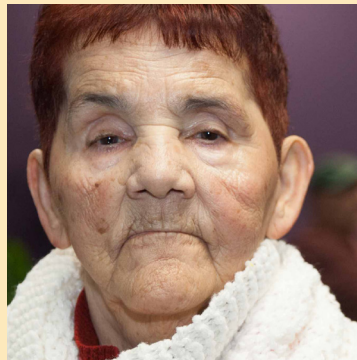


Live Beyond Expectations

Regional Strategic Plan Framework

2020-2025



Helping people live longer, healthier lives in the Atlanta region



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Framework Overview

The story we hear of aging in America is often one of increasing longevity: that, on average, we can expect to live several decades longer than our great-grandparents did, thanks to improvements in healthcare and lifestyle.

But this narrative ignores a stark truth: life expectancy is strongly correlated with geography. That is, you can expect to live a longer or shorter life, simply because of where you live.

Here in metro Atlanta, ZIP codes tell this tale of inequity. Someone who lives in the 30339 ZIP code can expect to live, on average, 25 years longer than someone just 6.7 miles away, in the 30314 ZIP code. Such life expectancy differences can be found within every county in the region. (See Appendix A for life expectancies across metro Atlanta.) The factors leading to these vastly different outcomes are numerous and complex—everything from health considerations like access to care, to built environment considerations such as access to transportation, to socioeconomic factors such as race, ethnicity, income, and level of education. Yet, as a community, we have the power to effect real change. It is due to these conditions that the Atlanta Regional Commission (ARC) is launching the Live Beyond Expectations Strategic Plan 2020 - 2025.

During the next five years, ARC, led by its Aging and Independence Services (AIS) group, will begin implementing the Live Beyond Expectations Regional Strategic Plan 2020-2025. This strategic framework is designed to identify and address the inequities that create disparities in life expectancy — explained further in this document. ARC will engage with regional, state, and national stakeholders to bolster current partnerships, develop new relationships, and marshal existing and new resources to support a long-range vision that all who live in the Atlanta region can lead long and healthy lives, no matter where they live.

(See Figure 1 and Appendix A for life expectancies across the Atlanta region.)

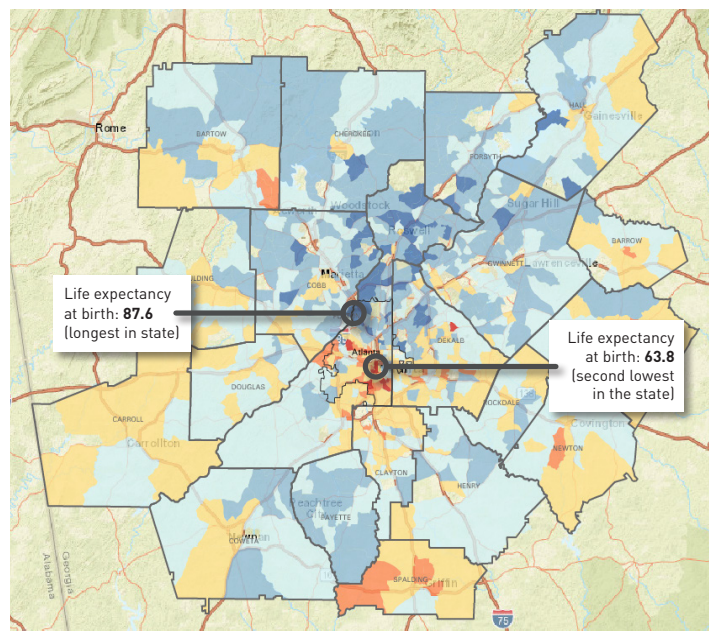
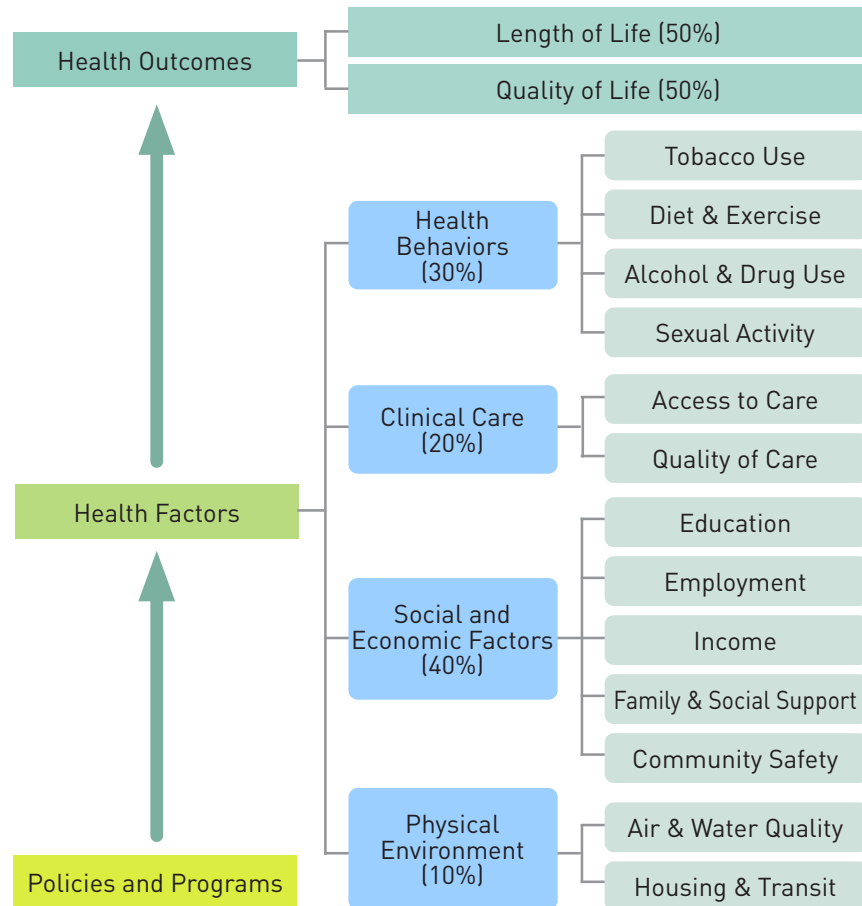


Figure 1: Varying Life Expectancies in the Atlanta Region

LIFE EXPECTANCY IS DETERMINED BY MORE THAN LIFE CHOICES

There's no doubt that factors such as genetics, diet, and exercise play a role in determining lifespan. However, research suggests that the strong ties between one's ZIP code and life expectancy¹ are rooted in a complex mix of issues that include the economic, social, and physical conditions in the environments in which people are born, live, learn, work, play, worship, and age. These include such issues as stable housing, safe neighborhoods, and access to healthy food.

Figure 2 illustrates the complex mix of factors that impact one's quality and length of life that are rooted in our policies and programs. These health factors represent those things we can modify to improve the length and quality of life for residents.



County Health Rankings model © 2014 UWPHI

Figure 2

Reducing disparities in life expectancy requires addressing issues of equity. Any long term solutions must include a revision of the policies and programs that can lead to inequitable outcomes, such as discriminatory housing loans and unequal investment in public transportation, sidewalks, and other infrastructure.

¹ "Life Expectancy" is a summary mortality measure often used to describe the health status of a population and defined as the average number of years a population of a certain age would be expected to live, given a set of age specific death rates in a given year (Healthy People 2020).

For example, someone who lives in a neighborhood without access to healthy food or safe spaces to walk is likely to experience negative health outcomes. Those who lack access to quality education may struggle economically and not have access to quality healthcare.

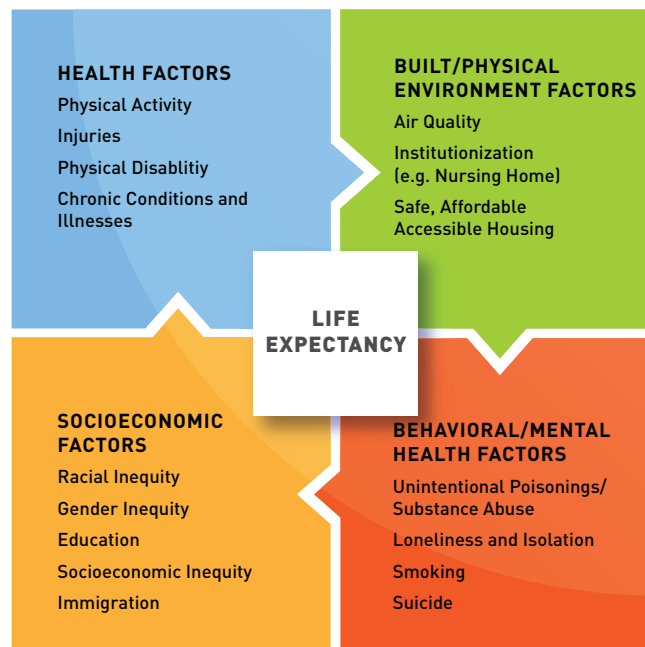
Life Expectancy Research

Research shows that many factors impact life expectancy. Figure 3 illustrates some of the key factors that research indicates impact life expectancy. For added clarity, ARC has grouped these factors into four areas:

1. Health
2. Built/Physical Environment
3. Socioeconomics
4. Behavioral/Mental Health

Figure 3 illustrates that a mixture of individual characteristics as well as environmental conditions (social determinants of health) can impact life expectancy. While several factors may be based on individual genetics (e.g., physical disability at birth), many are part of the larger context in which individuals live that are out of an individual's personal control (i.e., social determinants of health) such as air quality and access to safe and affordable housing. Furthermore, several factors that are seemingly within the control of the individual are directly linked to and dependent on multiple social determinants of health factors. For example, obesity may be linked to an individual's genetics and health characteristics, but it is additionally dependent on access to healthy and culturally appropriate foods and ability to engage in physical activity safely in one's neighborhood, among other social determinants of health. For a summary of literature on factors that contribute to or correlate with life expectancy, see Appendix B.

Figure 3



REDUCING DISPARITIES IS CRITICAL TO EVERYONE'S FUTURE

There's no easy solution to this challenge. Increasing the life expectancy of people in disadvantaged communities will likely take decades and requires intentional interventions in factors as disparate as public health, the environment, and education.

However, such interventions are critical if we are to succeed as a region. And, while ARC's work may not impact all of these factors, we are committed to identifying which factors we can influence – and how we can make a difference.

At present, nearly 30% of all metro Atlantans ages 65 and older are unable to handle a \$400 emergency, and a third spend more than 30% of their income on housing, leaving insufficient funds for groceries, medicine, and other necessities. But there is a way forward. Across metro Atlanta, numerous interventions are already taking place aimed at diverse factors affecting life expectancy. This plan is the first phase of a long-term, agency-wide commitment to provide new support and resources to existing efforts, coordinating processes for maximum impact, and innovating where there are gaps. When we pool our strengths and knowledge, we can create substantial change, together.

This framework is designed to clearly identify the challenges our region is facing and to set forth a process by which ARC, led by its Aging and Independence Services Group, will work with community members over the next few years to make meaningful progress.

- **Year One: Research and Outreach**

Establish strategic plan steering committee, identify key focus areas, develop relationships with key community partners, and establish evaluation techniques.

- **Years 2-5: Implement Place, Policy, and Practice Interventions**

Work with partners to execute strategies to address disparities related to:

- **Place** – Focus on locations, within each county, where residents experience the most inequity
- **Policy** – Change systems and structures that create inequities and advance policies that promote equity
- **Practice** – Provide services and programs that address unmet needs

Communicate efforts to governmental, philanthropic, educational, nonprofit, and business leaders, as well as residents across the region to build to build support, evaluate ongoing progress, and refine efforts as needed.

Goals and Objectives

During the next five years, the Atlanta Regional Commission (ARC), led by its Aging and Independence Services (AIS) Group, will implement a planning and communication framework, Live Beyond Expectations Regional Strategic Plan 2020 -2025, designed to address inequities that create disparities in life expectancy.

The plan includes four top line goals:

1. Identify key areas of focus for concerted regional effort.
2. Enhance existing partnerships and expand engagement with new community partners.
3. Create increased awareness of disparities in life expectancy and the factors driving them throughout the Atlanta region.
4. Marshal resources to address disparities.

Goals and objectives for Year 1.

