

# The Aging States Project:

## Promoting Opportunities for Collaboration Between the Public Health and Aging Services Networks

*A Report to:*

Centers for Disease Control and Prevention &  
Administration on Aging  
United States Department of Health and Human Services

*From:*

Chronic Disease Directors  
National Association of State Units on Aging

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# Acknowledgements

## Project Director

Ruth Palombo, MS, RD  
Director, Office of Elder Health  
Massachusetts Department of Public Health

## Assistant Project Directors

Anne Annunziata, PhD, RD, Consultant  
Anne McHugh, MS, Consultant  
Massachusetts Association of Older Americans

## Project Statistical Analyst

Wee Lock Ooi, DrPH  
Senior Evaluation Coordinator  
Massachusetts Department of Public Health

## Ad Hoc Health and Aging Advisory Committee

### Chair

Betty H. Wisner, EdD  
Director, Older Adult Health Branch  
North Carolina Department of Health and Human Services

### Members

Margo C. Blake  
Medical/Health Care Program Analyst  
Florida Department of Health  
Jean Chabut, BSN, MPH  
Director, Division of Chronic Disease and Injury Control  
Michigan Department of Community Health

Anne Connaughton, MA  
Executive Director  
Massachusetts Association of Older Americans

Allan B. Goldman, MPH  
Director of Health Promotion and Disease Prevention Programs  
Georgia Division of Aging Services

Gerry Mackenzie, MSS, MLSP  
Supervisor, Older Adult Health and Wellness  
Division of Senior Affairs  
New Jersey Department of Health and Senior Services

Chris Maylahn, MPH  
Director, Bureau of Risk Reduction  
New York State Department of Health

Ramona Schaffer, MEd, CHES  
Chronic Disease Prevention Program Director  
Virginia Department of Health

Jody L. Stones, MS  
Cardiovascular Health Program Manager  
Division of Chronic Disease Prevention and Nutrition  
Virginia Department of Health

Joan Ware, RN, MSPH  
Director, Cardiovascular Health Program  
Utah Department of Health

### Ex Officio Members

Greg Case, MA  
Program Director  
National Association of State Units on Aging

Rick Greene, MSW  
Program Specialist, Office of State and Community Programs  
Administration on Aging

Andree R. Harris  
Program Analyst, Health Care and Aging Studies Branch  
National Center for Chronic Disease Prevention and Health Promotion  
Centers for Disease Control and Prevention

Elizabeth C. King  
Program Manager  
Association of State and Territorial Chronic Disease Directors

John Korn  
Public Health Advisor, Division of Adult and Community Health  
National Center for Chronic Disease Prevention and Health Promotion  
Centers for Disease Control and Prevention

Maggie Kownaski, MPH  
Public Health Advisor, Healthcare and Aging Studies Branch  
National Center for Chronic Disease Prevention and Health Promotion  
Centers for Disease Control and Prevention

Theresa Lambert, MEd  
Deputy Director  
National Association of State Units on Aging

Jason E. Lang, MPH, MS  
Public Health Advisor, Healthcare and Aging Studies Branch  
National Center for Chronic Disease Prevention and Health Promotion  
Centers for Disease Control and Prevention

Suzanne M. Smith, MD, MPH, MPA  
Chief, Health Care and Aging Studies Branch  
National Center for Chronic Disease Prevention and Health Promotion  
Centers for Disease Control and Prevention

Fran C. Wheeler, PhD  
Director of Technical Assistance and Program Services  
Association of State and Territorial Chronic Disease Program Directors

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For further information about the Aging States Project or for additional copies of this report or the *Aging States Project: Data Supplement*, please contact

Greg Case ([gcase@nasua.org](mailto:gcase@nasua.org)) at the National Association of State Units on Aging, 202-898-2578 or Heather Kyrouz ([info@chronicdisease.org](mailto:info@chronicdisease.org)) at the Association of State and Territorial Chronic Disease Program Directors (Chronic Disease Directors), 703-610-9033.

For an up-to-date list of the Directors of the State Units on Aging, go to the NASUA Web site at [www.nasua.org](http://www.nasua.org). For an up-to-date list of the state Chronic Disease Directors, go to the CDD Web site at [www.chronicdisease.org](http://www.chronicdisease.org).

# Table of Contents

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<b>Introduction</b>	Background: the Aging States Project The role of the public health and aging services networks in healthy aging The benefits of collaborating to promote healthy aging	<b>1</b>
<b>Methodology</b>	Pilot questionnaire Final questionnaire Data analysis Limitations of data	<b>6</b>
<b>Results</b>	Responding to the health needs of older adults: priorities and barriers Program support needs Collaboration between state units on aging and state health departments Funding Promising programs	<b>9</b>
<b>Discussion</b>	Responding to the health needs of older adults Program support needs Collaboration issues Funding Summary Next steps	<b>22</b>
<b>Recommendations to Improve the Health of Older Adults</b>		<b>25</b>
<b>Promising Programs: Case Studies</b>	California Department of Health Services: <i>Preventive Health Care for the Aging Program</i> Delaware Division of Services for Aging and Adults with Physical Disabilities: <i>Millennium March to Wellness</i> Maine Bureau of Elder and Adult Services: <i>A Matter of Balance</i> Massachusetts Department of Public Health: <i>Keep Moving Program</i> Missouri Department of Health and Senior Services: <i>The Missouri Arthritis and Osteoporosis Program</i> New Jersey Department of Health and Senior Services: <i>Health Promotion Initiative</i> New York State – Office for the Aging and Department of Health: <i>Adult Immunization Campaign</i> Pennsylvania Department of Aging: <i>PrimeTime Health: Peer Exercise Program Promotes Independence</i>	<b>27</b>
<b>Glossary</b>		<b>35</b>
<b>Appendices</b>	A. Needs assessment questionnaire B. Respondents to needs assessment C. Coding categories for open response questions D. Older Americans Act, Title III-D	<b>36</b>
<b>References</b>		<b>44</b>

## List of Exhibits

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- Exhibit 1:** The demographic revolution. Projected change in the age distribution of US population, 2000-2050
- Exhibit 2:** Projected increase in the number of people aged 65 years or older, by state, 1993-2020
- Exhibit 3:** Schematic representation of the public health and aging services networks
- Exhibit 4:** Needs assessment questions
- Exhibit 5:** Top health issues for older adults, by state units on aging and state health departments
- Exhibit 6:** Relationship between identified top health issues for older adults and moderate-to-high involvement, reported by state health departments
- Exhibit 7:** Relationship between identified top health issues for older adults and moderate-to-high involvement, reported by state units on aging
- Exhibit 8:** Moderate-to-high involvement in health problems of older adults, by state units on aging and state health departments
- Exhibit 9:** Barriers to promoting health among older adults, by state units on aging and state health departments
- Exhibit 10:** Perceptions of transportation in relation to the health needs of older adults, by state units on aging and state health departments
- Exhibit 11:** Level of involvement in transportation for older adults, by state units on aging and state health departments
- Exhibit 12:** Unmet program support needs, by state units on aging and state health departments
- Exhibit 13:** Use of data sources, by state units on aging and state health departments
- Exhibit 14:** Level of access to research expertise, by state units on aging and state health departments
- Exhibit 15:** Collaborative activities between state unit on aging and state health department, with and without health promotion/disease prevention lead, by state units on aging and state health departments
- Exhibit 16:** Barriers to coordination with counterpart, by state units on aging and state health departments
- Exhibit 17:** Funding sources for health promotion for older adults, by state units on aging and state health departments

## Introduction

Poor health is not an inevitable consequence of aging. Increasing numbers of Americans in their 70s, 80s, and 90s enjoy independent, active living with minimal health problems<sup>1</sup>. Yet steps that we as a nation could take to further assure healthy aging for greater numbers of people are not consistently implemented. Many older adults suffer from chronic and infectious diseases, injuries, and functional limitations that are avoidable or can be delayed. Scientifically proven measures are available now that can improve health, reduce the impact of disease, and delay disability and the need for long-term care.

The gain in life expectancy in the United States during the 20th century was a triumph for public health. The success of public health initiatives in areas such as infectious disease control, immunizations, and chronic

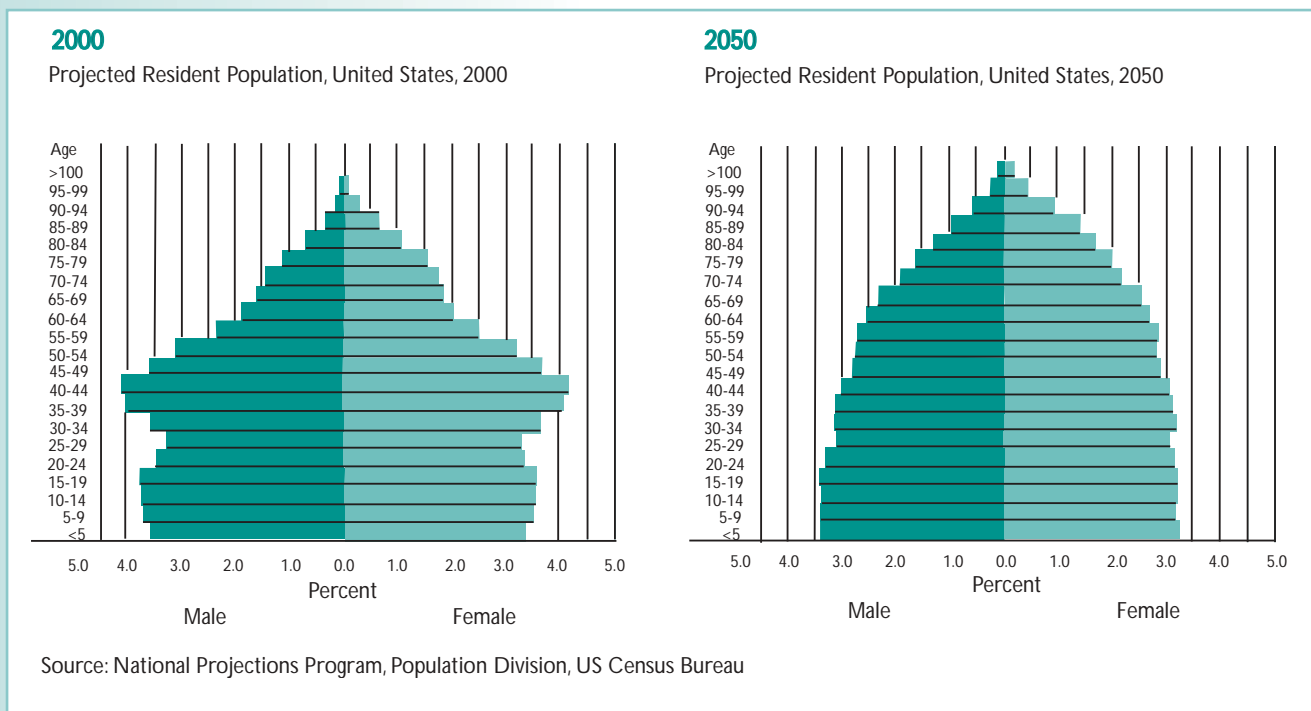
disease prevention has resulted in longer, healthier lives for Americans. The new challenge for public health is to develop a focus on healthy aging—to assure that older adults maintain optimal health status and quality of life in their later years.

As a result of successful public health efforts, the number of adults age 65 years and older will more than double to over 70 million by 2030 (Exhibit 1). One in every five Americans will be 65 years or older, a sixty percent increase over the proportion of older Americans in 2000.

