited to community meetings. • Indian River County Health Department implemented door-to-door community tours and meetings to solicit input from older adults to improve community parks and recreational facilities. • Volusia County Health Department collaborated with the Council on Aging (AAA) to facilitate focus groups to gather input from older adults on their community needs and implemented an education program to these residents about health department services.

Communicating and disseminating research findings and best practices to support healthy aging.	
INDICATOR	**EXAMPLES**
Develop messaging or communication strategies and tools to engage additional partners and/or improve visibility of healthy aging programs/services.	• Manatee County Health Department developed a handout for older adults focused on suicide prevention and included resources for the older adult population on mental health and suicide prevention. • Seminole County Health Department leveraged an existing county-wide PSA opportunity to create a video on all of the county programs and services targeted toward older adults. • Walton County Health Department created an info brief in the form of a placemat to share key data on the county's older adult population in community meetings and other venues to educate and engage partners in healthy aging.
Increase awareness of existing services and facilitate referrals to improve access.	• Charlotte County Health Department is working with the county health services to expand access to mental health screenings and referrals to clinical services. • DeSoto/Highlands County Health Departments are working with local food banks to expand access to nutritious meals for older adults, providing food totes with nutrition messaging, and linking residents to SNAP benefits. • Sumter County Health Department provides a comprehensive list of benefits for all older adult participants in the Able, Stable, and Well fall prevention program.

Florida HEALTH Manatee County
Florida HEALTH Seminole County
Florida HEALTH Walton County
Florida HEALTH Charlotte County
Florida HEALTH Highlands County
Florida HEALTH Sumter County

SPOTLIGHT: Age-Friendly Public Health System Practice

Complementing and supplementing existing supports and services, particularly in terms of integrating clinical and population approaches to healthy aging	
INDICATOR	**EXAMPLES**
Implement at least one new education program or service targeted at older adults.	• Collier County Health Department implemented a healthy aging in parks program to provide physical prescriptions to increase physical activity among older adults. • Hernando County Health Department implemented the Matter of Balance program through a train the trainer process and implemented the Diabetes Counts program for older adult residents. • Martin County Health Department created a new preparedness kit for older adults to be distributed through the Medical Reserve Corps in the community.

SPOTLIGHT: Age-Friendly Public Health System Practice

Connecting and convening multiple sectors and professions that provide the supports, services and infrastructure to promote healthy aging.	
INDICATOR	**EXAMPLES**
Create or join a multi-sector coalition, committee or council that addresses healthy aging	• Lee County Health Department created a new multi-sector AGING (Agencies Gathering and Identifying Needs for Generations) coalition that meets monthly to identify and meet the needs of the county's older adults. • Leon County Health Department helped form a new health equity leadership panel through partnership efforts on the community health improvement plan. • Miami-Dade County Health Department led the Elder Issues Committee of the Consortium for a Healthier Community that works to enhance healthy lifestyles in areas like nutrition, chronic disease prevention and tobacco-free campaigns.
Engage in or lead policy, systems and/or environmental change to improve older adult health and wellbeing	• Alachua County Health Department initiated and led efforts to join the age-friendly communities' network and align public health work on the social determinants of public health and the eight domains of livability. • St. Lucie County Health Department worked with City on neighborhood improvement through community engagement to ensure an older adult focus in neighborhood improvements. • St. Johns County Health Department targeted 2020 census for accuracy to ensure the county has the appropriate level of support a resources for the growing aging population.

Coordinating existing supports and services to avoid duplication of efforts, identify gaps and increase access to services and supports.	
INDICATOR	**EXAMPLES**
Review and strengthen the emergency preparedness plan to ensure it addresses the needs of vulnerable older adults.	• Citrus County Health Department completed an assessment of its special needs shelters to address the needs of individuals with Alzheimer's and related dementias, as well as their caregivers. • St. Johns County Health Department performed a fall risk assessment, fine-tuning the layout of their special needs shelter, including the traffic flow plan around registration, meal distribution, and restroom access, resulting in zero falls during the next emergency activation. • Okaloosa County Health Department implemented the Lean on Me program, enlisting community volunteers to ensure broad registration of vulnerable older adults for emergency special needs shelters.

Looking Ahead

Equitable Healthy Aging will continue to evolve as one of the world's most pressing societal imperatives of the 21st century. Understandings and practices that enhance health equity, healthy aging and public health will undoubtably be subject to changes in the years ahead. Considerable efforts to advance equitable healthy aging in community health improvement practice is well underway.

Anticipated changes include policy and practice standards and guidelines across established governmental health authorities such as CDC, DHHS, NIH and Office of the Surgeon General. The development of a division of Healthy Aging at the CDC is in stages of legislative support. Leading public health organizations such as ASTHO, NACCHO and PHAB are already redefining roles and activities pertaining to healthy aging and health equity. Additional efforts through such entities as the APHA and other research and educational bodies across the nation will continue to emerge and facilitate the research, education and training necessary to create proficiencies in the public health workforce to enhance equitable healthy aging.

Schools of public health are incorporating concepts from healthy aging and life course perspective into curricula across fields of population health, epidemiology, biostatistics, health policy, health education and communication, child and maternal health, nutrition and community health practice. Innovative interdisciplinary work will continue to propel efforts forward.