Goals	Objectives
Identify key areas of focus for concerted effort.	<p>Establish steering committee to guide interdisciplinary effort.</p> <p>Identify disparities and indicators through analysis of available data and data sources on life expectancy disparities, factors that impact life expectancy, and ARC service delivery; disaggregate top line data to gain more detailed information.</p> <p>Identify gaps in community efforts where ARC may establish leadership or catalyze efforts.</p> <p>Apply a structured and collaborative process to all information gained to identify the limited number of areas where ARC will focus direct effort.</p>
Enhance existing partnerships and expand engagement with new partners in the community.	<p>Inventory existing community initiatives that address disparities in health access, social determinants, or life expectancy to identify resources and gaps.</p> <p>Develop approaches to meet identified gaps in community needs, such as services, information, and/or outreach.</p> <p>Develop actionable outreach strategy to identify and connect with underserved persons in metro area.</p>
Create increased awareness throughout the metro region of disparities in life expectancy and the factors that drive those.	<p>Develop Life Expectancy Scorecard.</p> <p>Develop and implement communication strategy.</p>
Marshal resources to address disparities.	<p>Increase available funding to support plan objectives.</p> <p>Update strategies for targeting of ARC Aging and Independence Services funding.</p> <p>Explore public-private partnerships and/or foundation grants that are targeted to the same objectives and/or communities identified by ARC.</p>

Figure 4

Impact of COVID-19 Pandemic

It is impossible to ignore the devastating effects of COVID-19 on older persons and other people already experiencing disparities. The focus of this plan was set in Fall 2019, before the U.S. onset of the pandemic in early Spring 2020. Though at present we are still learning all the nuances and repercussions of COVID-19, it is clear that older persons are disproportionately affected by the novel coronavirus and experience greater rates of hospitalization and mortality if infected. As emphasized by the American Psychological Association (<https://www.apa.org/topics/covid-19/research-ageism>), “COVID-19 risks and effects for older adults are not uniform. The oldest adults (aged 80+), those with other diseases and those in nursing homes are at greatest risk. While still at-risk, the young-old (60-70 years) have notably better outcomes.” Additionally, the fear of COVID-19 exposure and widespread practice of social distancing has resulted in social isolation for more individuals, negatively impacting their emotional and physical health.

Older adults are diverse in many ways, including race, ethnicity, economic status, disability, sexual orientation, and gender identity. Any conversation about marginalization and discrimination toward under-represented groups in the pandemic must include old age. Age has proven to be a compounding factor when it comes to inequity in the pandemic; within marginalized groups, older adults are most likely to lack needed resources, and to need healthcare and community services during this crisis. It is expected that plan development will include strategies to create a more equitable environment for those most at risk during crises such as COVID-19.

Background: ARC’s Aging and Independence Services Group and the Region’s Aging Network

ARC is the federally designated Area Agency on Aging (AAA) serving as the regional planning, development, and intergovernmental coordination agency for the Atlanta region, which is composed of ten contiguous counties: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, and Rockdale. Its mission is to maximize the independence, health, and well-being for older persons, individuals with disabilities, and their care partners today, while preparing the 10-county region for the future.

In 2019, an estimated 792,000 adults age 65 or older lived in the region, constituting 35% of Georgia’s older residents.

ATLANTA REGIONAL COMMISSION’S AGING AND INDEPENDENCE SERVICES

Vision Well-designed well-being: The Atlanta region is a place where people of all ages, abilities, and incomes can live high-quality lives, regardless of location.

Mission Maximize the independence, health, and well-being for older persons, individuals with disabilities, and their care partners today, while preparing the 10-county region for the future.

The ARC AAA serves as the steward of funds from the federal government (through the Older Americans Act (OAA), the Social Services Block Grant, and other sources as well as state Aging Services Funds administered through the Georgia Division of Aging Services (DAS). ARC supports the region's residents through Empowerline™, a resource that helps older people, individuals with disabilities, and their caregivers to make informed life decisions with the help of certified professionals and free online tools and information at empowerline.org and (404) 463-3333. In addition to its AAA responsibilities, ARC administers a centralized intake system for access to Medicaid home and community-based services waivers and assists nursing home residents to transition to the community. The Georgia Department of Human Services (DHS) contracts with ARC to administer transportation innovation programs. ARC also provides and administers services through a variety of public and private grants. ARC works with local governments, community partners, and residents to design more inclusive lifelong communities that offer multiple housing types and enhanced transportation options, increased opportunities for healthy living, and convenient access to services and information.

ARC's AAA role, as specified in the OAA, requires the creation of an "Area Plan on Aging" for the region every four years. While there is overlap in the Area Plan and this Framework for ARC's Live Beyond Expectations Strategic Plan, the two are separate in essential ways and have distinct purposes. ARC's Area Plan on Aging reflects goals set forth by Georgia's DAS and is primarily related to programs and services funded by that agency. The Area Plan addresses how ARC intends to deploy DAS-funded resources, and as such, is restricted to activities allowed by those funding sources. By contrast, this document — the Framework for ARC's Live Beyond Expectations Strategic Plan — is designed to create a holistic vision for improving the lives of older persons in the region by addressing their most critical needs and social risk factors (unrelated to specific program funding), while setting priorities that ARC and other partners in the Atlanta region can join together to address. The plan's overall goal — to focus resources to address inequities — aligns with the critical OAA requirement to target resources to underserved older adults with the greatest need, which it defines as those who are: low-income, minority, limited in English proficiency, frail, and in greatest social need. These factors are also among the most critical determinants of life expectancy, and this is the population toward whom ARC seeks to target the use of its annual budget of more than \$25 million.

ARC's Internal Organizational Analysis

As its strategic planning framework, the Plan will employ "SOAR," an acronym which stands for "Strengths/Opportunities/Aspirations/Results." Based in appreciative inquiry², SOAR is designed to focus on organizational strengths in order to initiate change. Given the scope and long-range nature of the Plan's goal to impact disparities in life expectancy, the initial plan period focuses on goals and objectives to build a foundation of capacity, knowledge, and resources to support the

strategic goal. SOAR is strengths-based and future-focused. Many of the objectives and activities associated with this plan are based on evaluating and building on strengths and planning for an aspirational vision of the future.

SOAR is rooted in the following questions:

1. What are ARC's strengths?

ARC has significant strengths, both internal and external, to build on in this five-year period in order to develop the platform for longer range planning.

a. Internal strengths include (but are not limited to):

- i. ARC is the federally designated Area Agency on Aging for metro Atlanta's 10 counties. This designation establishes the centrality of ARC to the lives of older adults in the metro region, with a responsibility for planning, advocacy, and service delivery systems that are designed to support quality of life for older people.
- ii. The ARC Aging and Independence Services Group has a well-established vision and mission that encompasses big-picture, aspirational thinking.
- iii. ARC has a wealth of organizational resources that include research, data analysis, communications, and community planning (including arts, transportation, housing, and employment), to contribute to the ongoing development of this plan.
- iv. The ARC Equity Playbook indicates organizational willingness to bring an equity focus to prioritizing and planning and creates a framework for articulating how ARC's work impacts equity at the Policy, Place, and Practice levels.
- v. This plan is rooted in ARC's Guiding Principles:
 1. **Interdisciplinary** and **Holistic**– Achieving this goal will require integrated work across all of ARC's functional disciplines and build stronger relationships among the work of ARC's Groups and other community partners.
 2. It is designed to be **Actionable**, with concrete objectives that will move ARC forward toward clearly stated short- and long-range outcomes.
 3. ARC will **Ensure Colleagues' Success** through strong collaboration with stakeholders both internal and external to ARC, and by developing and providing community-wide infrastructure that will allow for the sharing of information, promoting efforts, and celebrating successes in addressing disparities across the region.

b. Community strengths include:

- i. A community with growing awareness of inequities and the

[2] Appreciative inquiry is a model for organizational change based on a collaborative and strengths-based approach that focuses on what is working, as opposed to what's not working, to design the future.

disparities that have been created

- ii. Community partners who may already be engaged in related work and who are eager to engage with ARC to tackle the strategic goal of reducing life expectancy disparities
- iii. Existing community assets to tap for expert assistance, including, but not limited to, the Centers for Disease Control and Prevention

2. Where are ARC's opportunities for change?

ARC has already identified the biggest opportunity for change: the startling disparity in life expectancy based on where people live within metro Atlanta. Other matters may present as strengths but are also opportunities to build on:

- a. Stakeholder engagement revealed community partners were aware of some disparity but not the magnitude. Growing awareness of these disparities will be one way to catalyze community efforts to reduce them.
- b. There are several large- and small-scale initiatives occurring in the Atlanta region that address the social determinants instead health that drive life expectancy outcomes. But there is a lack of coordination and synergy of these efforts to facilitate meaningful change. This means that critical gaps may exist, or that there is unnecessary duplication of efforts that creates confusion and reduces effectiveness or impact.
- c. Older individuals are far too often marginalized and discriminated against because of their age. Furthermore, aging is often misunderstood, and this misunderstanding creates obstacles to productive policies and practices. ARC has an opportunity to shift public understanding of aging and create a more age-integrated region that engages older people more fully in our communities and systems.

3. What does ARC aspire to?

ARC's foremost aspiration through this plan is to reduce disparities in life expectancy. This first five-year plan outlines a set of goals and objectives to build organizational and community capacity and awareness as well as the infrastructure to focus efforts on.

4. How will ARC evaluate results?

It will be many years before ARC might see any indication of a reduction in life expectancy disparities. The agency must develop a combination of process and outcome measures to evaluate progress on goals and objectives along the way. One key objective for the plan is to establish a community-wide life expectancy scorecard and publish this broadly on a regular basis as a means of raising awareness and then facilitating ongoing awareness of life expectancy issues throughout the region.

Community Input and Stakeholder Interviews

Between October 6, 2019 and January 16, 2020, ARC conducted 14 key informant interviews and seven stakeholder meetings. The purpose of the interviews and meetings was to gather information to be used in the development of the five-year Live Beyond Expectations Regional Strategic Plan on Aging, starting in 2020.

Early interviews and meetings focused on learning from respondents which factors ARC might concentrate its efforts on. Most responded with suggestions related to their organization's area of focus. As stakeholder interviews progressed, ARC recognized the importance of leading a holistic process- working with those affected by these disparities to inform the plan's eventual priorities, strategies, and tactics.

As collective knowledge and understanding evolved, ARC shifted its focus. Rather than looking at the factors themselves, interviews and meetings instead concentrated on how to impact life expectancy for the better, including:

- ARC's role as we embark on this plan
- How ARC might examine resource distribution and new ways of targeting funds
- The effective elements of a communication strategy
- How ARC might connect with populations throughout the Atlanta region that have been historically marginalized

The agency identified key respondents based on their health and human service subject matter expertise, their knowledge of the Atlanta region, or their experience with regional collaborative initiatives. Other stakeholder input was gathered through a variety of meetings. Meetings included groups internal to ARC as well as groups that exist in an advisory capacity, provider network/grantee function, or other stakeholder role to the agency. ARC recognizes that more guidance and input from the voices of persons with lived experience of disparities is needed to fully develop this Plan's focus areas and strategies.

Appendix C provides a summary of the process and findings of community input gathered for the development of the Plan. Some general themes that emerged are:

- Stakeholders are generally aware of life expectancy disparities
- Several existing community initiatives touch on life expectancy issues
- Impacting life expectancy was recognized as a very long-range goal — far exceeding a single five-year plan
- Concern for maintaining community engagement over such a long period of time
- Importance of letting data drive this initiative
- Need for the process to enable ARC to effectively focus on specific factors

Next Steps

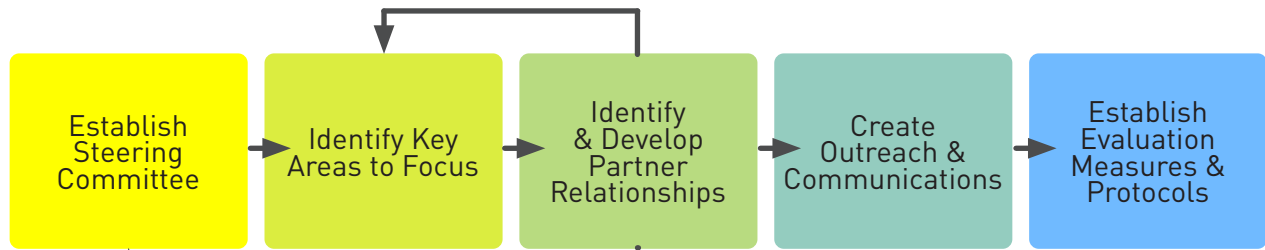


Figure 5

As appropriate, add representatives from partner groups

First Year Strategies to Launch the Plan:

Return to these steps as necessary

- Establish Strategic Plan Steering Committee with both internal ARC and external organization members.
- Identify key areas for focused efforts to reduce disparities.
- Identify and develop relationships with community partners working in this arena.
- Create outreach and communication avenues to increase awareness and support for Plan goals and share progress towards goals.
- Establish appropriate evaluation measurements to track progress over time.

The collaborative partnership process established in year one of the plan will identify specific targets with strategies to measure, evaluate, and achieve goals over the five-year plan period. As implementation moves forward, flexibility is paramount. As the agency evaluates its progress, we must be willing to revise both our focus and strategies as needed.