Within this demographic revolution, the fastest growing segment of the U.S. population will be even older: 8.5 million people will be over the age of 85 by 2030. Increases in the older adult population will occur in all states; some states, in fact, will experience more than a 100% increase in the population of residents age 65 and older between 1993 and 2020 (Exhibit 2).

This growing population of older adults places increased demands on the health care system. Currently, almost one-third of total U.S. health care expenditures, \$300 billion each year, is spent on older adults<sup>2</sup>. Targeted health promotion and disease prevention measures may be among the most effective strategies for stemming growing health care expenditures in the coming years.

**Exhibit 1:** The demographic revolution: projected change in the age distribution of U.S. population, 2000-2050



As the American population ages, the role of states in assuring that the health status of older Americans is protected and enhanced will become more crucial. Currently, however, most states have a fragmented and limited approach to addressing the health needs of older adults. In particular, inadequate resources and attention are focused on health promotion and prevention of disease or secondary disability for older adults—the very population that experiences the highest rates of chronic disease and disability. One cause of this fragmentation is the lack of collaboration between state agencies that are responsible for assuring healthy residents and those that are responsible for aging adults.

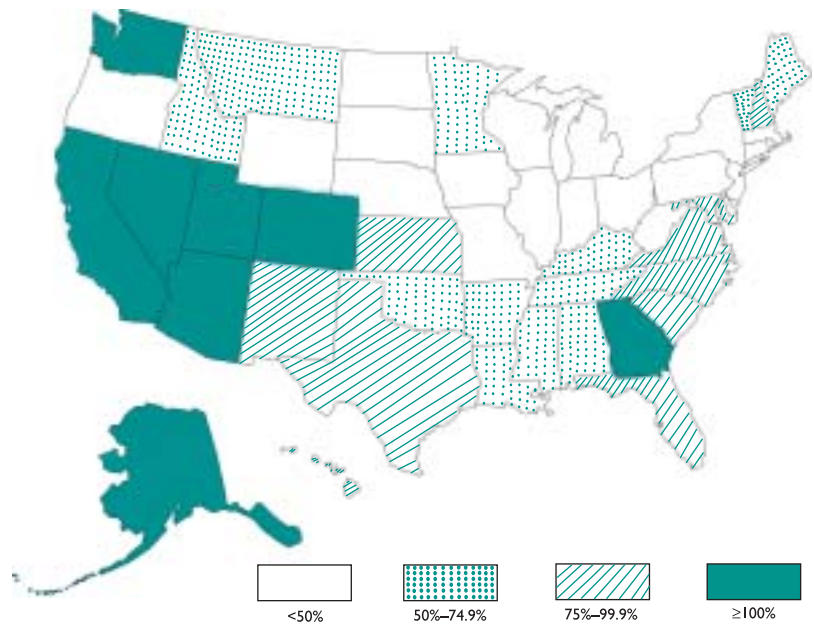
**Background:  
The Aging States Project**

At the state level, the public health and aging services networks share the mission of addressing the health needs of older adults. The public health network, spearheaded by state health departments (SHDs), and the aging services network, led by state units on aging (SUAs), bring different strengths and resources to this mission, frequently serving the older adult population using different strategies and mechanisms. In many cases, these networks work independently of each other within the same state. Developing an integrated system of health promotion and disease prevention services for older adults will require stronger collaboration and cooperation between these two essential networks.

*The Aging States Project: Promoting Opportunities for Collaboration between the Public Health and Aging Services Networks* was developed to help bridge this gap. Its goal is to bring together the strengths and expertise of state public health and aging networks to better meet their shared responsibility for ensuring optimal health for our nation’s older residents.

Initiated in spring 2001, the Aging States Project is a collaborative effort of the Association of State and Territorial Chronic Disease Program Directors, hereafter referred to as Chronic Disease Directors (CDD), and the National Association of State Units on Aging (NASUA), with support from the Centers for Disease Control and Prevention (CDC) and the Administration on Aging (AoA). NASUA and CDD are each non-profit membership organizations comprised of, respectively, the state and territorial SUAs

**Exhibit 2:** Projected increase in the number of people aged 65 years or older, by state, 1993-2020



Source: US Census Bureau

and the chronic disease programs of state and territorial SHDs. NASUA’s mission is to advance social, health, and economic policies responsive to the needs of a diverse aging population and to enhance the capacity of its membership to promote the rights, dignity, and independence of older persons, adults with disabilities, and their families. CDD supports SHD efforts in chronic disease prevention and control through education, training, advocacy, partnership development, and policy analysis. Each of these organizations recognizes the central role of protecting the health of older adults within its mission. NASUA and CDD have enthusiastically embraced the opportunity to collaborate in this needs assessment of their members and to develop the capacity of their members to collaborate more closely in efforts to improve the health of older adults.

The Aging States Project has compiled information on health needs, activities, and partnerships related to older adults through a needs assessment questionnaire sent to all state and territorial SUAs and SHDs. The information collected provides an overview of their current health promotion and disease prevention efforts for older adults. It identifies barriers, program support needs, and the status of collaborations between SUAs and SHDs across the United States. It identifies opportunities to strengthen these collaborations and improve resource use that will better address the health needs of older adults.

It is our hope that in partnership with the CDC and AoA, the state aging and public health networks will use this information to further integrate the expertise and capacity of both networks. This will help to define the critical next steps in addressing the health challenges of the growing population of older adults.

## The role of the public health and aging services networks in healthy aging

### Public health

The public health network in the United States protects and promotes the health and well being of all Americans across the life span through efforts at the national, state, and local levels. Primary functions of the public health network include collecting health status information, prioritizing health problems, developing health-related policies, and establishing systems that prevent disease and promote health. The public health network relies on partnerships among the CDC, other federal agencies, state and local health departments, voluntary and professional organizations, academic institutions, community-based organizations, and others.

State health departments (SHDs) are responsible for protecting and promoting the health of all their residents. They accomplish this in part by focusing on specific at-risk populations. However, few SHDs have programs targeting older adults, even though they are at high risk for chronic disease, injury, and disability. There is some irony in the fact that, while the “graying of America” has been largely a product of a century of public health successes in extending life expectancy, SHDs still do not have a clearly defined role in health promotion and disease prevention for older adults.

The CDC, as the lead federal agency that provides funding, technical assistance, research-based practices, and training for health promotion and disease prevention, is a key player in influencing state-level programmatic initiatives. As the CDC developed best practices and funding opportunities in chronic disease prevention and control, many SHDs responded by developing programs that addressed various categorical diseases, e.g., breast and cervical cancer, diabetes, arthritis, and cardiovascular disease. However, CDC funding levels are not sufficient to support these programs in all SHDs. Those SHDs that have successfully obtained federal funding for chronic disease programs typically focus on early primary or secondary prevention and do not specifically target older adults.

In addition, all SHDs receive block grant funding through CDC for preventive health services. These grants are relatively small but allow for state flexibility in their use. Some SHDs use a portion of these block grant funds to support chronic disease initiatives. Some SHDs also receive state-appropriated funds for chronic disease prevention and

control or other aspects of health promotion relevant to older adults.

The overall result of such public health structures and funding sources is a wide variety in the configuration of health promotion and chronic disease prevention programs within SHDs. This organizational configuration can be challenging for SUAs or other partners concerned with aging programs as they seek appropriate partners for collaboration.

### Aging services

Across the nation, the aging services network provides health and supportive services to approximately nine million older Americans each year. This network is comprised of the federal Administration on Aging; 57 state and territorial agencies on aging, also known as state units on aging (SUAs); 660 state-designated area agencies on aging (AAAs); and over 27,000 local service provider organizations. With a policy framework and funding from the Older Americans Act (OAA), the aging services network assists older adults to continue to live independently in their communities.

The Administration on Aging is the lead federal agency for the concerns and needs of older Americans. AoA administers the Older Americans Act, which funds a wide range of services and programs with a special focus on low-income and minority older adults, and also those at risk of losing their independence. These services and programs are specified in several sections, or titles, of the OAA and include:

- *supportive services*, such as information and assistance, transportation, case management, adult day care, senior centers, personal care, homemaker/chore assistance, home health, respite, home repair, housing services, and employment services;
- *nutrition services*, including congregate and home-delivered meals;
- *elder rights*, including the long-term care ombudsman, elder abuse prevention, health insurance and benefits counseling, pension counseling, and legal assistance;
- *family caregiver support*, including information about services, assistance with access to services, individual counseling, support groups, caregiver training, and respite care; and
- *health promotion/disease prevention*

At the state level, the OAA is administered by state units on aging—agencies of state government designated by the governor and state legislature to be the focal point for all matters affecting older citizens in the state. Established nationwide with the passage of the Older Americans Act in 1965, SUAs share a common mission of assuring older people every opportunity to achieve

maximum self-reliance, independence, and well-being while maintaining close family and community ties.

SUAs provide OAA funding to their communities through designated area agencies on aging, which may be public, governmental agencies or non-profit organizations serving defined geographic regions within each state. Based on local needs and priorities, AAAs contract with local provider organizations for services and/or provide services directly.

In response to the challenges of the growing number and increasing longevity of older adults, SUAs have continued to evolve, significantly expanding their scope of responsibilities since 1965. Today, they oversee complex service systems that are funded by a variety of federal resources, state resources, and private foundations. For example, a major priority of SUAs continues to be the development of policies and programs to assist those with disabilities, chronic conditions, or functional limitations to remain in their own homes. Toward this end, SUAs administer home and community-based long-term care programs that are funded by both state and federal Medicaid monies.

SUAs have been involved in health promotion and disease prevention activities since the early days of the OAA. However, in 1992 Congress added new language to the Older Americans Act authorizing *disease prevention and health promotion services*. Known as Title III-D (formerly Title III-F), it also establishes a statutory basis for the collaboration between public health and aging services by directing AoA to consult with the CDC in carrying out

this disease prevention and health promotion mandate. Although the amount of funding allocated for Title III-D is modest in comparison to many other OAA programs, its availability assists states in addressing this critical need among older persons.