TFAH's Age-Friendly Public Health System Practice model continues to expand and influence professional and departmental practice in this area. Indeed, the future portends increasingly important roles and opportunities for public health ahead in advancing equitable healthy aging for all persons.

Alignment across major organizations and foundations such as AARP, The John A. Hartford Foundation, the Robert Wood Johnson Foundation and others will continue to catalyze efforts that situate equitable healthy aging in the context of community life. This will further mobilize sectors across government as well as businesses and nonprofits in and outside of the traditional health and aging network as virtually every industry has a shared interest in equitable healthy aging in the growing Age-Friendly Ecosystem.

The movement to improve healthy aging for all people will perhaps receive its greatest impetus from individuals and groups committed to a just society that optimizes equitable healthy aging trajectories for all people at all stages of life, particularly at the local level. Specifically, this will align many stakeholders towards a collective and unified cause. Moreover, this will create pathways to mobilize the capital of the nation's substantial older adults themselves to realize the adage of our time 'nothing about us without us.'

Together, equitable healthy aging can be achieved through our collective efforts. This includes addressing the health needs and preferences of our esteemed older cohorts today as well as the mid-stream social determinants of health, structural inequities and systemic racism that underlies our vision - and mission - for all people to age well.

APPENDIX

A. Appendix A - List of Acronyms

ABCD: Asset-based Community Development

APHA: American Public Health Association

ASTHO: Association of State and Territorial Health Organizations

CBPR: Community-based Participatory Research

CDC: Centers for Disease Control

CHA: Community Health Assessment

CHI: Community Health Improvement

CHIP: Community Health Improvement Plan

CI: Collective Impact

MAPP: Mobilizing for Action through Planning and Partnerships

NACCHO: National Association of County and City Health Officials

NAM: National Academies of Medicine

PHAB: Public Health Accreditation Board

PHNCI: Public Health National Center for Innovation

RWJF: Robert Wood Johnson Foundation

TFAH: Trust for America's Health

UN SDG: United Nations Sustainable Development Goals

US DHHS: United States Department of Health & Human Services

USF: University of South Florida

WHO: World Health Organization

B. Appendix B – Summary of Equitable Healthy Aging Toolkit Pilot Survey

Pilot testing to inform the development of the *Health Equity and Healthy Aging Public Health* toolkit was conducted across all of the Florida Department of Health's local health departments. A total of 104 public health professionals working in community health improvement practice were identified to participate in the 38-item e-based survey (Qualtrics platform) designed to solicit professionals' input on content (i.e., knowledge and interest of Health Equity and Healthy Aging considerations per MAPP 2.0 processes) and format of the toolkit. The survey was conducted between October 12th and November 8th. A total of 77 responses were received (74% response rate).
Overall findings among respondents include:

- There was representation across all 11 Health Councils representing every geographic region throughout the state.
- Most professionals (92%) report at least some familiarity with Age-Friendly Public Health Practice.
    - Among the age-friendly public health practices, nearly all (89%) identified Connecting, Coordinating, Collecting and Complementing as most familiar and Complementing as least familiar (86%).
- The professionals report a wide variation (ranging from 1-10) in their self-reported knowledge of health equity (mean 7.79, range 3-10) and healthy aging (mean 7.23, range 1-10).
- Most respondents report at least some familiarity of MAPP 2.0 (51%), though 15% report no familiarity at this time.
- Ranging from 0 (no interest) to 10 (highest interest), among the three MAPP 2.0 phases:
    - While Phase 2 Telling the Community Story received an overall rating of 8.04 across the three assessments, the greatest interest was reported in Community Status (quantitative assessment, 5 items, mean 8.53, with the highest interest in SDOH (mean 8.72) and lowest in risk factors (mean 8.31); Partner Assessment (6 items, mean 7.86, with highest interest in health equity capacity (mean 8.35) and lowest in workforce (7.44); and Community Context (5 items, mean 7.74 with highest interest in built environment (mean 8.03) and lowest in historical context (mean 7.12).
    - Phase I Building a CHI Infrastructure (3 items, mean 8.25, with highest interest in strengthening community partnerships and engagement (mean 8.39) and lowest in establishing CHI leadership structures (mean 8.05).
    - Phase 3 Continuously Improve Community Health (4 items, mean 8.20, with highest interest in joint implementation of CHIP (mean 8.39) and lowest in complete power analysis and partner profiles (mean 7.98).
- Seven respondents provided additional comments regarding Health Equity, Healthy Aging and/or MAPP steps including: interest in collaborating further (3), plans to apply MAPP and incorporate into CHIP (2), efforts should address entire lifespan, population, all ages (2), request for funding to support activities (1).
- Among helpful toolkit features, with ratings on a scale ranging from 1-10, Key points was rated as most helpful (mean 8.36), followed by Resource links (mean 8.29), Interactive (mean 8.15) and Case Studies was noted as less helpful (mean 7.86)
- 15 respondents shared a brief story, example, or link to illustrate how their community is currently addressing health equity in healthy aging. These findings will be incorporated into the toolkit.
- 19 shared a personal email to express interest in further engaging on the topic of health equity and healthy aging in public health.

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