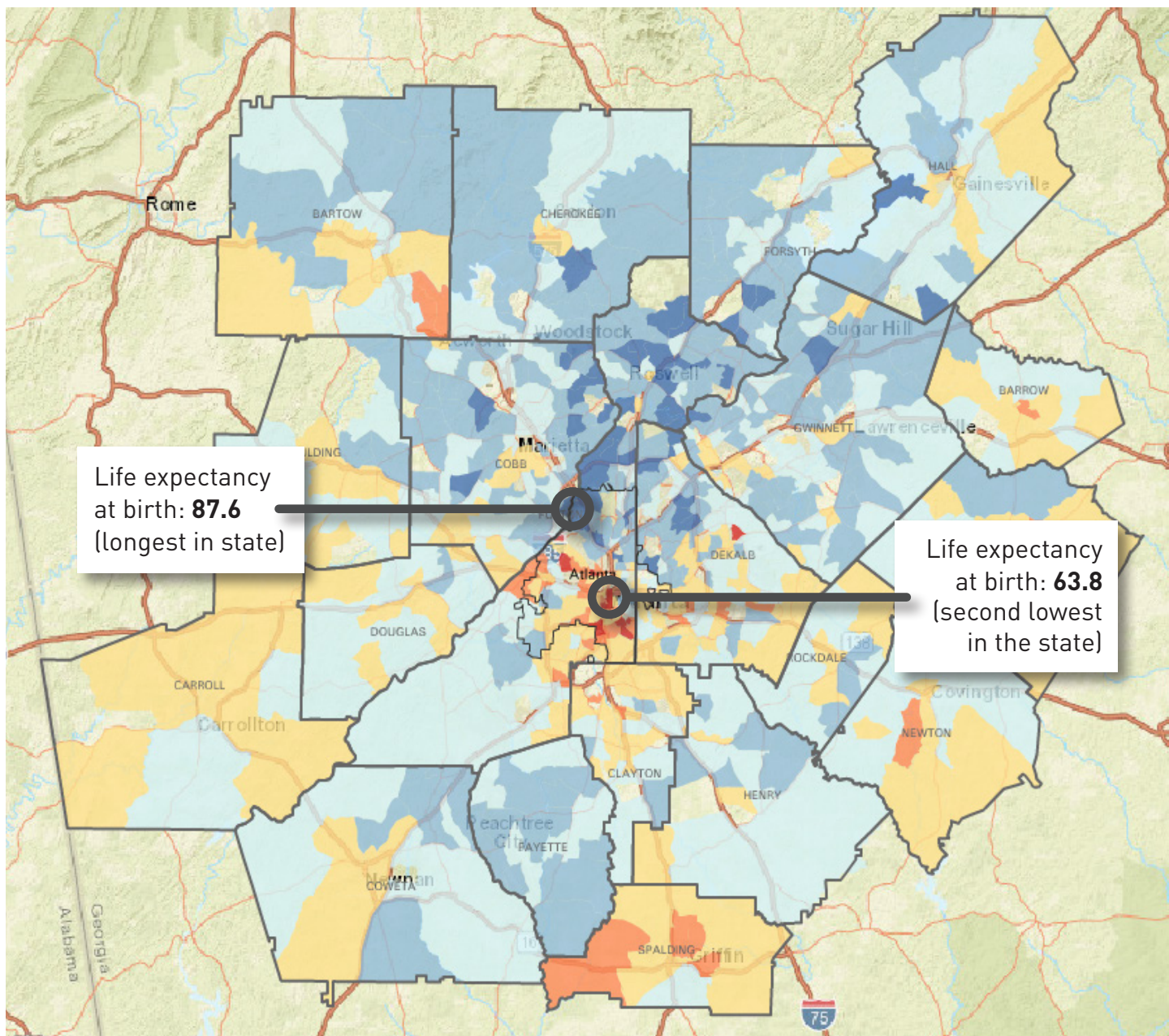
The first year of the plan will focus on the examination and refinement of ARC's internal operations to ensure it is responsive to this effort. Additionally, the focus will be on selecting data-driven measures and having conversations to build a strong, sustainable partnership network. At the end of five years, ARC should have a robust and rich network of core partnerships actively focused on addressing inequities in life expectancies.

The Atlanta Regional Commission seeks to ensure our region's future success and ensure quality of life through world-class infrastructure; healthy, livable communities; and a competitive economy. But the stark fact is that we cannot achieve those goals when we allow a metro Atlantan's opportunities in life to be determined by a ZIP code. Working together for the long term — across our agency and across the region — we can address the region's life disparity challenge. The ingenuity is there. So are the resources. When we work together to channel our strengths into action, then the dream of high quality of life for all becomes achievable.

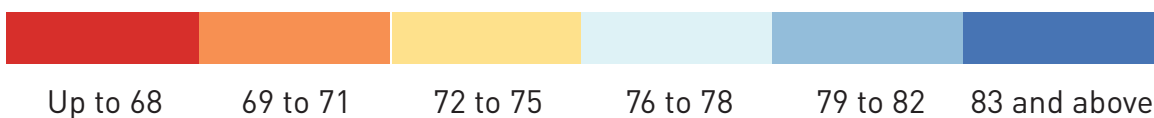
This framework is an invitation to all interested individuals and organizations to join with ARC in working to ensure that the Atlanta region is a place where people of all ages, abilities, and incomes can live high quality lives, regardless of location.

Appendix A: Life Expectancy in Years

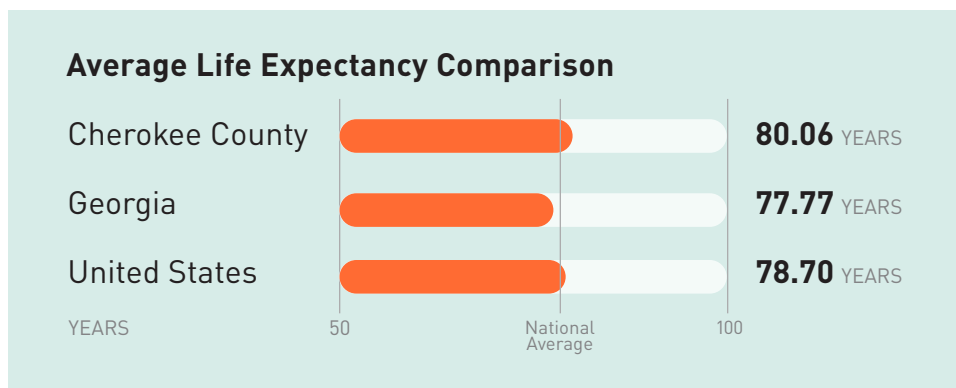
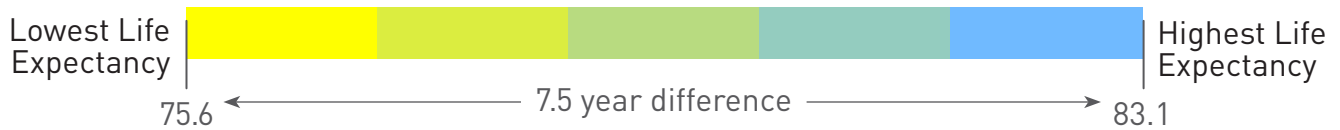
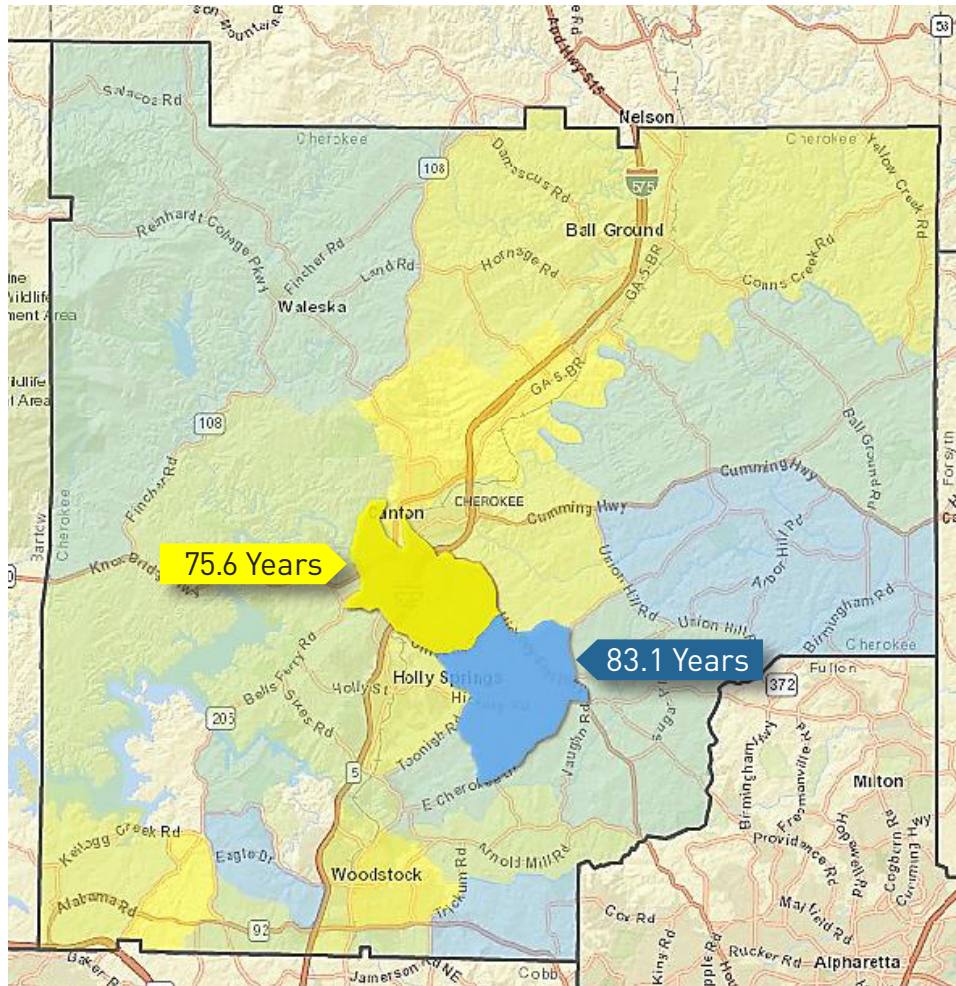
Atlanta Region Life Expectancy in Years



Life Expectancy at Birth

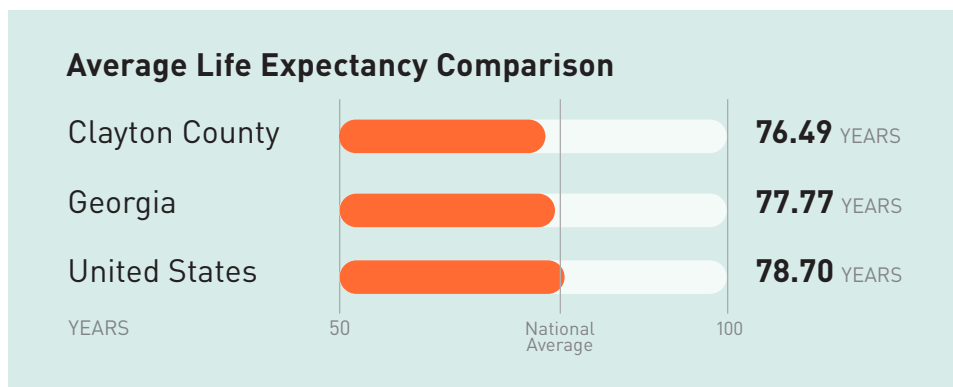
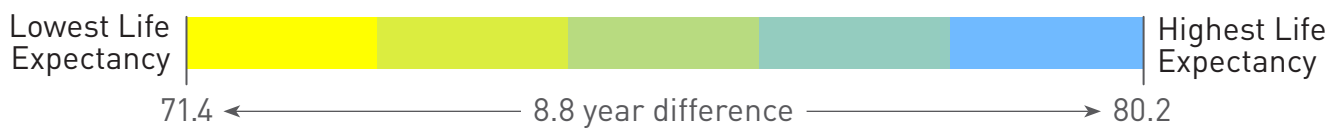
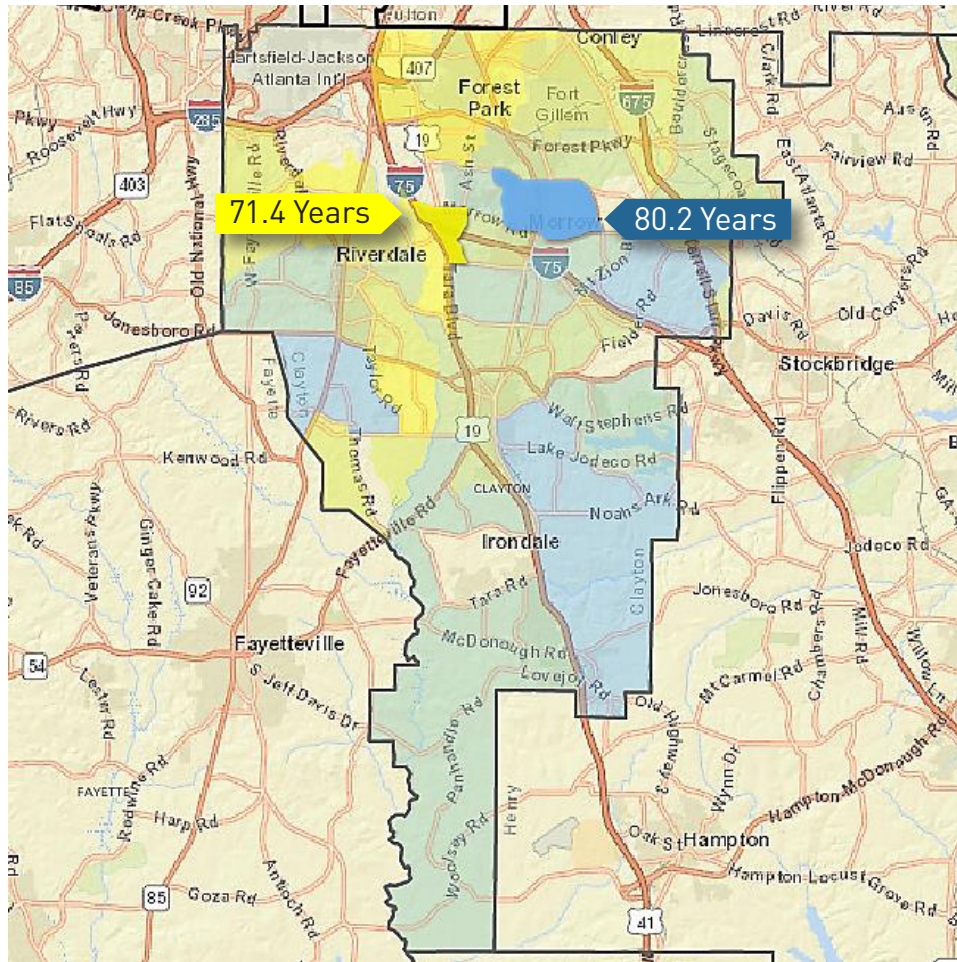