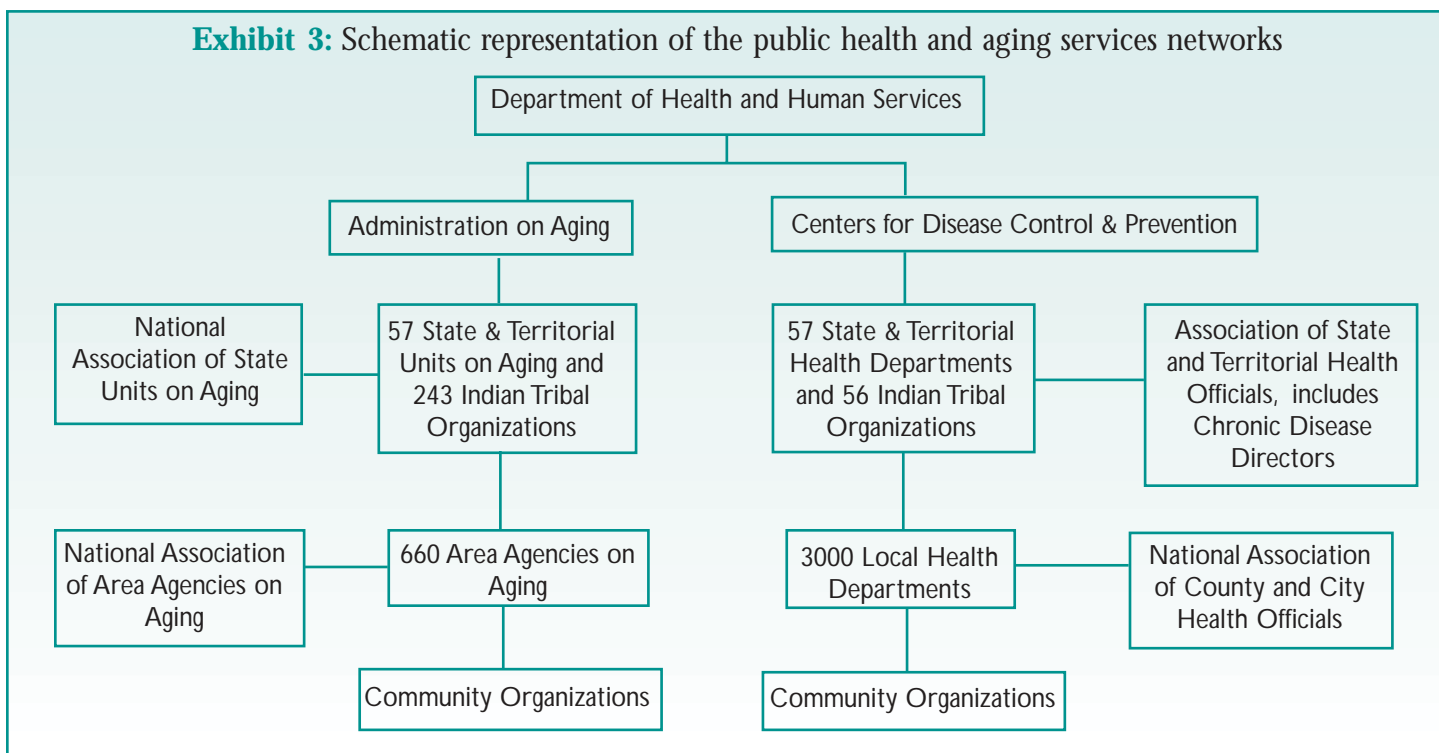
### Promoting collaboration between the public health and aging services networks

As the discussion above illustrates, the public health and aging networks operate through a complex web of public and private agencies at different levels of government, with an array of providers and multiple funding sources. Despite this complexity, there is a clear symmetry between the two service networks (Exhibit 3).

At each level of government (national, state and local), the public agencies and their private partners in both aging and public health have a clearly defined role. At each level, there are opportunities for collaboration that could enhance health promotion/disease prevention for older adults.

There has been recognition for some time that, through closer collaboration, these networks could more effectively address the health needs of older adults. In 1994, a major conference to address the intersection of public health and our aging society was sponsored by CDC, AoA, the National Institute on Aging, the American Association of Retired Persons and the Gerontological Society of America<sup>3</sup>. In 1996, the CDC and AoA jointly published and disseminated the *Guide to State Health Departments*

**Exhibit 3:** Schematic representation of the public health and aging services networks





and *State Aging Agencies Working Together*<sup>4</sup>, which contained specific recommendations to facilitate coordination between the two agencies at a state level.

This prior work in defining areas of increased collaboration sets the stage for the Aging States Project, which is the first effort to solicit systematic direct feedback from SUAs and SHDs to assess these issues.

## **The benefits of collaborating to promote healthy aging**

The focus on health promotion, disease prevention, and delay of disability is well established for younger populations, but their benefits have not been as widely recognized or implemented for older adults. Yet there is a growing body of research that demonstrates that health promotion for older adults has tangible benefits<sup>5</sup>. This research can guide the development of best practices that can be implemented through the programs of SHDs, SUAs, and their many state and community partners. Examples of key areas that contribute to older adult health are highlighted below.

### **• Physical Activity**

The single most important step that most adults, including older adults, can take to improve their overall health is to become more physically active<sup>6</sup>. Research continues to accumulate demonstrating the health benefits of increasing physical activity even among “old-old” adults.

Regular, moderate physical activity, for at least 30 minutes on most days, has a number of positive health benefits. These include preventing or reducing disability from chronic diseases such as heart disease, hypertension, diabetes, and arthritis. Physical activity, along with diet, is a key factor in maintaining a healthy body weight.

Additionally, physical activity that includes muscle strengthening can improve mobility and balance, reducing the risk of falls. Regular exercise also positively affects mental health by improving alertness and reducing depression.

Despite clear evidence of its benefits, few older adults engage in recommended levels of physical activity and significant numbers do not participate in any physical activity. Only 16% of adults aged 65-74 report participating in 30 minutes or more of moderate activity five or more days per week, while 28-34% of adults in this age bracket report no physical activity<sup>7</sup>.

Accessible, age-appropriate programs to promote increased physical activity are increasingly available. Many AAAs use their Title III-D health promotion funds to support community-based programs that improve strength, endurance, or flexibility. These include resistance training classes, walking clubs, yoga, tai chi, and water aerobics. Strategies and resources to expand these programs, and to reach high-risk and isolated groups, can contribute to improving the overall health of older adults.

### **• Immunizations**

Older adults are at higher risk for death from several vaccine-preventable diseases than are younger adults. Pneumonia and influenza account for more than 50,000 deaths annually of people ages 65 and older<sup>8</sup>. Although immunization can reduce the incidence of these diseases by as much as 80%, many older adults do not receive these vaccinations. In 1999, 33% of older adults reported not having received an influenza vaccine in the previous year, and 46% reported never having received a pneumococcal vaccine<sup>9</sup>.

Strategies to increase vaccination rates are dependent on state and local health departments conducting successful outreach to older adults. However, many SHDs may not have the knowledge or resources to reach older adults at the community sites where immunization campaigns can occur. The aging services network has these resources and knowledge and could serve as an invaluable partner to health departments in these efforts.

### **• Fall prevention**

One of every three Americans age 65 years and older experiences a fall each year and 20-30% of these individuals sustain moderate to severe injuries that reduce mobility and independence, and increase the risk of premature death. In 1994, the total direct cost of these fall-related injuries for people age 65 and older was \$20.2 billion<sup>10</sup>.

The high incidence of falls among older adults is due to a number of modifiable factors. Improving strength and balance through physical activity programs focusing on resistance training has been shown to be effective. Environmental adaptations in the home reduce safety hazards that can contribute to falls. Effective management of medication use can reduce the side effects that can contribute to falls.

Programs that address related issues of physical activity, home modification, and medication use are authorized through OAA funding. Many, however, do not have ready access to the research expertise and implementation strategies necessary to integrate fall prevention into such programs.

Physical activity, immunizations and fall prevention are three important areas in which SUAs and SHDs could collaborate more effectively to address health promotion and disease prevention efforts for older adults. By drawing on their combined expertise and resources, this healthy aging network can continue the work of improving the health status and quality of life for older Americans.

## Methodology

This needs assessment was designed to compile information from state health departments and state units on aging on health promotion and disease prevention activities, partnerships, and needs related to older adults, and to identify opportunities for enhanced collaboration and improved resource use. The results of the needs assessment will be used to bring together the respective strengths and expertise of the public health and aging networks to better meet a shared responsibility for ensuring optimal health for our nation's older adults.

The development of the needs assessment was guided by the Ad Hoc Health and Aging Advisory Committee and selected outside experts. Through a series of telephone conference calls and electronic communication, a pilot questionnaire was developed and tested. The results of the pilot were reviewed and utilized to plan the final needs assessment questionnaire. After approval by the Advisory Committee, the final needs assessment was sent to all state and territorial health departments and units on aging.

### Pilot questionnaire

In March 2001, a questionnaire was piloted to test proposed questions and the viability of electronic submission of responses through Zoomerang™, a Web-based response format. A set of open-response questions was

developed based on suggestions from the Advisory Committee. Questions explored the core activities of SUAs and SHDs related to health promotion and disease prevention for older adults and the relationship between the two agencies in each state or territory. Ten states with diverse regional and demographic criteria as well as varying capacity and expertise regarding health promotion and disease prevention for older adults were selected for the pilot. Seven SUAs and nine SHDs completed and returned the questionnaire. These respondents were subsequently contacted by telephone to clarify answers and to seek input on the utility of the electronic submission of responses through Zoomerang™.

### Final questionnaire

Based on responses to the pilot and the telephone interviews with respondents, questions were refined. Questions that had clusters of common responses in the pilot were modified to have fixed-choice responses. Responses to pilot questions about unmet needs and barriers overwhelmingly referred to funding and staffing. While these are acknowledged to be significant underlying issues, these response options were omitted from the final questionnaire in order to gain greater insight into other needs and barriers.

While most of the information being sought through the needs assessment was common to both SUAs and SHDs, two questions were tailored to the SHD and one to the SUA in order to solicit information particular to each agency. Therefore, the final SUA questionnaire contained 29 questions, while the final SHD questionnaire contained 30 questions. All other questions were symmetrical in each version of the needs assessment questionnaire. Each version contained 12 open-ended response questions, with the remainder being fixed-choice questions. (See Exhibit 4 for a list of all needs assessment questions and Appendix A for a copy of the full questionnaire.)

The Zoomerang™ Web-based questionnaire was used as the primary data collection instrument. Although there were some known limitations, such as a predefined maximum of 30 questions and the requirement that all questions be completed and submitted in one session because of the lack of a "save" function, it was felt that using this modality would increase the response rate and reduce respondent fatigue.

In June 2001, the questionnaire and cover letter were mailed to all state and territorial SHD chronic disease directors (or an individual they designated) and SUA directors, using the mailing lists of CDD and NASUA. The cover letter was also sent via e-mail with hyperlink access to the Web-based questionnaire to the same

participants. Respondents were given the option of submitting their completed questionnaires using Zoomerang™, postal mail, or fax. Technical assistance by telephone was available to respondents who chose to use Zoomerang™. Project staff entered data submitted via paper questionnaires into the Web-based application. The cover letter urged the SHD chronic disease director and SUA director to seek input for the responses from other staff within their agencies with responsibilities for health promotion and disease prevention for older adults. This request to make the responses a collaborative effort within their respective agencies was made to ensure that answers would be as accurate and comprehensive as possible. The issue of whether to collaborate with their counterpart agency (either SUA or SHD) in their response was not addressed in the cover letter.

Up to five follow-up contacts by e-mail and telephone were made during the month of September 2001 to ensure an adequate response rate. Responses were received from 38 state/district and one territorial SUA and from 43 state/district and no territorial SHDs (see Appendix B for list of respondents). Eighty-seven percent (87%) of SUAs and 70% of SHDs that responded used the electronic format. Responses were received from both the SUA and SHD for 31 states. Neither the SUA nor SHD responded for one state and six territories. Final state/district response rates were 75% for SUAs and 84% for SHDs. Final response rates, including all states and territories, were 68% for SUAs and 75% for SHDs.

Five responding agencies submitted multiple responses, replying by both electronic submission and mail. Project staff contacted these respondents and clarified which response set to use.

## Data analysis

SUA and SHD responses were separately analyzed. Descriptive statistics, including frequency distributions and cross-tabulations of selected questions, were used to characterize the responses. The 31 paired-state responses were also examined for congruence of selected responses. Because the needs assessment was an exploratory study, tests for statistical significance were not conducted.

The project team developed a set of codes to analyze questions with open-ended responses. A qualitative, analytical approach was used, whereby a master list of ten major thematic categories<sup>i</sup> was developed based on the observed responses. Within these major categories, 70 more specific sub-categories were developed. This

coding methodology facilitated cross-tabulation of responses and in-depth analysis of the data.

Results displayed in this report are based on the most frequent responses given by SUAs and SHDs. A full display of all responses in tabular format can be found in the companion document, *The Aging States Project: Data Supplement*. To obtain a copy of the *Aging States Project: Data Supplement*, contact Greg Case (gcase@nasua.org) at the National Association of State Units on Aging, 202-898-2578 or Heather Kyrouz (info@chronicdisease.org) at the Association of State and Territorial Chronic Disease Program Directors (Chronic Disease Directors), 703-610-9033.

## Limitations of Data

Technical issues in access to and use of the questionnaire presented the first limitation to data yielded from this needs assessment. Some respondents reported difficulties with the Web-based format of the assessment questionnaire that resulted in submissions being lost and requiring re-submission.

Subjective interpretation of questions on the part of the respondent, as well as the knowledge base of the respondent, presented additional limitations. The instructions for the needs assessment requested that respondents use knowledgeable staff in their agencies to assist in answering the questionnaire. However, it is not known which individual(s) from each agency actually contributed to the responses.

It is also important to note that the characteristics of non-responding states and territories may differ from those that responded. Six of seven territories did not respond. The only discernable pattern in geography or state size was that all states in the northeast region responded.

Finally, the classification of open-ended questions into thematic categories by project staff may be subject to bias.

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<sup>i</sup>The 10 major categories were chronic disease prevention and control; risk reduction/behavioral change; mental health, behavioral health and dementia; concrete services; health care access, coverage and quality; systems and program management; quality of life; training/knowledge issues; program implementation and evaluation; and staffing. See Appendix C for a complete list of codes.

#### **Exhibit 4:** Needs assessment questions\*

(OR = Open Response; FC (n) = Fixed Choice Response with number of choices)

1. Please list the top 5 health issues affecting older adults in your state. OR
2. Within your agency, is there an organizational unit or person specifically designated for health promotion/disease prevention activities related to older adults? FC (2)
3. Does your agency have a plan for serving older adults that addresses health promotion/disease prevention? Please check all that apply. FC (6)
4. In your state, which state agency has lead (or primary) responsibility for health promotion/disease prevention activities for older adults? FC (5)
5. Please identify other state agencies/public programs involved in (or responsible for) health promotion/disease prevention activities for older adults. Please check all that apply. FC (8)
6. Please identify other partners you work with around health promotion/disease prevention activities for older adults. Please check all that apply. FC (20)
7. Describe the organizational relationship between the state health department and the state unit on aging in your state. FC (4)
8. What are the collaborative activities engaged in by the state unit on aging and the state health department? Please check top 3. FC (12)
9. On average, how often do you engage in health promotion/disease prevention activities for older adults with your counterparts in the other state agency? FC (6)
10. What do you see as the strengths of your agency in health promotion/disease prevention activities for older adults? (Identify the top 3). OR
11. What do you see as the strengths of your counterpart state agency in health promotion/disease prevention activities for older adults? (Identify the top 3). OR
12. Choose the three most important organizational, programmatic, geographic, or political barriers other than funding that limit or prevent coordination with your counterpart agency. FC (11)
- SHD 13.** Are you aware of the health promotion/disease prevention provisions of Title III-D of the Older Americans Act? FC (2)
- SUA 13.** Please identify the 3 types of activities for which your OAA Title III-D funds have been used most frequently. FC (18)
14. Does the state health department participate in any health promotion/disease prevention activities funded under Title III-D of the Older Americans Act? FC (5)
15. Aside from funding, what are the 3 main barriers to fully promoting health and preventing disease among older adults in your state? FC (20)
16. What are the funding sources used for health promotion/disease prevention for older adults by your agency? FC (13)
17. Other than funding or staffing what are the 3 top unmet support needs for health promotion/disease prevention for older adults in your state? FC (11)
18. If greater funding were available, what 3 health promotion/disease prevention issues for older adults would you address? OR
19. The following is a list of health problems affecting older adults. Please indicate the current level of involvement of your agency in addressing each problem. FC (38)
20. Please describe one health promotion/disease prevention success story in your state that you would like others to know. How do you define success? OR
21. What data sources do you use to identify, plan, monitor or evaluate the health needs of older adults in your state? Please check all that apply. FC (12)
- SHD 22.** What Administration on Aging resources do you use? FC (8)
- SUA 22 / SHD 23.** What are the 3 top areas where you could benefit most from technical assistance and training to more effectively address the health promotion/disease prevention needs of older adults? OR
- SUA 23 / SHD 24.** Do you have access to up-to-date research expertise for health promotion/disease prevention program planning, implementation and evaluation for older adults? Please check all that apply. FC (7)
- SUA 24 / SHD 25.** Give one example of a health promotion/disease prevention program in your state that you would nominate for best practices for older adults. Provide the name of the program, a description and how outcomes were evaluated, if they were. OR
- SUA 25 / SHD 26.** In what areas of health promotion/disease prevention would you most like to see best practices (evidence-based programs) developed? OR
- SUA 26 / SHD 27.** What do you perceive as the Centers for Disease Control and Prevention's current role in health promotion/disease prevention for older adults? OR
- SUA 27 / SHD 28.** If additional funds were made available to the Centers for Disease Control and Prevention, what would be the priorities for state-based programs targeting health promotion/disease prevention for older adults? OR
- SUA 28 / SHD 29.** What are the urgent hot button issues in your state related to older adults e.g. interests of the governor, the legislature, media or advocates? OR
- SUA 29 / SHD 30.** Is there anything else you would like to tell us regarding gaps in health promotion/disease prevention programs/services/activities related to older adults at your agency? OR

\*See Appendix A for the full needs assessment questionnaire, including response options.

## Results

### Responding to the health needs of older adults: priorities and barriers

The top health issue for older adults identified by both SUAs and SHDs is chronic disease prevention and control<sup>i</sup> (Exhibit 5). Other issues selected by at least a third of respondents were risk reduction/behavior change (including nutrition, physical activity and fall prevention) (SUA 39%, SHD 48%), prescription drug access/coverage (SUA 45%, SHD 38%), mental/behavioral health (SUA 42%, SHD 38%), and health care access (SUA 29%, SHD 36%).

Within chronic disease prevention and control, cardiovascular disease was the single most common health issue mentioned (SUA 55%, SHD 57%). Additionally, both SUAs and SHDs frequently identified other chronic diseases as top health concerns: diabetes (SUA 39%, SHD 36%), cancers (SUA 34%, SHD 45%), and arthritis (SUA 26%, SHD 40%).

Several areas of health concern received little attention in this assessment. Few SUAs and no SHDs identified oral health or dental care as a top concern. Tobacco and alcohol abuse were each mentioned only once, by SHDs.

**Exhibit 5:** Top health issues by state units on aging and state health departments

Health issue	SUAs (n=38)	SHDs (n=42)
Chronic disease prevention & control	74%	81%
– Cardiovascular disease	55%	57%
– Diabetes	39%	36%
– Cancer	34%	45%
– Arthritis	26%	40%
Prescription medications	45%	38%
Mental/behavioral health	42%	38%
Risk reduction & behavior change	39%	48%
Health care access	29%	36%

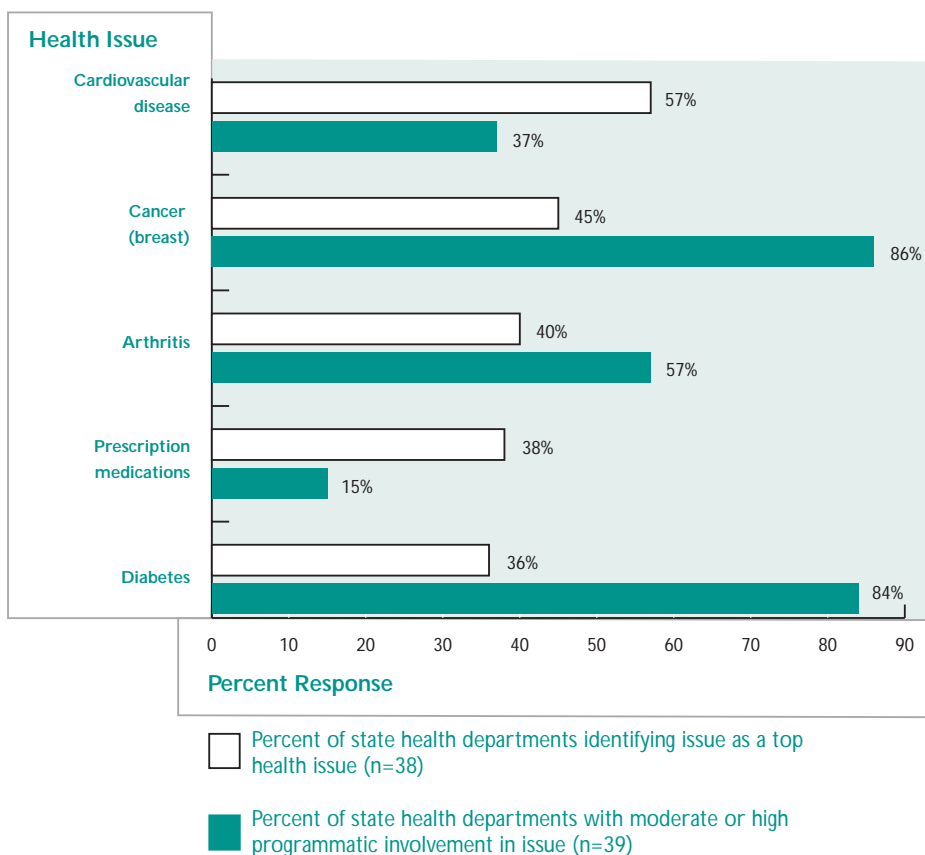
<sup>i</sup> Question 1 of needs assessment. See Exhibit 4 for a list of all needs assessment questions.

The level of involvement of SUAs and SHDs in addressing issues<sup>i</sup> does not necessarily relate to the top health issues for older adults that they identified (Exhibits 6 and 7). Although cardiovascular disease was the health concern mentioned most frequently, fewer than half of the responding agencies reported moderate to high involvement<sup>ii</sup> in this area (SUA 40%, SHD 37%). For prescription drug access/coverage, three-fourths of SUAs (75%) but only 15% of SHDs reported moderate to high program involvement. In general, the level of programmatic involvement is higher in those programs that receive federal funding (Exhibit 8). Most SHDs had moderate to high levels of involvement in breast cancer programs (SUA 46%, SHD 85%) and immunization programs (SUA 54%, SHD 72%), which are funded in all states by the CDC. Many SHDs also have CDC funding in the areas of arthritis and diabetes—programs in which more than half of SHDs had moderate to high levels of involvement. A high proportion of SUAs had moderate to high levels of involvement in a number of areas that are supported through Older Americans Act funding, including nutrition, caregiver issues, dementia, domestic violence, and legal assistance/advocacy.