Cherokee County Life Expectancy in Years



Sources: U.S. Small-area Life Expectancy Estimates Project, 2010-2015
 Life Expectancy Bar Charts: Robert Wood Johnson Foundation Life Expectancy Tool, January 2020

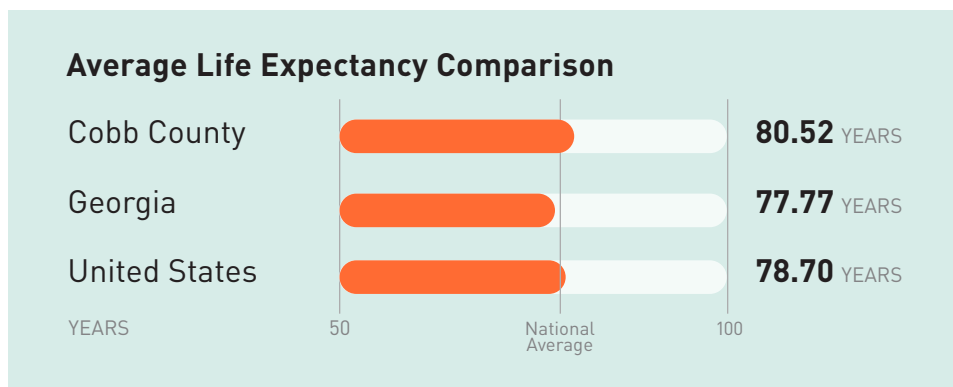
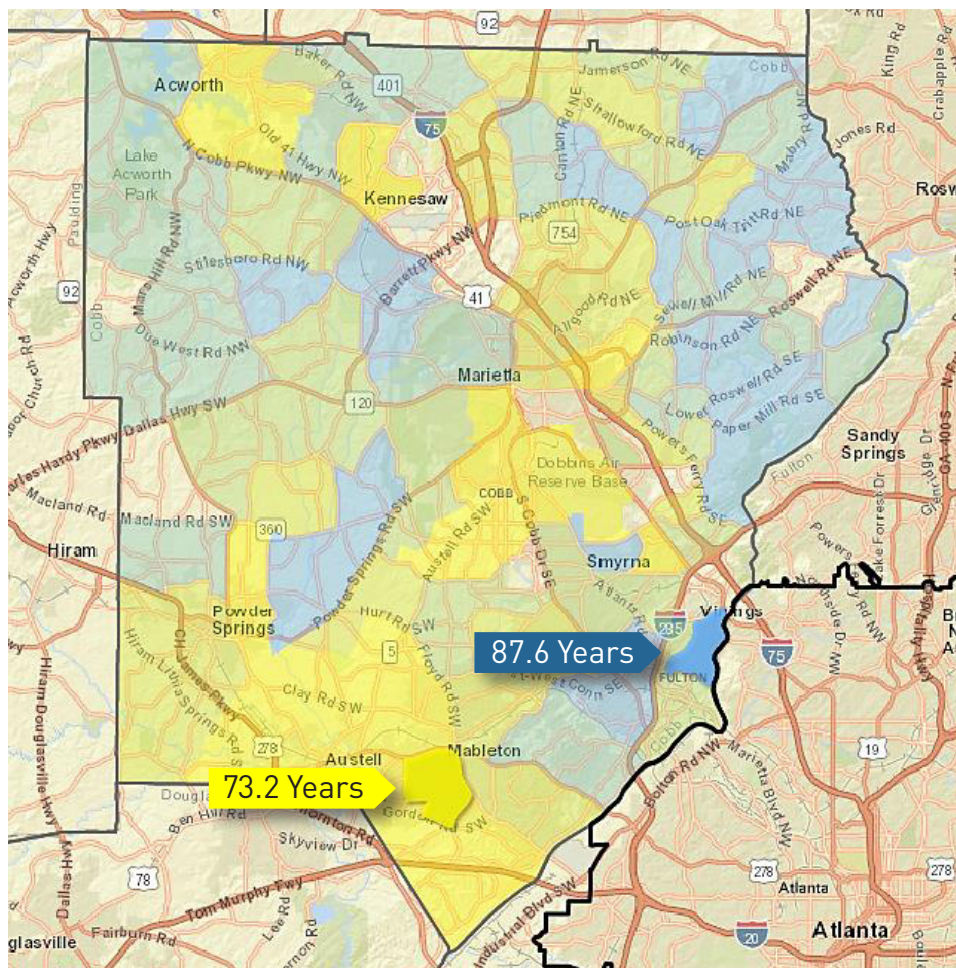
Clayton County Life Expectancy in Years



Sources: U.S. Small-area Life Expectancy Estimates Project, 2010-2015

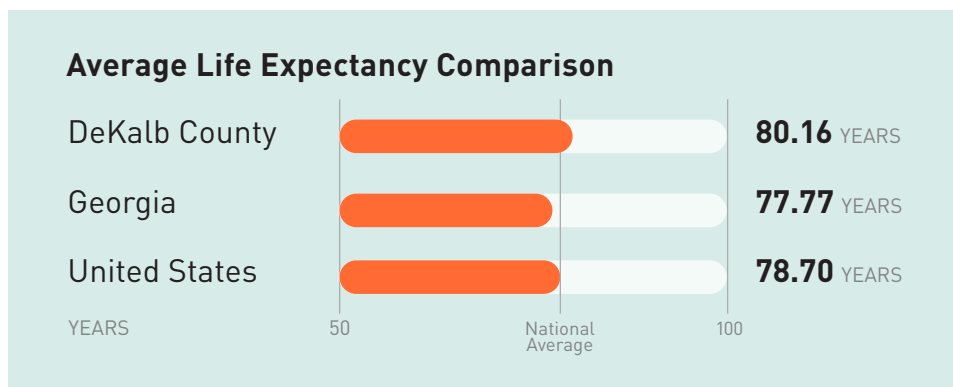
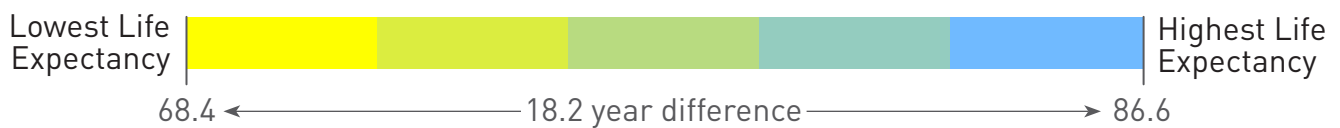
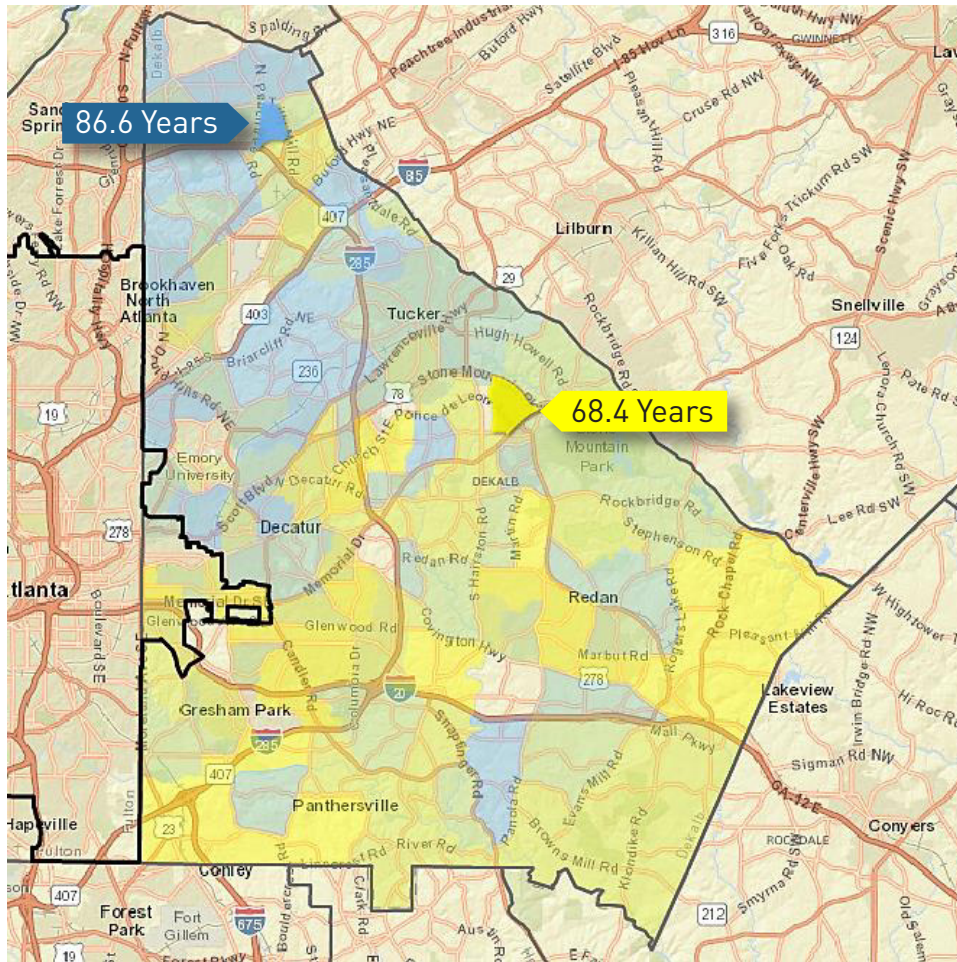
Life Expectancy Bar Charts: Robert Wood Johnson Foundation Life Expectancy Tool, January 2020

Cobb County Life Expectancy in Years



Sources: U.S. Small-area Life Expectancy Estimates Project, 2010-2015
 Life Expectancy Bar Charts: Robert Wood Johnson Foundation Life Expectancy Tool, January 2020