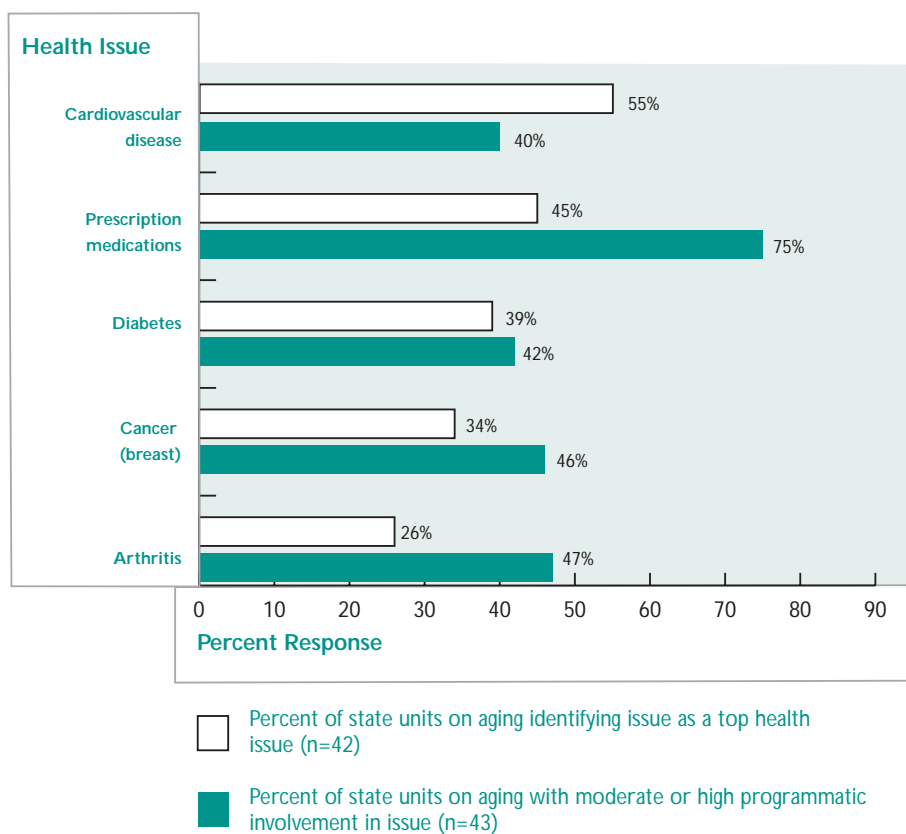
<sup>i</sup> Question 19 of needs assessment.

<sup>ii</sup> Respondent were given the following definitions of possible involvement levels: *None*: Not involved in this area at all. *Limited*: Participate in a task force, planning/advisory committee, conference, etc., without specific focus on older adults or at a low level of involvement. *Moderate*: Have program efforts specifically targeted to older adults, e.g., training or development of education materials but limited in scope, geographic reach, and/or diversity of older populations served. *High*: Statewide program targeted to older adults, with significant commitment of staff and funding. The discussion of results combines response choices for moderate and high involvement.

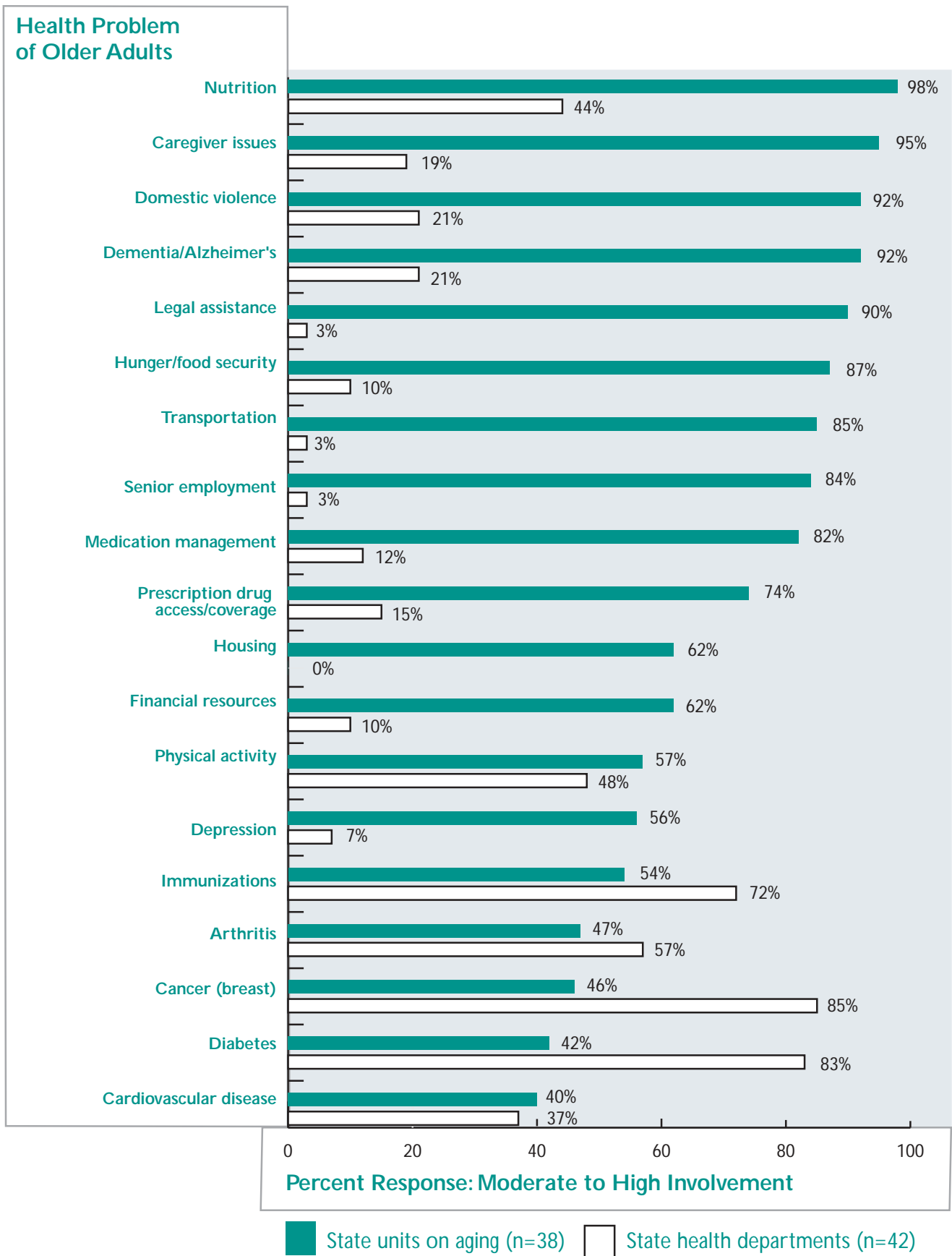
**Exhibit 6:** Relationship between identified top health issues for older adults and moderate to high involvement, reported by state health departments



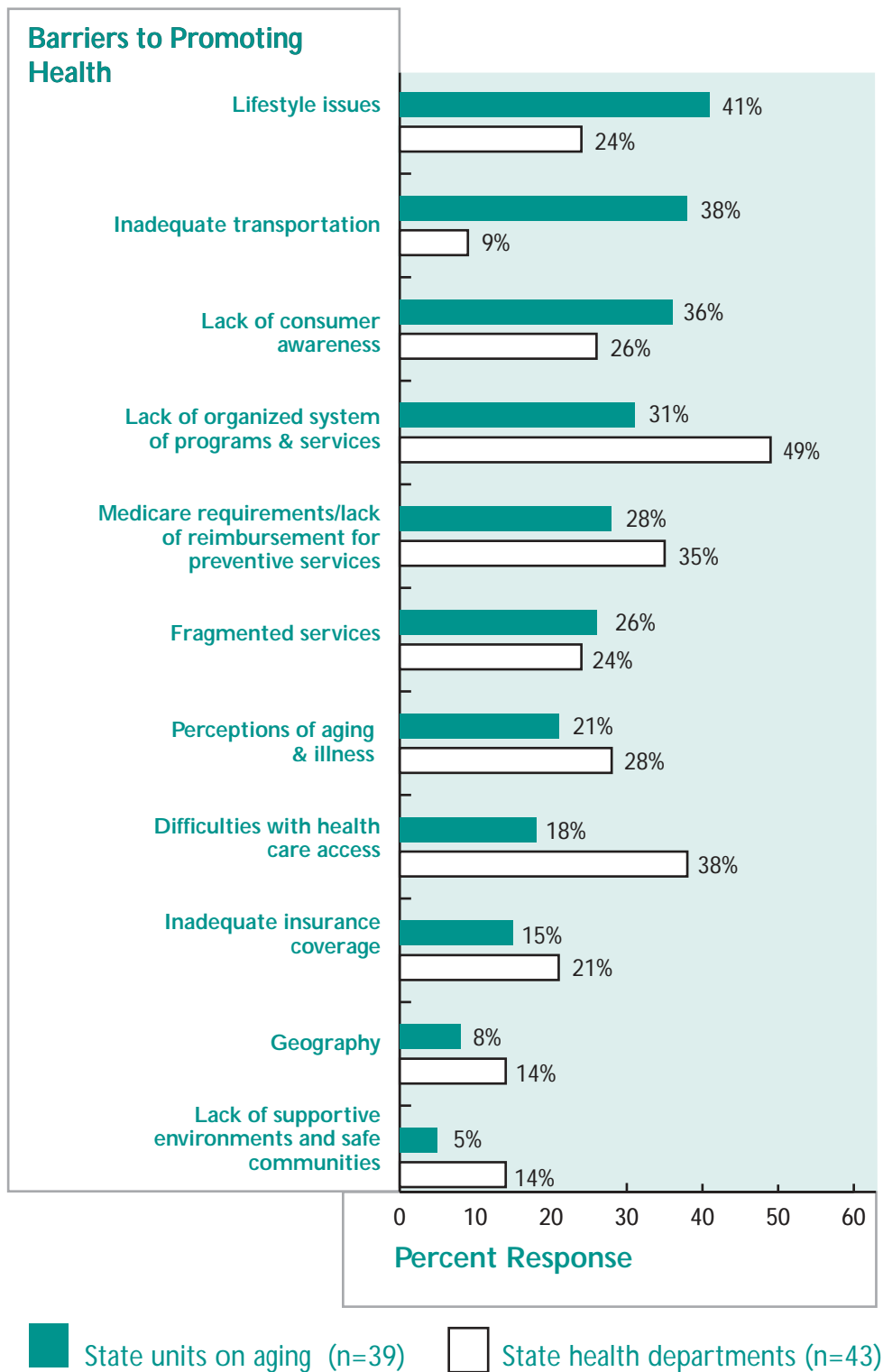
**Exhibit 7:** Relationship between identified top health issues for older adults and moderate to high involvement, reported by state units on aging



**Exhibit 8:** Moderate to high involvement in health problems of older adults, by state units on aging and state health departments



**Exhibit 9: Barriers to promoting health among older adults, by state units on aging and state health departments**





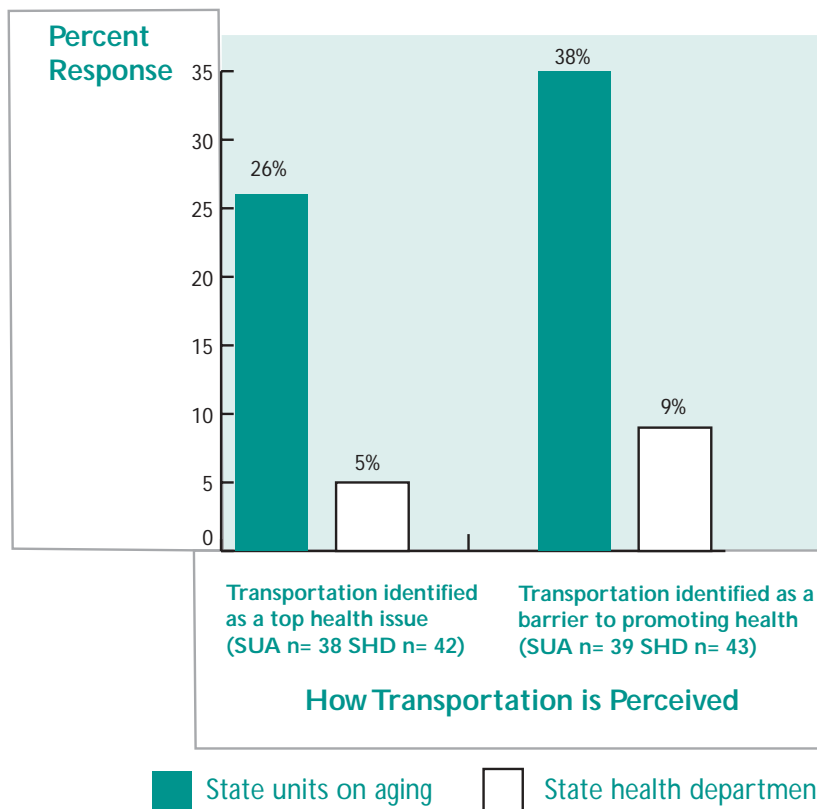
Both agencies identify a range of important barriers to promoting health among older adults.<sup>i</sup> No single barrier was identified by a majority of SUAs or SHDs<sup>ii</sup> (Exhibit 9). However, the top choices of SUAs and SHDs were differentiated by the clusters of issues selected. The types of barriers identified by SUAs focused more heavily on the individual (lifestyle issues, inadequate transportation, and lack of consumer awareness), which is consistent with their mission of providing community-based direct services to older adults. In contrast, the barriers selected more frequently by SHDs were systems barriers to providing programs and services on a population basis: lack of an organized system of programs and services, health care access, and fragmented services.

Many SUAs, but few SHDs, identify transportation as an important issue<sup>iii</sup>. SUAs were five times more likely to identify transportation as a top health issue (SUA 26%, SHD 5%) (Exhibit 10), more likely to have moderate to high program involvement in it (SUA 85%, SHD 3%) (Exhibit 11), and four times more likely to identify it as a barrier to promoting health (SUA 38%, SHD 9%) (Exhibit 9).

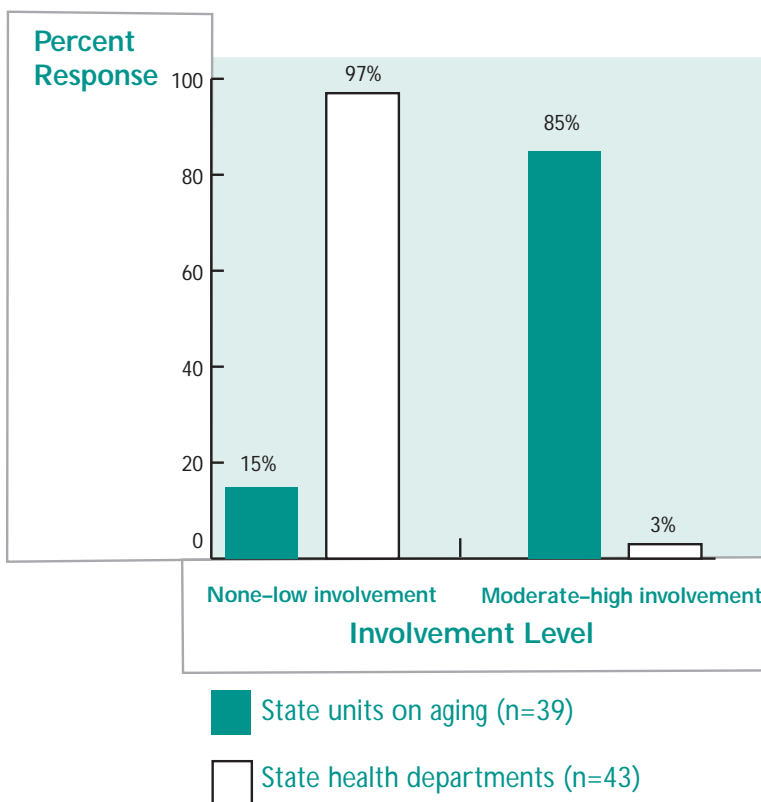
Transportation is a community support service that SUAs provide with OAA funding, while SHDs generally do not provide or fund transportation.

Prescription drug access/coverage is the issue most frequently identified as having high visibility within states. The majority of SUAs and SHDs (SUA 59%, SHD 58%) identified prescription drug access/coverage as an urgent, hot-button issue (data not shown)<sup>iv</sup>. This coincides closely with the identification of prescription drug access/coverage as a top health issue (see Exhibit 5) and one in which many SUAs, but few SHDs, have moderate to high levels of program involvement (see Exhibit 6). Prescription drug access/coverage also appear to be one of the few issues in which program involvement is based on state, rather than federal, funding.

**Exhibit 10:** Perceptions of transportation in relation to the health needs of older adults, by state units on aging and state health departments



**Exhibit 11:** Level of programmatic involvement in transportation for older adults, by state units on aging and state health departments



<sup>i</sup> Question 15 of needs assessment.

<sup>ii</sup> States were asked to identify main barriers to promoting health for older adults from a fixed-choice list. Funding and staffing were not included as options.

<sup>iii</sup> Questions 1, 19, and 15 of needs assessment.

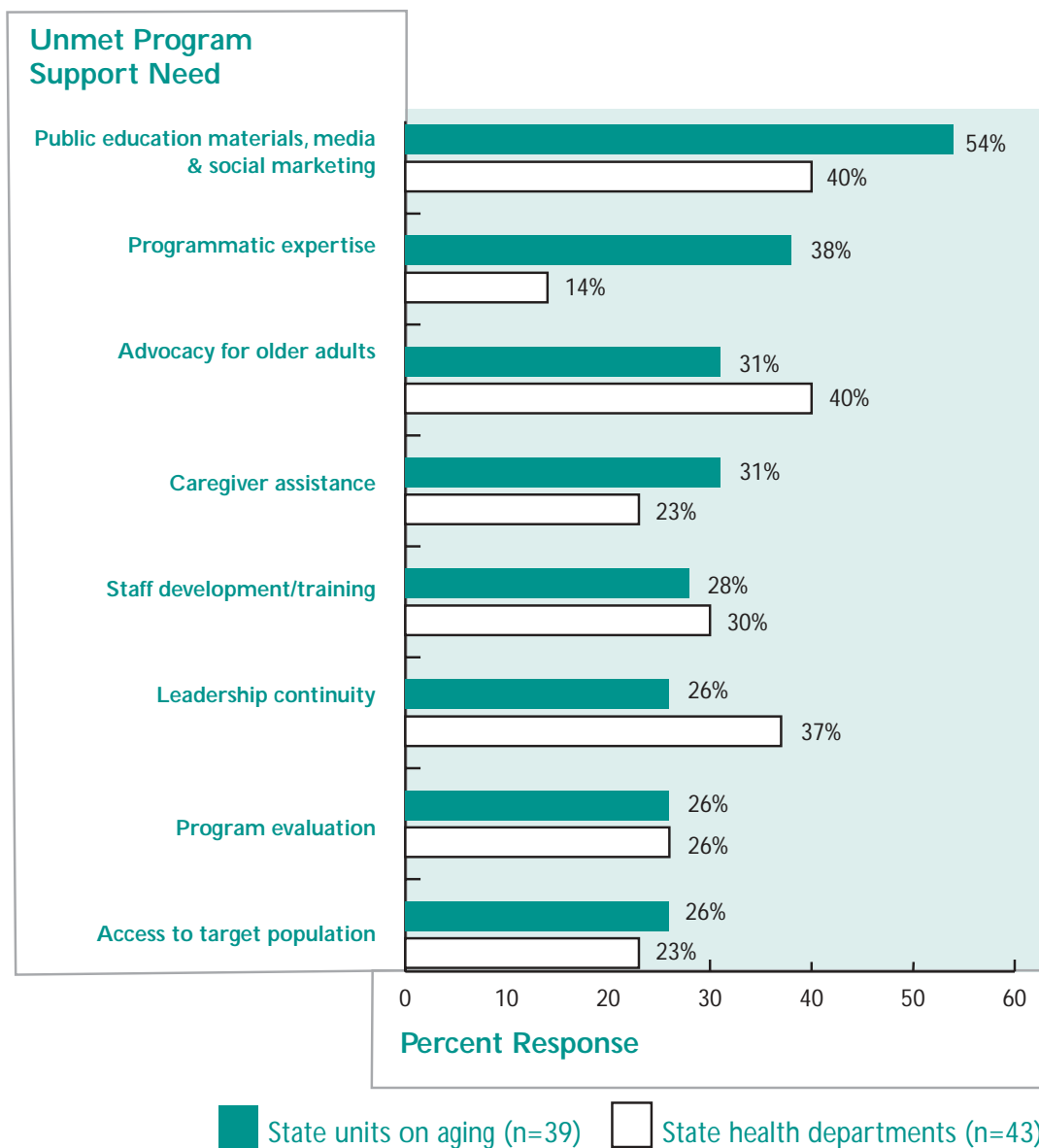
<sup>iv</sup> Question 28/29 of needs assessment.

## Program support needs

Public education materials, media, and social marketing were identified by both SUAs and SHDs as their top unmet program support needs (Exhibit 12)<sup>i</sup>. SHDs also frequently selected advocacy for older adults (SUA 31%, SHD 40%) and leadership continuity (SUA 26%, SHD 37%) as top unmet needs, while SUAs identified programmatic expertise as their second most frequent program support need (SUA 38%, SHD 14%). Almost one-third of SUAs and SHDs also cited the need for staff development/training (SUA 28%, SHD 30%).

SUAs and SHDs want additional information about best practices, particularly in risk reduction and chronic disease, to more effectively address the health promotion and disease prevention needs of older adults (data not shown)<sup>ii</sup>. Most frequently mentioned by both SUAs and SHDs was a need for best practices in risk reduction/behavior change, including physical activity, nutrition, and weight control (SUA 36%, SHD 59%). More than a quarter of respondents also asked to see best practices developed in chronic disease prevention and control (SUA 25%, SHD 31%), with cardiovascular disease and diabetes

**Exhibit 12:** Unmet program support need, by state units on aging and state health departments



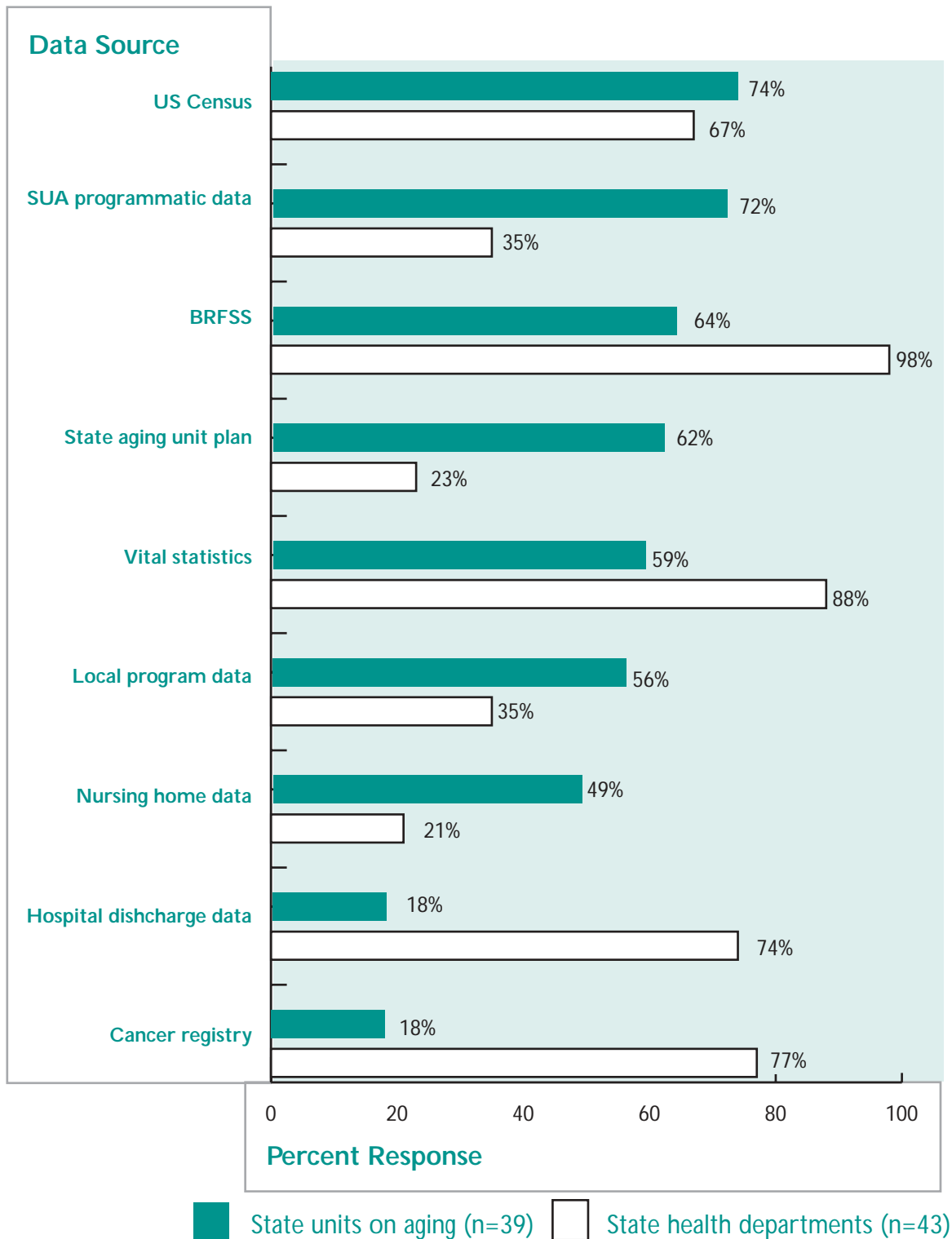
<sup>i</sup> Question 17 of needs assessment. Funding and staffing were not included as response options, since these were already known to be frequently identified needs from the pilot.