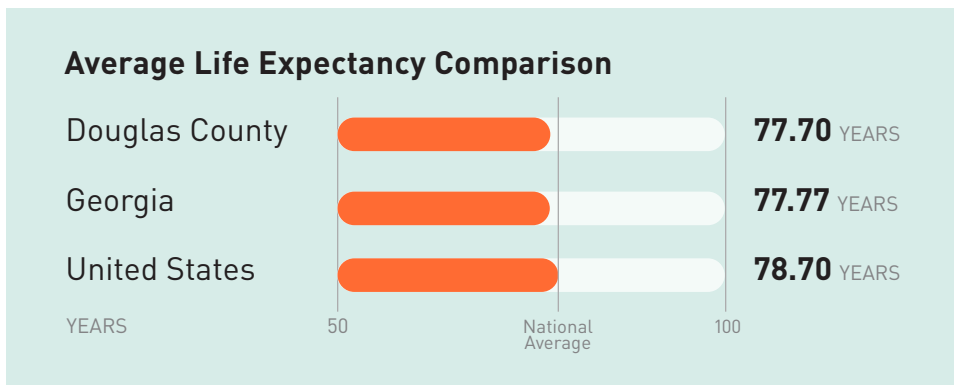
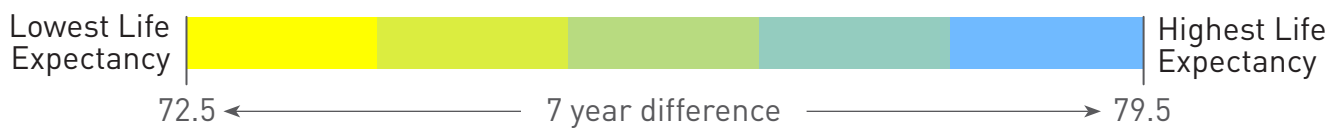
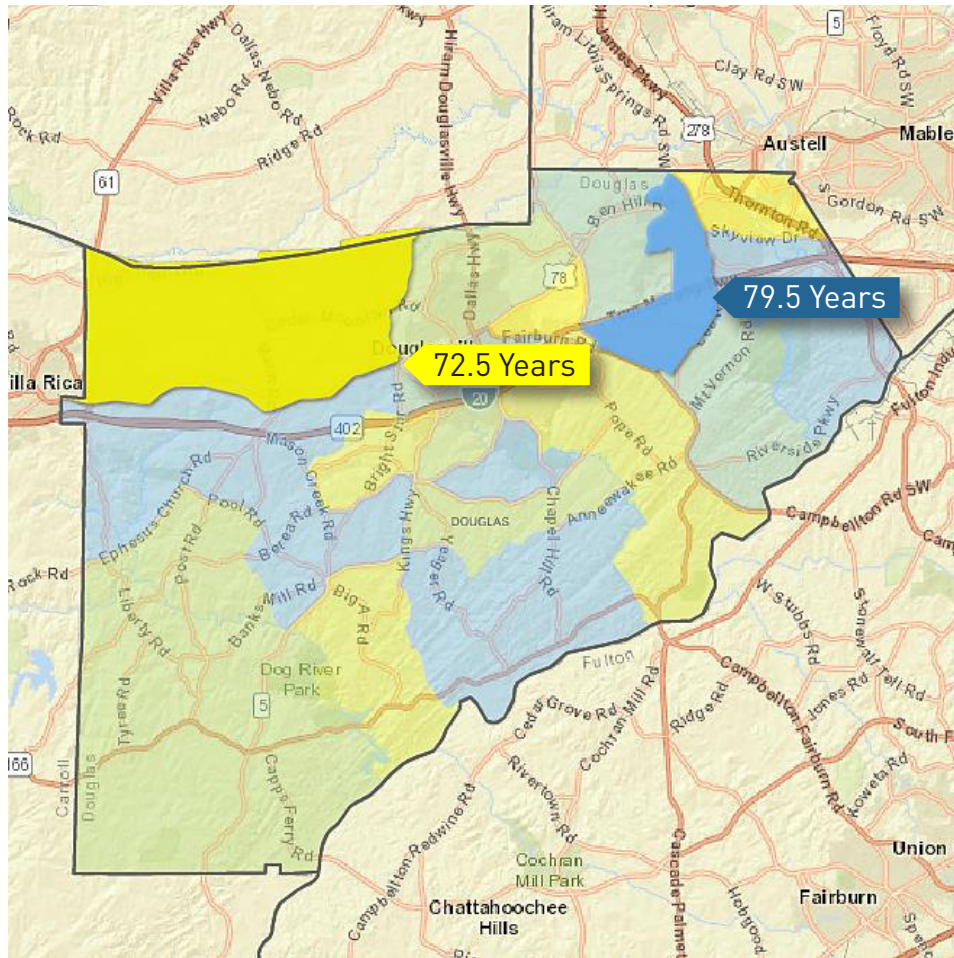
DeKalb County Life Expectancy in Years



Sources: U.S. Small-area Life Expectancy Estimates Project, 2010-2015

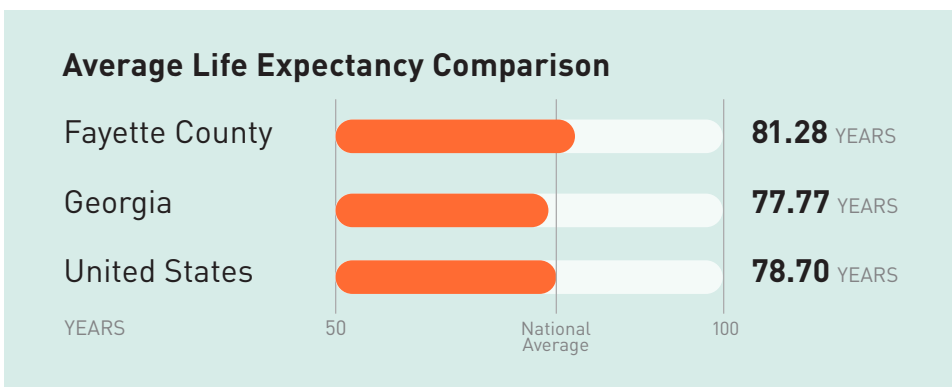
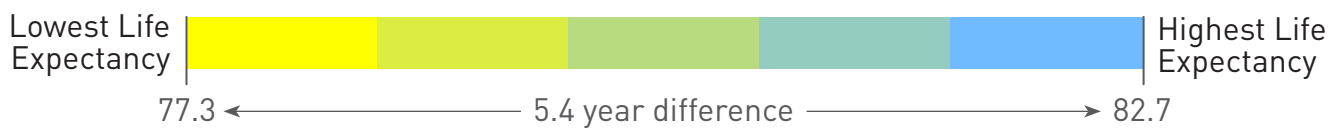
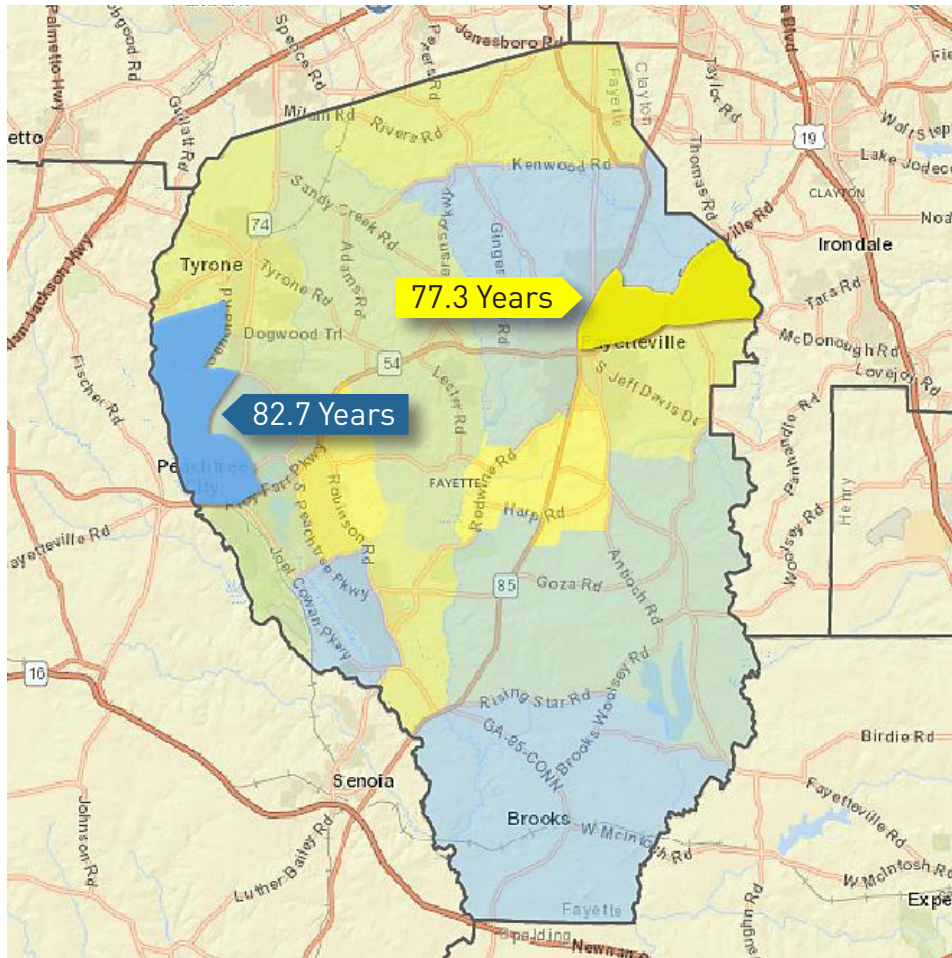
Life Expectancy Bar Charts: Robert Wood Johnson Foundation Life Expectancy Tool, January 2020

Douglas County Life Expectancy in Years



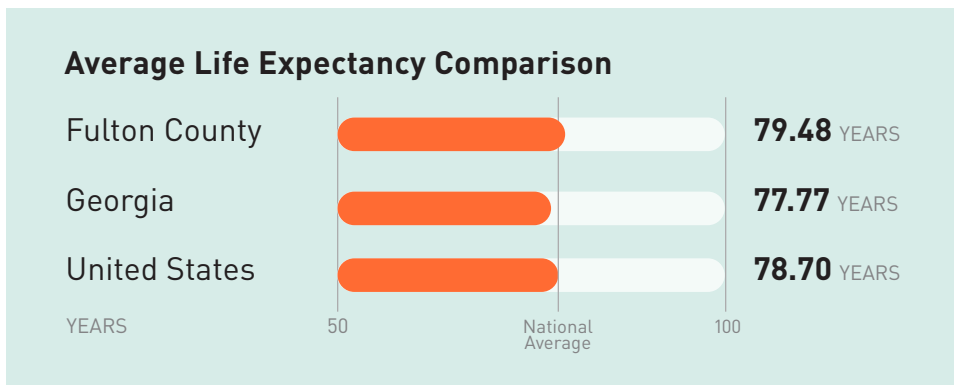
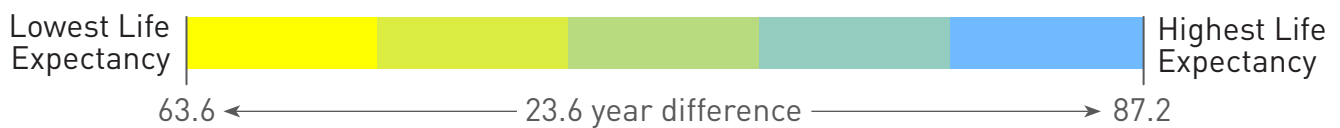
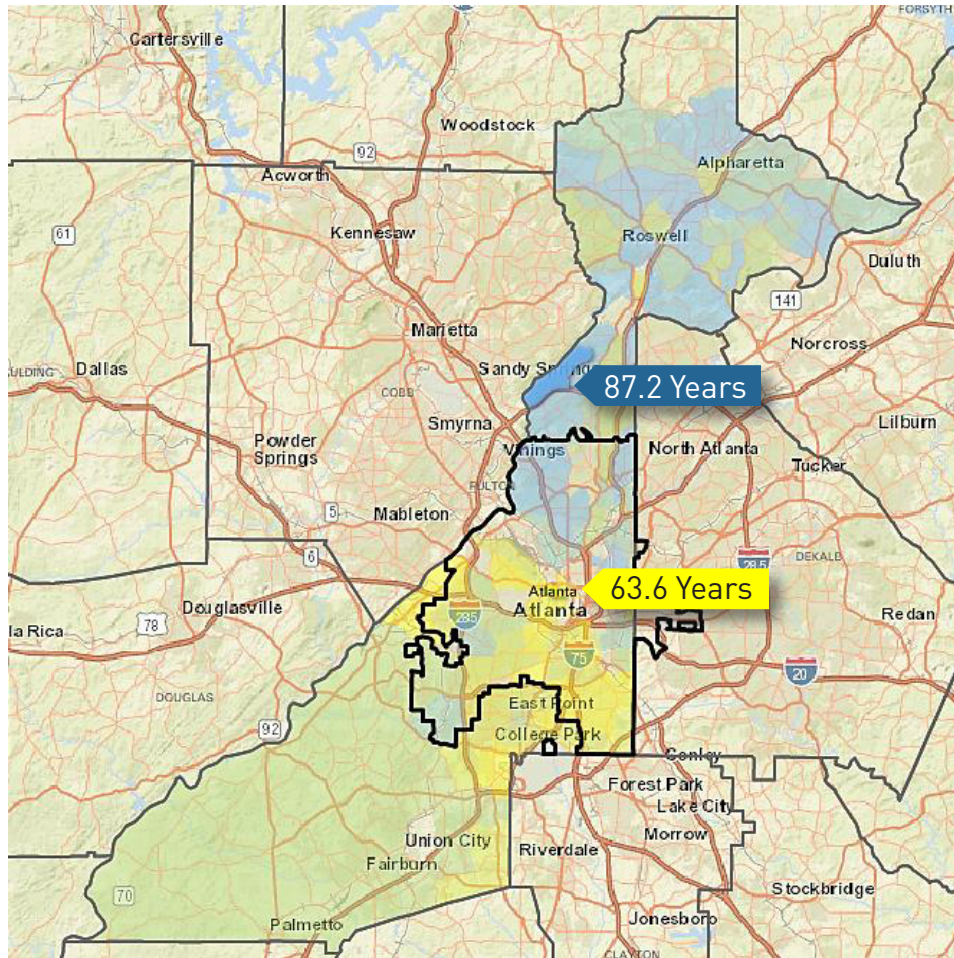
Sources: U.S. Small-area Life Expectancy Estimates Project, 2010-2015
 Life Expectancy Bar Charts: Robert Wood Johnson Foundation Life Expectancy Tool, January 2020