<sup>ii</sup> Question 25/26 of needs assessment.

being the most commonly mentioned specific conditions. Other than the CDC's state-based Behavioral Risk Factor Surveillance System (BRFSS), which both agencies use, SUAs and SHDs generally use different data sources to identify, plan, monitor, and evaluate the health needs of older adults (Exhibit

13)<sup>i</sup>. All but one SHD and the majority of SUAs use the BRFSS (SUA 64%, SHD 98%). SUAs most frequently use U.S. Census data (SUA 74%, SHD 67%) as well as their internal programmatic data (SUA 72%, SHD 35%) for planning and evaluation. Apart from the BRFSS, SHDs

**Exhibit 13: Use of data sources, by state units on aging and state health departments**

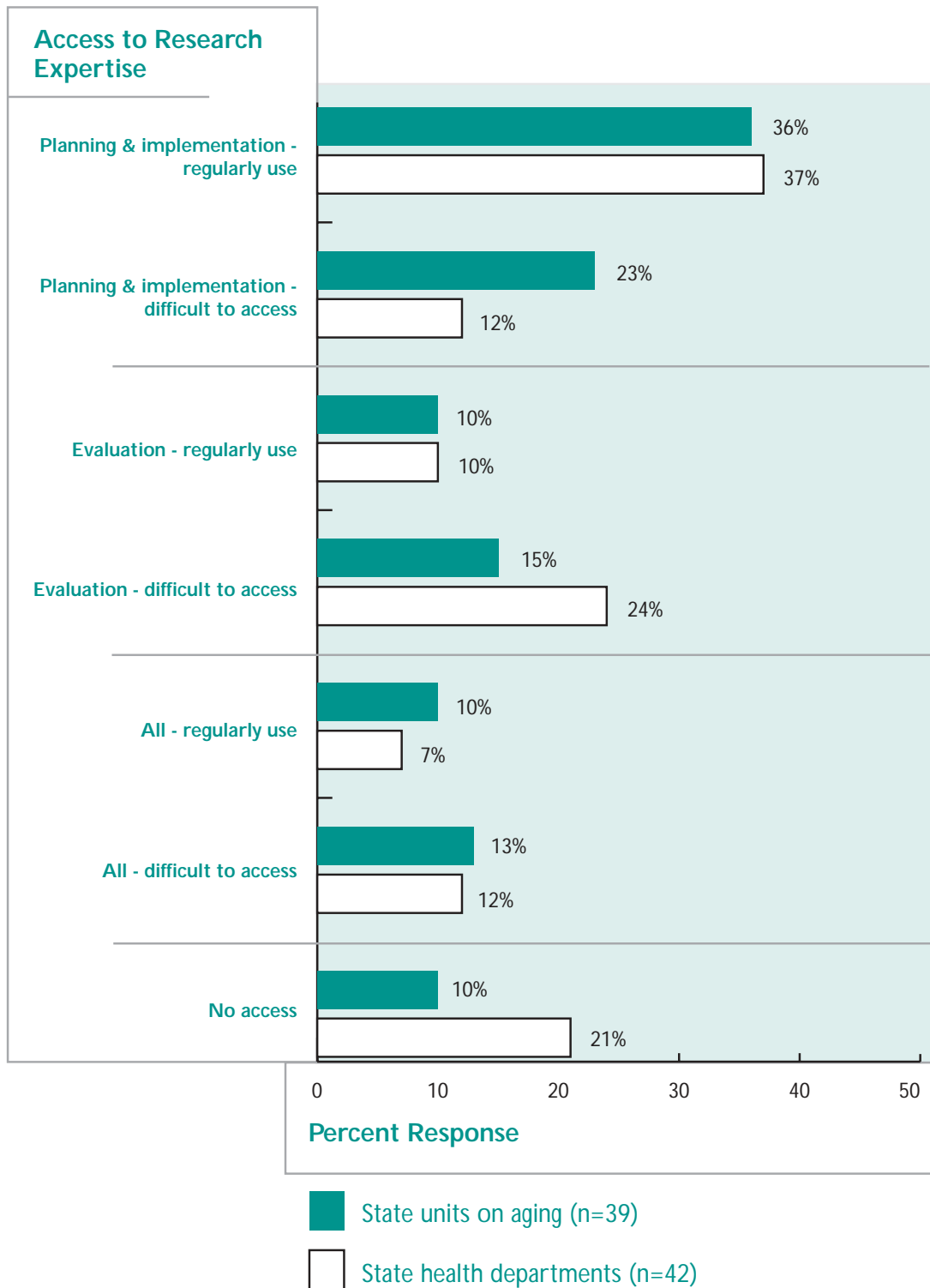


<sup>i</sup> Question 21 of needs assessment.

most often utilized vital statistics (SUA 59%, SHD 88%) and cancer registry (SUA 18%, SHD 77%) data. SHDs were also asked about their use of Administration on Aging (AoA) resources. The AoA publishes extensive

publicly available data and other resources on aging, much of which SUAs, but not SHDs, receive directly. A majority of SHDs (53%) reported using AoA resources, including its publications and Web site (data not shown)<sup>i</sup>. Twenty-eight

**Exhibit 14:** Level of access to research expertise, by state units on aging and state health departments



<sup>i</sup> Question 22 of needs assessment.

**Exhibit 15:** Collaborative activities between state units on aging and state health departments with and without health promotion/disease prevention lead

Collaborative Activity	SUA w/lead (n=29) %	SUA w/o lead (n=10) %	SHD w/lead (n=16) %	SHD w/o lead (n=27) %
Participation on committees/boards	76	90	69	44
Joint programs/activities at state level	66	70	81	30
Joint planning/development of programs	55	60	63	37
Conference attendance/planning	55	20	63	37
Joint programs/activities at community level	45	30	63	30
Advocacy	35	20	25	11
Joint grant writing	24	20	13	0
Joint training	24	10	38	4
Joint contracts	10	0	25	0
None	0	0	0	15
Don't know	0	0	0	7

percent (28%) of SHDs reported specifically using AoA data. *Most respondents do not regularly use research expertise resources for planning, implementation, and evaluation of health promotion/disease prevention programs for older adults<sup>i</sup>* (Exhibit 14). *Both SUAs and SHDs would like to receive technical assistance and training in these areas<sup>ii</sup>*. About a third of SUAs and SHDs had resources that they regularly used for program planning and implementation (SUA 36%, SHD 37%). Only ten percent of either SUAs or SHDs had resources they regularly used for program evaluation. Very few respondents reported that they had resources they regularly used for both planning/implementation and evaluation of programs (SUA, 10%, SHD 7%). In some cases, research expertise was available but difficult to access. Up to a quarter of respondents reported difficulty in gaining access to existing research expertise for program plan-

ning or implementation (SUA 23%, SHD 12%), evaluation (SUA 15%, SHD 24%), or both (SUA 13%, SHD 12%). More SHDs than SUAs reported having no access to research expertise for health promotion programming for older adults (SUA 10%, SHD 21%). The most frequently requested areas of need for training and technical assistance were program planning, needs assessment, and evaluation (SUA 42%, SHD 59%) (data not shown).

### Collaboration between state units on aging and state health departments

*Most SUAs and SHDs collaborate to some extent with their counterpart agency* (Exhibit 15). The types of interagency collaboration most often identified were participation on committees/boards (SUA 79%, SHD 53%), joint programs/activities at the state level (SUA 67%, SHD 49%),

<sup>i</sup> Question 23/24, 22/23 of needs assessment.

<sup>ii</sup> Questions 8 and 9 of needs assessment.

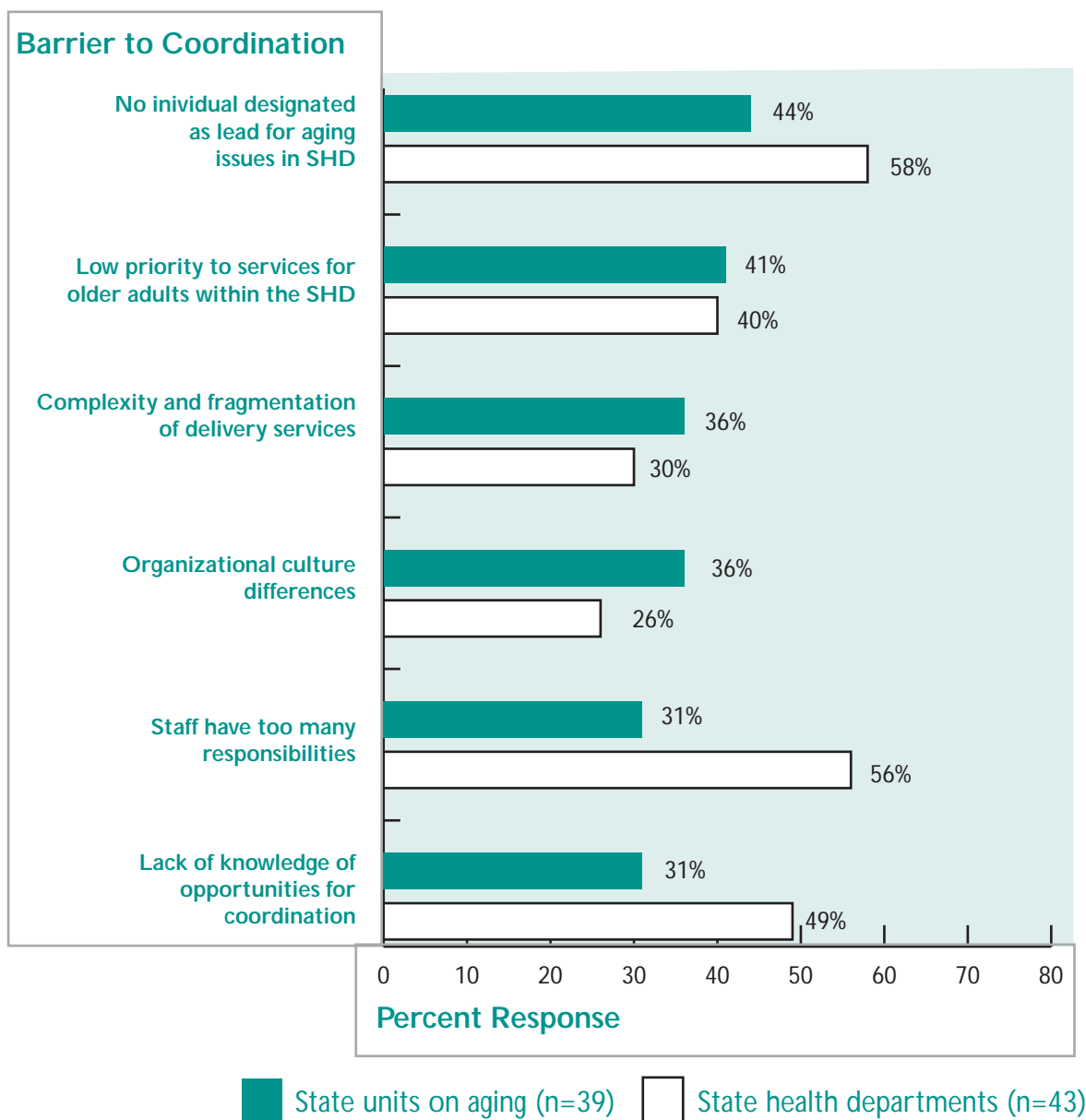
and joint planning/development of programs (SUA 56%, SHD 47%). SUAs reported a broader range of collaborative activities with SHDs, indicating collaborations with more diverse organizational units within SHDs than was reported by the counterpart SHD respondent. About a quarter of respondents collaborate in some activity at least monthly (SUA 33%, SHD 24%) (data not shown).