Fayette County Life Expectancy in Years



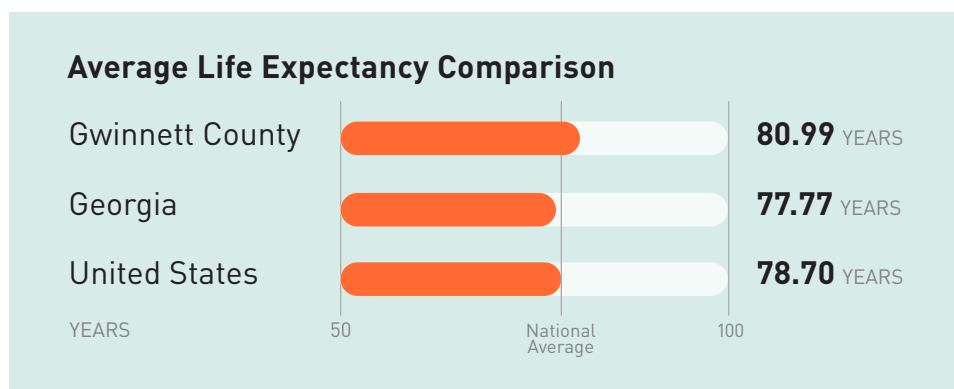
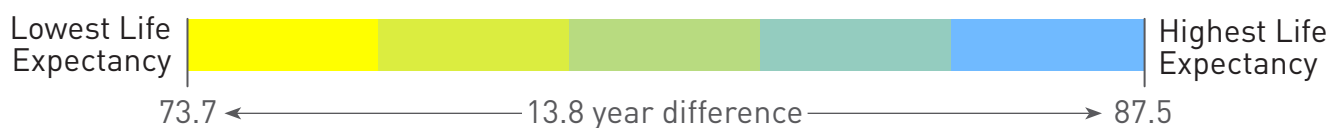
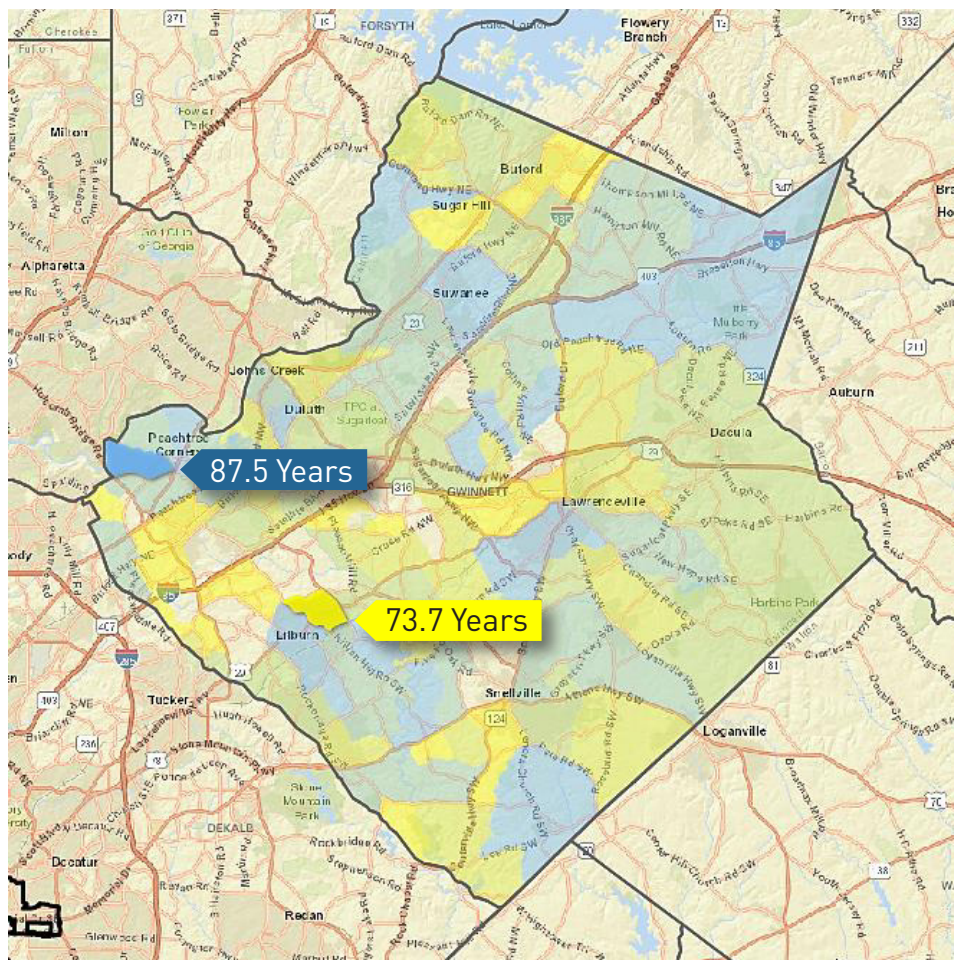
Sources: U.S. Small-area Life Expectancy Estimates Project, 2010-2015
 Life Expectancy Bar Charts: Robert Wood Johnson Foundation Life Expectancy Tool, January 2020

Fulton County Life Expectancy in Years



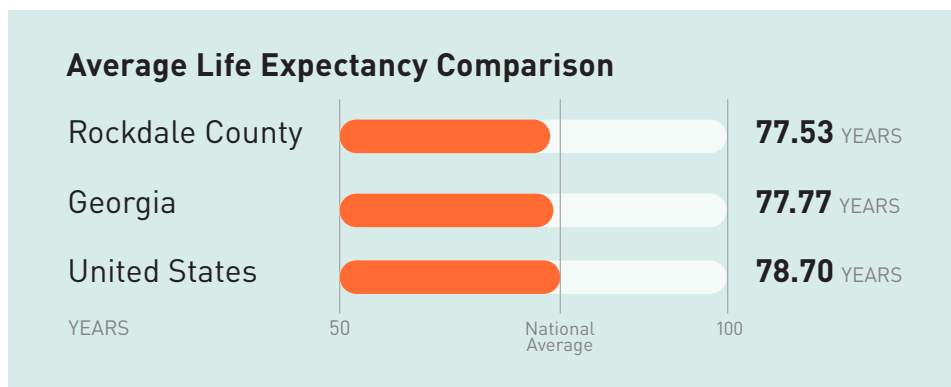
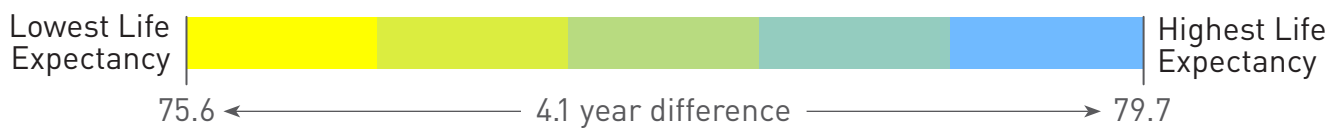
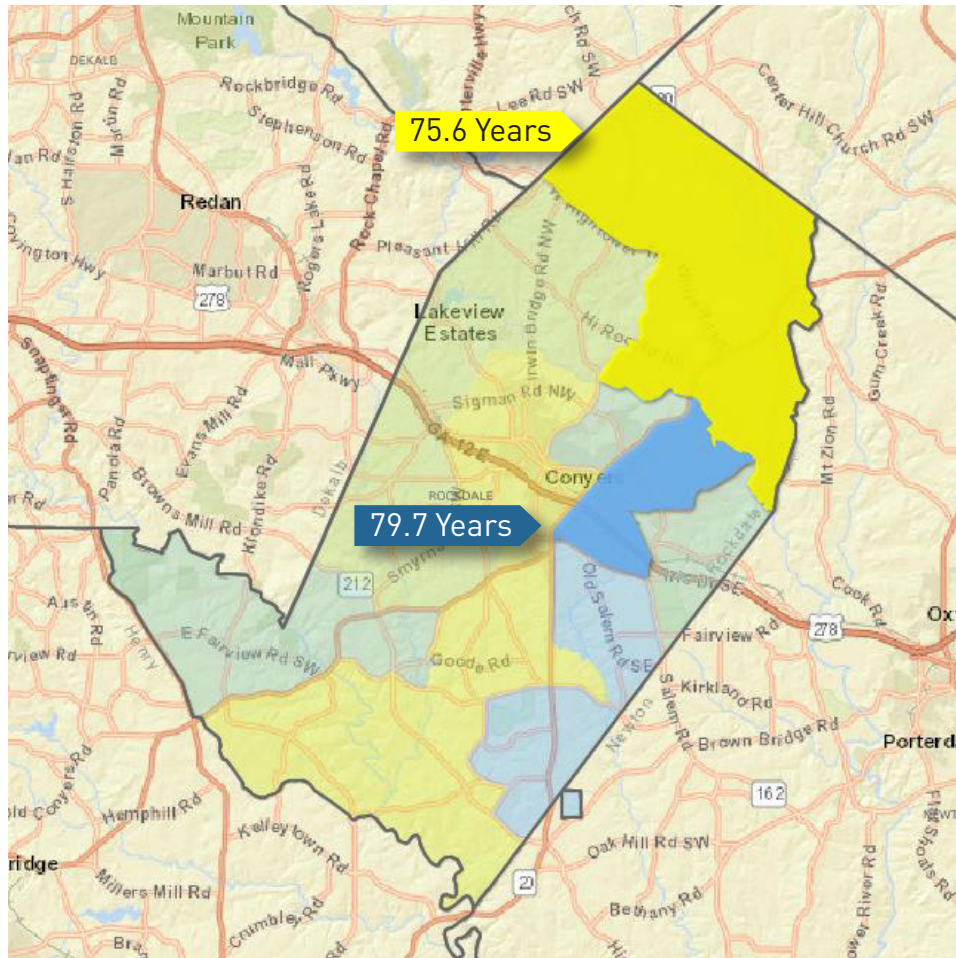
Sources: U.S. Small-area Life Expectancy Estimates Project, 2010-2015
 Life Expectancy Bar Charts: Robert Wood Johnson Foundation Life Expectancy Tool, January 2020

Gwinnett County Life Expectancy in Years



Sources: U.S. Small-area Life Expectancy Estimates Project, 2010-2015
 Life Expectancy Bar Charts: Robert Wood Johnson Foundation Life Expectancy Tool, January 2020

Rockdale County Life Expectancy in Years



Sources: U.S. Small-area Life Expectancy Estimates Project, 2010-2015
Life Expectancy Bar Charts: Robert Wood Johnson Foundation Life Expectancy Tool, January 2020

Appendix B: Life Expectancy Research

Population Level Factors that Cause, Contribute to, or Correlate with Changes in Population Level Life Expectancy

Increasing these factors decreases life expectancy

- Alzheimer's disease
- Chronic Liver disease
- COPD
- Diabetes
- Hypertension
- Institutionalization
- Lung cancer
- Obesity
- Physical inactivity
- Suicide
- Unintentional poisonings (including drug and alcohol poisoning)
- Unintentional injuries

Increasing these factors increases life expectancy

- Education
- Government spending
- Immigration
- Per capita income

Reducing these factors increases life expectancy

- Air pollution
- Aortic aneurysm
- Cancer
- Cardiovascular disease
- Ethnic inequity
- Gender inequity
- Heart disease
- Infant mortality
- Older adult mortality
- Physical inactivity
- Physical disability
- Pneumonia
- Racial inequity
- Socioeconomic inequity
- Smoking
- Stroke

Excerpts from Literature

- 1) Source: Oeppen, Jim, and James W. Vaupel. "Broken limits to life expectancy." *Science* 296.5570 (2002): 1029-1031. <http://truemedmd.com/wp-content/uploads/2013/07/Life_expectancy_scienceMay2002.pdf> Factors: Infant Mortality, Older Adult Mortality
 - a. "Mortality improvements result from the intricate interplay of advances in income, salubrity, nutrition, education, sanitation, and medicine, with the mix varying over age, period, cohort, place, and disease. Before 1950, most of the gain in life expectancy was due to large reductions in death rates at younger ages. In the second half of the 20th century, improvements in survival after age 65 propelled the rise in the length of people's lives."
- 2) Source: Olshansky, S. Jay, et al. "A potential decline in life expectancy in the United States in the 21st century." *New England Journal of Medicine* 352.11 (2005): 1138-1145. <<https://www.nejm.org/doi/full/10.1056/NEJMsr043743>> Factors: Obesity, Diabetes
 - a. "[T]he life-shortening effect of obesity could rise from its current level of about one third to three fourths of a year to two to five years, or more, in the coming decades, as the obese who are now at younger ages carry their elevated risk of death into middle and older ages."
 - b. "We anticipate that as a result of the substantial rise in the prevalence of obesity and its life-shortening complications such as diabetes, life expectancy at birth and at older ages could level off or even decline within the first half of this century."
- 3) Source: Lee, I-Min, et al. "Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy." *The Lancet* 380.9838 (2012): 219-229. <<https://www.sciencedirect.com/science/article/pii/S0140673612610319>> Factors: Physical Inactivity
 - a) "We estimated that elimination of physical inactivity would increase the life expectancy of the world's population by 0.68 (range 0.41–0.95) years."
- 4) Source: Pope III, C. Arden, Majid Ezzati, and Douglas W. Dockery. "Fine-particulate air pollution and life expectancy in the United States." *New England Journal of Medicine* 360.4 (2009): 376-386. <<https://www.nejm.org/doi/full/10.1056/NEJMsa0805646>> Factors: Air Pollution, Per Capita Income, Lung Cancer, COPD
 - a) "A decrease of 10 µg per cubic meter in the concentration of fine particulate matter was associated with an estimated increase in mean (±SE) life expectancy of 0.61±0.20 year (P=0.004). The estimated effect of reduced exposure to pollution on life expectancy was not highly sensitive to adjustment for changes in socioeconomic, demographic, or proxy variables for the prevalence of smoking or to the restriction of observations to relatively large counties."
 - b) "[O]n average, life expectancy increased more in areas with larger reductions in air pollution"
 - c) "Reduced air pollution was only one factor contributing to increased life expectancies, with its effects overlapping with those of other factors... Multicausality and competing risk issues make it difficult to quantify changes in life expectancy attributable to single risk factors, but these results suggest that the individual effect of reductions in air pollution on life expectancy was as much as 15% of the overall increase."
 - d) "[T]he three variables in the analysis that were most strongly associated with changes in life expectancy are all proxy variables. Increases in per capita income probably serve as a proxy variable for, or are highly correlated with, such factors as access to medical care, higher-quality diets, and healthier lifestyles. The use of rates of death from lung cancer and COPD as proxy variables was necessitated by the lack of reliable data on smoking, especially for the period from 1978 through 1982, yet these rates reflect the cumulative effects of smoking, which may similarly affect life expectancy."
- 5) Source: Lubitz, James, et al. "Health, life expectancy, and health care spending among the elderly." *New England Journal of Medicine* 349.11 (2003): 1048-1055. <<https://www.nejm.org/doi/full/10.1056/NEJMsa020614>> Factors: Physical Disability, Institutionalization

- a) “We classified health status on the basis of responses to questions about five activities used as measures of physical functioning, developed by Nagi, six instrumental activities of daily living, and six activities of daily living... The five Nagi activities are stooping, crouching, or kneeling; lifting or carrying objects weighing up to 6 kg (10 lb); extending the arms above the shoulder; grasping small objects; and walking two to three blocks. Respondents are asked how much difficulty, if any, they have with the activity, and the answers range from ‘no difficulty at all’ to ‘not able to do it.’ We counted persons who responded that they had any difficulty or that they were unable to perform the activity as having a limitation in physical functioning.”
- b) “The six instrumental activities of daily living are using the telephone, doing light housework, doing heavy housework, preparing meals, shopping for personal items, and managing money. The six activities of daily living are bathing or showering, dressing, eating, getting into or out of a bed or a chair, walking, and using the toilet. For the purpose of our study, persons who reported having any difficulty or not being able to perform the activity for reasons of health were considered to have a limitation in the activity.”
- c) “We defined states of health according to the following classification: no limitations, at least one Nagi limitation but no other limitations, a limitation in at least one instrumental activity of daily living but no limitations in activities of daily living, a limitation in at least one activity of daily living, institutionalization (e.g., in a nursing home), or death.”
- d) “Persons with no limitations had the longest life expectancy, and institutionalized persons the shortest.”
- e) “[P]ersons in good health live longer, and longevity is associated with lack of social support (e.g., widowhood) and frailty, and thus with a high risk of institutionalization. However, in our study the annual risk of institutionalization was lower for those in better health at 70 years of age; they lived longer, but the expected time spent in an institution was the same as for persons in poorer health.”
- f) “Our analysis shows not only that persons in good health at 70 years of age can expect to live longer and to have more years of good health than those in poor health at age 70, but also that their total expected medical care expenses appear to be no greater than those for less healthy persons, even though healthier persons live longer. Lower annual expenditures from the age of 70 until death among healthier persons offset the greater time they have to accumulate health care costs — a finding hinted at in earlier research.”
- 6) Source: Kochanek, Kenneth D., et al. “The effect of changes in selected age-specific causes of death on non-Hispanic white life expectancy between 2000 and 2014.” *Heart disease 1* (2017): 0-581. <<https://pdfs.semanticscholar.org/e38b/785511fe2125a5c3548de8e6293e2680ea8e.pdf>> Factors: Heart Disease, Cancer, Stroke, Pneumonia, Aortic Aneurysm, Unintentional Injuries, Suicide, Alzheimer’s Disease, Chronic Liver Disease, Hypertension, Unintentional Poisonings
- a) “The increase in life expectancy for the non-Hispanic white population was positively affected by decreases in death rates due to heart disease, cancer, stroke, pneumonia, and aortic aneurysm. On the other hand, increases in death rates due to unintentional injuries, suicide, Alzheimer’s disease, chronic liver disease, and hypertension had negative effects on the change in life expectancy.”
- b) “Increases in cause-specific death rates from only three causes—unintentional injuries, suicide, and chronic liver disease—were large enough to affect the all-cause death rates for the non-Hispanic white population in the age groups 25–34 (27.6% increase), 35–44 (2.7% increase), and 45–54 (7.0% increase). No other cause, including Alzheimer’s disease, had a large enough influence to affect all-cause age specific death rates.”
- c) “Increases in death rates due to unintentional poisonings (mostly drug and alcohol poisoning) for these three age groups had the single greatest negative effect on the change in life expectancy.”
- 7) Source: Franco, Oscar H., et al. “Associations of diabetes mellitus with total life expectancy and life expectancy with and without cardiovascular

- disease.” Archives of internal medicine 167.11 (2007): 1145-1151. <<https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/412633>> Factors: Diabetes, Cardiovascular Disease
- a) “Women and men with diabetes who were 50 years and older were expected to live on average 8.2 and 7.5 years less, respectively, than their nondiabetic equivalents.”
 - b) “Life expectancy at age 50 years and older for diabetic women was 8.2 years less than for women at the same age but without diabetes.”
 - c) “The larger total [life expectancy] among nondiabetic subjects was predominantly the result of the larger number of years lived without [cardiovascular disease] and a slightly shorter—but nonsignificant—[life expectancy] with [cardiovascular disease].”
- 8) Source: Chetty, Raj, et al. “The association between income and life expectancy in the United States, 2001-2014.” *Jama* 315.16 (2016): 1750-1766. <<https://jamanetwork.com/journals/jama/article-abstract/2513561>> Factors: Income, Immigration, Education, Government Spending
- a) “[H]igher income was associated with greater longevity throughout the income distribution. The gap in life expectancy between the richest 1% and poorest 1% of individuals was 14.6 years (95% CI, 14.4 to 14.8 years) for men and 10.1 years (95% CI, 9.9 to 10.3 years) for women.”
 - b) “[G]eographic differences in life expectancy for individuals in the lowest income quartile were significantly correlated with health behaviors such as smoking ($r = -0.69$, $P < .001$), but were not significantly correlated with access to medical care, physical environmental factors, income inequality, or labor market conditions. Life expectancy for low-income individuals was positively correlated with the local area fraction of immigrants ($r = 0.72$, $P < .001$), fraction of college graduates ($r = 0.42$, $P < .001$), and government expenditures ($r = 0.57$, $P < .001$).”
- 9) Source: Franco, Oscar H., et al. “Effects of physical activity on life expectancy with cardiovascular disease.” Archives of internal medicine 165.20 (2005): 2355-2360. <<https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/486786>> Factors: Physical Activity
- a) “Life expectancy for sedentary people at age 50 years was found to be 1.5 years shorter than for people engaging in moderate daily physical activity and more than 3.5 years shorter than for people with high physical activity levels. These differences were similar for both sexes.”
 - b) “Moderate and high physical activity levels led to 1.3 and 3.7 years more in total life expectancy [...] for men aged 50 years or older compared with those who maintained a low physical activity level. For women the differences were 1.5 and 3.5 years in total life expectancy.”
- 10) Source: Stewart, Susan T., David M. Cutler, and Allison B. Rosen. “Forecasting the effects of obesity and smoking on US life expectancy.” *New England Journal of Medicine* 361.23 (2009): 2252-2260. <<https://www.nejm.org/doi/full/10.1056/NEJMsa0900459>> Factors: Smoking
- a) “Eliminating smoking could increase population life expectancy by as much as 1 to 2 years.”
 - b) “Our study also has some limitations. Although it quantifies the effects of obesity and smoking, it cannot account for the many other factors that determine life expectancy and quality of life, such as advances in medicine and public health.”
- 11) Source: Meara, Ellen R., Seth Richards, and David M. Cutler. “The gap gets bigger: changes in mortality and life expectancy, by education, 1981–2000.” *Health affairs* 27.2 (2008): 350-360. <<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.2.350>> Factors: Education, Racial Inequity, Smoking
- a) “Between 1990 and 2000, life expectancy grew 1.6 years for the high-education group but remained unchanged for the low-education group ($p < 0.001$ for the difference).”
 - b) “From 1990 to 2000, the life expectancy differences between blacks and whites decreased 1.8 years for low-education males, 1.5 years for high-education males, and 0.7 and 0.6 years for low- and high-education females, respectively.”
 - c) “One important exception to this pattern is that education-related mortality disparities

narrowed among young black men, a finding consistent with recent evidence that race-related mortality gaps narrowed in the 1990s. Nevertheless, a five-year gap in life expectancy between blacks and whites remains.”

d) “Our results suggest that differential trends in smoking may explain a large part of widening gaps in mortality and life expectancy.”

12) Source: Singh, Gopal K., and Barry A. Miller. “Health, life expectancy, and mortality patterns among immigrant populations in the United States.” *Canadian journal of public health* 95.3 (2004): 114-121. <<https://link.springer.com/article/10.1007/BF03403660>> Factors: Immigration, Ethnic Inequity

a) “Male and female immigrants had, respectively, 3.4 and 2.5 years longer life expectancy than the US-born.”

b) “Compared to their US-born counterparts, black immigrant men and women had, respectively, 9.4 and 7.8 years longer life expectancy, but Chinese, Japanese, and Filipino immigrants had lower life expectancy.”

13) Source: Singh, Gopal K., and Mohammad Siahpush. “Widening socioeconomic inequalities in US life expectancy, 1980–2000.” *International journal of epidemiology* 35.4 (2006): 969-979. <<https://academic.oup.com/ije/article/35/4/969/686385>> Factors: Gender Inequity, Socioeconomic Inequity

a) “A factor-based deprivation index consisting of 11 education, occupation, wealth, income distribution, unemployment, poverty, and housing quality indicators was used to define deprivation deciles... In 1980–82, the overall life expectancy at birth was 2.8 years longer for the least-deprived group than for the most-deprived group (75.8 vs 73.0 years). By 1998–2000, the absolute difference in life expectancy at birth had increased to 4.5 years (79.2 vs 74.7 years).”

b) “Inequalities in life expectancy at birth, as measured by both the absolute and relative differences, were larger for males than for females in each period, and the magnitude of the difference increased over time more for males than for females. For males, the absolute difference in life expectancy at birth

between the least-deprived and most-deprived groups increased from 3.8 years in 1980–82 to 5.4 years in 1998–2000. For females, the corresponding absolute differences were 1.3 and 3.3 years in the two time periods, respectively.”

c) “Between 1980–82 and 1998–2000, those in higher socioeconomic groups posted larger gains in life expectancy at birth than those in more-deprived groups, contributing to the widening gap. This was apparent for both men and women, but the pattern held much more strongly for men. For men in the most-deprived group, life expectancy at birth increased by 0.23% per year from 1980–82 to 1998–2000, whereas it increased by 0.34% per year for men in the least-deprived group over the same time period. For women in the most-deprived and least-deprived groups, the average annual increases were 0.04 and 0.18%, respectively. The sex difference in life expectancy at birth was higher in more-deprived groups in each time period, and the magnitude of the sex differentials decreased over time across all deprivation groups.”

14) Source: Olshansky, S. Jay, et al. “Differences in life expectancy due to race and educational differences are widening, and many may not catch up.” *Health affairs* 31.8 (2012): 1803-1813. <<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0746>> Factors: Gender Inequity, Racial Inequity, Education

a) “Regardless of their level of completed education, we found that women in the United States lived longer than men at every age, a result that is consistent with previous research findings.”

b) “White males and females outlived black males and females, respectively, at every age and level of education—with the exception of age sixty, where black females have a slight longevity advantage over white females.”

c) “Hispanics appear to have the highest reported life expectancy at birth among the three racial or ethnic categories. However, caution is required when evaluating Hispanic mortality in the United States because of known variation in death rates based on national origin, age, and cause of death.”

- d) “The largest disparity in life expectancy at birth in the United States among the subgroups for which there are reliable data involve differences between the highest educated whites, those with sixteen or more years of education by age twenty-five, and the lowest educated blacks, those with fewer than twelve years of education by the same age. The observed disparities in life expectancy at birth between these subgroups in 2008 were 14.2 years for males and 10.3 years for females.”
- e) “Within racial and ethnic groups, the difference in life expectancy at birth between those with the most and those with the least education in 2008 was 10.4 years for white females, 6.5 years for black females, 2.9 years for Hispanic females, 12.9 years for white males, 9.7 years for black males, and 5.5 years for Hispanic males.”
- f) “[I]n 1990 the disparities between life expectancy at birth between the most and the least educated were 13.4 years for males and 7.7 years for females, compared to the 14.2 years for males and 10.3 years for females in 2008 noted above—revealing that during this eighteen-year time period the disparities increased.”
- g) “We found that on average, blacks and Hispanics with sixteen or more years of education lived 7.5 years and 13.6 years longer, respectively, than whites with less than twelve years of education. This is a clear demonstration of the profound influence that education and its correlates have on length of life. Yet disparities within racial and ethnic groups persist even at the highest level of education. The same highly educated black men and women who live longer than less educated whites still live about 4.2 years less than comparably educated whites and 6.1 years less than comparably educated Hispanics.”

Appendix C: Summary of Community Input

SYNOPSIS

Key informant interviews were conducted by Sage Squirrel Consulting with 14 individuals and six stakeholder groups between October 6, 2019 and January 16, 2020. The purpose of the interviews was to gather information to use in the development of the five-year Live Beyond Expectations Strategic Plan starting in 2020.

KEY INFORMANTS

The key informants were identified based on their health and human services subject matter knowledge, their knowledge of the Atlanta metro region, and/or their experience with regional collaborative initiatives. Key informants included:

- **Abby Cox**, Director, Georgia Division of Aging Services
- **Debra Edelson**, Executive Director, Grove Park Foundation
- **Jeff Graham**, Executive Director, Georgia Equality
- **John Hammond**, Director, Center for Community Services, Atlanta Regional Commission
- **Nat Kendall-Taylor**, Chief Executive Officer, FrameWorks Institute
- **Keun Kim**, Chief Compliance Officer, Center for Pan-Asian Community Services
- **Kathryn Lawler**, Executive Director, ARCHI
- **Odetta MacLeish-White**, Managing Director, TransFormation Alliance
- **Cynthia McDonald**, Manager Accessibility Compliance and Resident Initiatives, Atlanta Housing Authority
- **Shalini Nag**, Entrepreneur and Business Consultant
- **Elizabeth O'Neill**, Research Supervisor, Multnomah County Area Agency on Aging
- **Lindsay Parsons**, Aging Policy Advocate and Planner, Boulder County Area Agency on Aging
- **Nathaniel Smith**, Founder and Chief Equity Officer, Partnership for Southern Equity

- **Ken Zeff**, Executive Director, Learn4Life

Key informants were asked the following questions:

1. Please describe your organization and the work you do.
2. ARC has identified the following as significant factors in life expectancy:
 - Loneliness/isolation
 - Physical activity
 - Smoking
 - Injuries
 - Suicide
 - Chronic conditions and illnesses
 - Physical disability
 - Race/ethnicity
 - Gender
 - Socioeconomic factors

Does your organization have interest in these areas? In what ways might your organization contribute to reducing inequities in life expectancy numbers and improving life expectancy overall?

3. Are you currently doing any projects in this area that ARC could assist with in some way?
4. How do you believe ARC can best address the issue of life expectancy? What factors do you believe are in their sphere of influence?
5. ARC is hoping to engage with diverse community partners. Are you aware of organizations that ARC should speak with?
6. Are there other individuals you recommend we speak with as part of this project?
7. What population gaps have you identified that may need to be more deliberately targeted? How would that best be accomplished?

STAKEHOLDER ORGANIZATIONS

Other stakeholder input was gathered through a variety of meetings. Meetings included groups internal to ARC, as well as groups that exist in an advisory or other stakeholder capacity to ARC. Meetings included:

- ARC Aging and Independence Services Group staff
- ARC program and Group managers
- Lifelong Communities Partnership
- ARC Aging and Independence Services Board Committee
- ARC Advisory Committee on Aging
- ARC provider network

Initial discussion questions included:

1. What specific factors can/should ARC prioritize?
2. How should they do this:
 - a. By focusing on specific services?
 - b. By focusing on specific populations?
3. What community groups should ARC be working with?
4. What do you see as potential barriers?

Later discussion questions included:

1. What words do you think of when you hear “life expectancy”?
2. Are you aware of any initiatives in the Atlanta area addressing life expectancy disparities?
3. What community groups should ARC be trying to talk to as part of this process?
4. What do you see as potential benefits to embarking on this work?
5. What do you see as potential barriers to embarking on this work?

T H E M E S

There was a high level of awareness among key informants of life expectancy disparities. Multiple informants quoted us life expectancy disparity data that they were already familiar with and incorporating in their work. Community stakeholders did not appear to be quite as familiar with the magnitude of the life expectancy gaps in the region as the key informants but were not surprised at the fact that there was a gap. Nearly all involved in interviews or stakeholder meetings were overwhelmingly positive about ARC making this effort and wanted to support it.

We were told of multiple large regional collaborative efforts ongoing in the Atlanta metro region that touch on some of the social determinants of health that contribute to life expectancy. These include health access, education, transit, and housing. Both key informants and stakeholders indicated that there are also smaller scale efforts in these areas, plus nutrition-focused initiatives. Community stakeholders identified initiatives that were local to their areas including employer wellness programs, the state program to promote standing desks, and health insurance programs including Silver Sneakers. Many informants and stakeholders emphasized programs or projects that were focused on the needs or quality of life of older adults.

Many of the key informants noted the proliferation of health-equity focused initiatives, but most stated that they knew there was more going on than they were aware of. A couple noted that there was little coordination among these efforts and many may be duplicative, so ARC was well-positioned to play a clearinghouse role. Both key informants and community stakeholders thought that an inventory might be needed and suggested that ARC develop an inventory database and/or a map.

Nearly all the interviewees and meeting attendees discussed the long-range nature of ARC's goal of impacting inequities and life expectancy disparities. Key informants concurred that this plan would focus on what ARC wants to do, how it wants to do it, and with whom it wanted to do it during the next five years; in short, a plan to plan. One key informant suggested outlining the plan as an assessment of where the Atlanta region is, where it wants to be, and how it plan to get there in five years, while noting that ARC will NOT be impacting life expectancy in that time frame. Some community stakeholders saw the long timeframes as a significant obstacle to accomplishing anything.

Many who participated shared thoughts and concerns about how to keep the community engaged in something so long-range. There was discussion of how ARC could leverage its role as a hub of efforts, acting as a connector and a centralized communicator of the different efforts and outcomes associated with the agency.

Key informants noted that specific factors, such as as areas of focus, do not need to be identified at this point in time. The initial plan can include a process for identifying focal areas and how those will be identified and measured. In many of their own initiatives, they utilized a defined process that involved stakeholders or outside resources to help them do this and noted that developing this process for that involvement and the development of areas of focus should be part of the planning process.

One informant stated that, at the end of five years, ARC should have a robust and rich network of core partnerships. The focus in the next year or two should be on data and having the early conversations to build that partnership network. The goal is to tell the richest story possible to as many people as possible. Another suggested that ARC pull groups and individuals together to share a common framework on how life expectancy issues are framed and include new ideas about aging in the conversation.

Almost all informants discussed the importance of being data-driven in developing the plan, implementing potential solutions, and measuring progress. Three informants discussed disaggregating data to look beyond

broad generalizations. Several noted the availability of Neighborhood Nexus as a significant resource for ARC to use in these efforts, although noted that there may be new data that needs to be collected. For example, one informant stated: “Figure out how to use that data to identify the most vulnerable populations and make sure to think about them the most,” giving, as an example, the LGBTQ population, noting that within that group there are black LGBTQ elders who may be disassociated with traditional supports because of their lifestyle.

Despite recognizing that it was premature to concentrate its efforts on specific factors, several informants and stakeholders suggested specific areas of focus for ARC’s efforts. Most discussions with key informants and many of the stakeholders centered on healthcare, the role that healthcare plays in longevity, and the barriers that many experience in accessing healthcare. Other major areas that came up in all discussions are those described as the “social determinants of health.” Housing, transportation (including the need for transportation to access other service needs), and nutrition were the most frequently mentioned. A specific recommendation from one key informant was to increase capacity to provide care coordination services, with a note that this is a revenue-generating activity.

NOTABLE QUOTES

- “Racism should not be forgotten as a factor, not just race itself.”
- “Don’t be afraid of the role ARC has played over the years.”
- “Health is sum of many other determinants including the lack of healthy options and the stress of not being able to access the supports and services that are necessary to well-being.”
- “Goal is to tell the richest story possible.”
- “Only way to be relevant as a AAA [Area Agency on Aging] is to demonstrate you are having an impact on health outcomes, and that has to be more than Older Americans Act (OAA) services.”
- “Three R’s: reach, relevance and resources.”
- “Limited funding is not why the underserved don’t get services; it’s just how we’ve always done it.” (The people most in need of services are the least able to advocate for what they need.)
- “Poverty is not a reason – try to get beyond that; they can’t fix that; physical health issues like vision might be the real problem – get a few layers deeper into the problem; disparities by race, but you can’t fix race – how do you get beyond that – strategies to fix those historical barriers – wealth inequality alone, you are not going to make any progress.”

BARRIERS

Barriers were not a focus of key informant interviews although a couple volunteered thoughts about barriers. Community stakeholder groups were asked about barriers. Barriers included:

- ARC is not in a position to change how OAA funds are distributed.
- The lack of translation services is a barrier to service delivery as well as quality outreach to immigrant communities and development of culturally appropriate service resources.
- The long-range time frame required to have any effect on measuring life expectancy and the inability to measure that outcome along the way
- How to sustain buy-in and engagement over that length of time
- Unprepared political environment and inadequate community planning
- Inadequate resources
- Ageism

TARGET POPULATION

Populations experiencing inequities were largely identified as people of color and those below the poverty line who live in older neighborhoods where infrastructure supports have worn away. Their housing supply is decaying; they may live in food deserts, and transit may be a particular challenge. This was true among all key informants and all stakeholder groups.

One informant stated that ARC should pay special attention to racial generational divides in the community because the majority of younger people are people of color while the older generation is majority white. He did not provide data to support this assertion, but data disaggregation and analysis described above would allow ARC to plan accordingly.

PROCESS CONSIDERATIONS

Most key informant interviewees described a process by which they winnowed down their work to concentrate on a limited number of key areas. Some informants provided input that was particularly helpful to the process of developing the plan and objectives.

- Define key factors and indicators you are focused on to “make the work smaller”
- Find trusted resources on these indicators rather than engaging in a lot of community debating; Learn 4 Life (L4L) found a think tank for each indicator
- Organize work groups on each indicator to figure out what is working and how to take it to scale
- Don’t have to be innovative – just find what is working and remove barriers to enable it to go to a larger scale

- Showcase what is working
- Figure out where there are gaps in which ARC could add value
- Identify indicators where there are gaps and that you can influence
- Figure out your lane – be disciplined in sticking to that lane
- Need dedicated resources working on plan to have sustainability/ momentum
- The process needs to keep moving quickly in order to keep people engaged
- Update indicators and publish annual report; L4L publishes the State of Education in Metro Atlanta on a regular basis.

Another key informant emphasized that a focus on addressing inequities means engaging more directly with communities of people who experience inequity. He strongly cautioned that these groups of people should be involved in the development of strategies and not just be asked to “rubber stamp” the strategies after they are developed.

OTHER GROUPS

All key informants and meeting attendees were asked about other groups that ARC should connect with. These groups include:

- Alzheimer’s Association (and other affinity groups)
- Centers for Disease Control and Prevention
- Culture Change Network of Georgia
- Food Banks
- Georgia Alliance for Health Literacy
- Georgia Watch
- Gilliam’s Community Garden
- Habitat for Humanity
- Historic West Side Gardens
- Morehouse School of Medicine
- Neighborhood Planning Units
- Tools for Life
- Urban League of Greater Atlanta

OTHER AREA AGENCIES ON AGING INPUT

Boulder, Colorado

The AAA in Boulder, CO was selected as a key informant, as it took on an approach to strategic planning that went beyond mandatory Older Americans Act area plans. While Boulder is still conducting its strategic planning process, it has completed the preliminary data report that will inform its planning process. Although the primary focus is older persons, it hopes to positively impact quality of life for all residents.

To that end, Boulder is planning across the eight domains that constitute age-friendly communities (as defined by AARP and the World Health Organization), but highlighting subpopulations with higher health and social risks. The domains include outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, and community and health services.

Boulder used the Community Assessment Survey for Older Adults (CASOA) from the National Research Center to glean insight into the views of older adults in their area across its domains, and then delved into that data and other primary data to gain specific knowledge about the subpopulations. This strategic plan is not yet aligned with Boulder's area plan, although that is its goal. The Boulder AAA plans to do this by looking at the strategic plan as "external" and the area plan as "internal."

Multnomah County, Oregon

In area plan alignment discussions, the AAA in Multnomah County, Oregon laid out its approach, which is somewhat reversed from Boulder's. Multnomah County is creating alignment by including client-facing elements in the area plan, while its strategic plan is aligned with county performance management strategy, but both include overlapping focal areas. The Oregon AAA includes similar key performance indicators in both plans for those overlapping areas.

The Multnomah County AAA was selected as a key informant for its experience in distributing OAA funding to increase equity. It conducted participant level stakeholder engagement in the community to engage with "left out" populations as part of this effort. Intensive effort was put into 21 community listening sessions that targeted minority, low income, and rural populations. For each of its nine focus areas, it asked 500 participants three questions:

- What is going well?
- What do you need more of?
- What can we do to improve?

The AAA then did "qualitative coding" of the data gathered through this process. Results will be incorporated into the area plan being developed for the next cycle. This stakeholder engagement was part of the process utilized by the AAA in determining how to distribute funds. The research of Raj Chetty was identified as an influence by Multnomah County in its efforts to restructure OAA funding distribution to address inequities in service administration and outcomes in that area.