*A major barrier to coordination is the lack of a designated lead unit or person for health promotion/disease prevention for older adults.*

SUAs were twice as likely to have a designated lead unit or staff as were SHDs (data not shown) (SUA 74%, SHD 37%)<sup>i</sup>. Those SHDs with a lead unit or person collaborated with their counterpart more frequently and around a broader scope of activities than those without a designated lead. For SUAs, the presence of a lead unit or person increased the frequency, but not the scope, of collaboration.

Both SUAs and SHDs identified the lack of an SHD-designated lead individual for health promotion/disease prevention

**Exhibit 16:** Barriers to coordination with counterpart, by state units on aging and state health departments



<sup>i</sup> Question 2 of needs assessment.

for older adults as an important barrier to collaboration (SUA 44%, SHD 58%) (Exhibit 16). A majority of SHDs also identified that staff having too many responsibilities was a barrier (SUA 31%, SHD 56%).

*Respondents frequently do not agree on which agency has the lead responsibility within the state for health promotion and disease prevention for older adults (data not shown)<sup>i</sup>.* SUAs most frequently stated that the responsibility was shared (SUA 44%, SHD 21%), while SHDs more often stated SUAs had the lead responsibility (SUA 18%, SHD 40%). Only six (19%) of the 31 matched-pair states had internally consistent answers on lead responsibility, indicating a lack of clearly defined roles to promote healthy aging.

*Most states do not have a formal plan for health promotion and disease prevention for older adults (data not shown)<sup>ii</sup>.* Almost half the SUAs but very few SHDs reported having a formal plan (SUA 44%, SHD 9%). Those SHDs with a formal plan all had a designated lead unit or person for older adult health. Some respondents without a formal plan reported other levels of planning activity. About a quarter had identified goals, objectives, and priorities for older adults (SUA 26%, SHD 23%). The majority of SHDs did not have either a formal plan or any other planning activities for health promotion/disease prevention for older adults (SUA 20%, SHD 51%).

*A majority of both SUAs and SHDs (SUA 74%, SHD 57%) see the aging services network and its infrastructure as strengths of the SUAs (data not shown)<sup>iii</sup>.* Through this network, a wide range of health and social services for older adults is available in nearly every community nationwide. Although SHD strengths were not as clearly defined, both respondent groups frequently identified SHDs as having strength in health programming, including needs assessment, program development, and evaluation (SUA 35%, SHD 32%). About a third of respondents also identified collaborations and partnerships as a strength for both their own agency (SUA 31%, SHD 36%) and their counterpart agency (SUA 29%, SHD 30%).

*Both agencies involve external partners in their health promotion and disease prevention activities (data not shown)<sup>iv</sup>.* Senior centers (SUA 95%, SHD 84%) and local health departments (SUA 59%, SHD 79%) were identified as partners by a majority of both SUA and SHD respondents. Common private sector partners included numerous nonprofit organizations dedicated to specific diseases, such as the Arthritis Foundation (SUA 44%, SHD 91%) and the Alzheimer's Association (SUA 77%, SHD 37%).

SHDs and SUAs differed somewhat in their identification of public partners, consistent with their different priorities. While SHDs named state Peer Review Organizations—now known as Quality Improvement Organizations (QIOs)—most frequently (SUA 49%, SHD 60%), SUAs most frequently named their state departments of mental health (SUA 62%, SHD 37%). QIOs are state-based organizations designated by the federal Centers for Medicare and Medicaid Services to oversee the quality and utilization of services for Medicare beneficiaries. Their priorities include several preventive health areas in which they collaborate with SHDs, including mammography screening, immunization, diabetes, and cardiovascular disease. For SUAs, their mandate to provide community support services involves assisting many older adults with mental illness. Local aging network service providers such as senior housing, senior centers, and case management programs anecdotally report that coordinating services for these clients is time-consuming and difficult. Grassroots efforts in a number of states have resulted in coalitions between aging and mental health at both local and state levels to begin to develop programs and policies to assist this population. A number of national organizations, including the National Coalition on Mental Health and Aging, have provided an impetus to develop stronger partnerships between SUAs and state mental health departments.

Other common public partners for both SUAs and SHDs included state agriculture departments (SUA 54%, SHD 49%), which administer the senior farmers' market nutrition programs, and state Medicaid agencies (SUA 49%, SHD 47%).

## Funding

*Funding sources drive priorities in SUAs and SHDs.* SUAs are funded through the Older Americans Act, Title III-D (see Appendix D for statute) specifically to carry out health promotion and disease prevention activities, which are traditional strengths of the public health system. SUAs can choose how to use Title III-D funds from a menu of possible options. The most frequently reported uses are for health screenings (56%) and physical fitness/exercise programs (51%) (data not shown)<sup>v</sup>. SHD programs are similarly driven by their funding sources. SHDs obtain funding for health promotion and disease prevention programs from federal sources such as CDC's disease-focused cooperative agreements (72%) and Preventive Health and Health Services Block Grants (65%)<sup>vi</sup> (Exhibit 17). Cooperative agreements are generally categorical; that is, they address a

<sup>i</sup> Question 4 of needs assessment.

<sup>ii</sup> Question 3 of needs assessment.

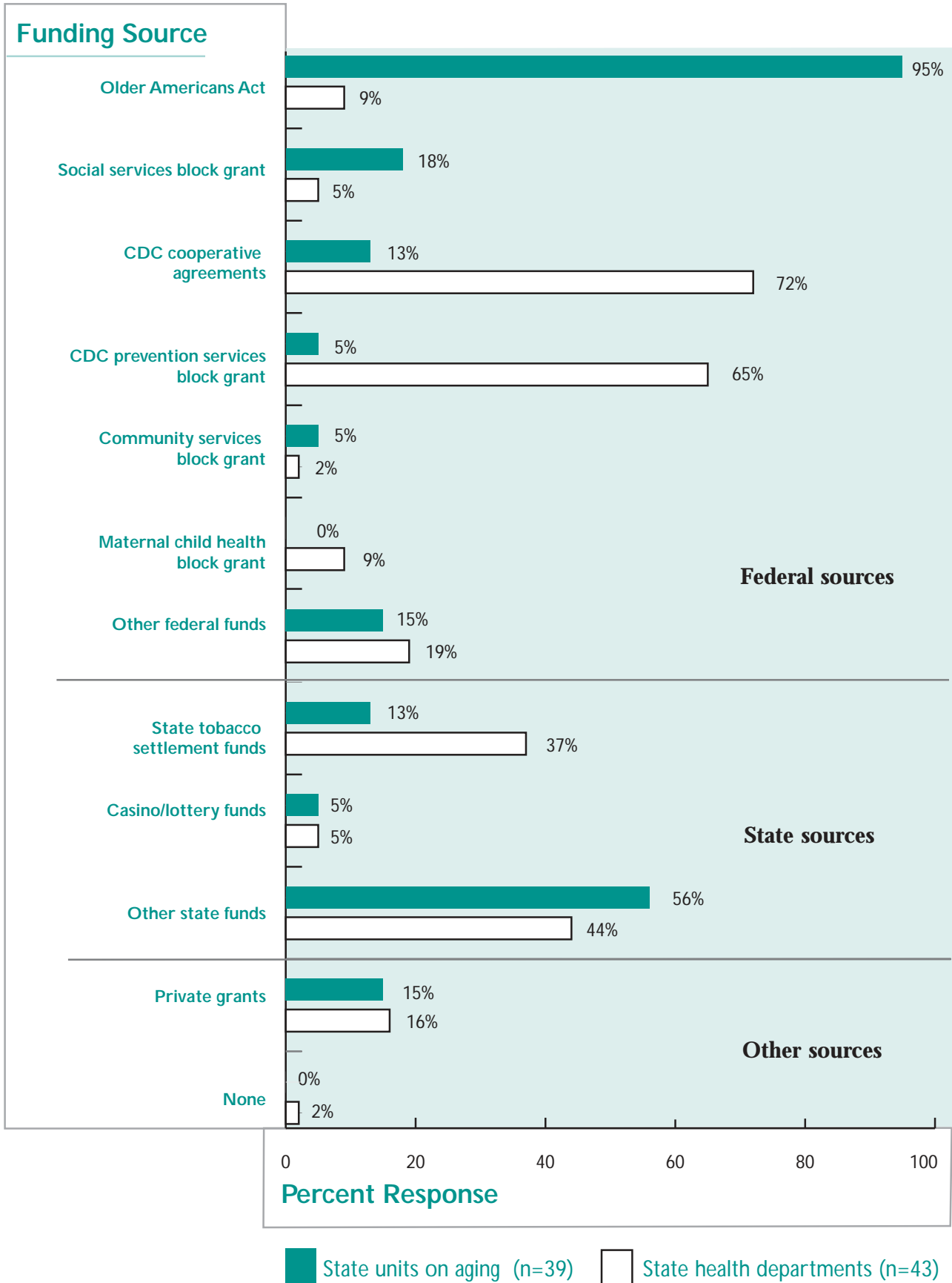
<sup>iii</sup> Questions 10 and 11 of needs assessment.

<sup>iv</sup> Questions 5 and 6 of needs assessment.

<sup>v</sup> Question 13 (SUA) of needs assessment.

<sup>vi</sup> Question 16 of needs assessment.

**Exhibit 17:** Funding sources for health promotion for older adults, by state units on aging and state health departments





specific disease or public health issue. Neither of these public health funding sources requires older adults to be a priority population. SUAs generally do not qualify for cooperative agreement funds, which are restricted to SHDs. Both SUAs and SHDs received state funding, including state tobacco settlement funds.

*Fifty percent of SHDs are not familiar with Title III-D of the Older Americans Act (data not shown)<sup>i</sup>. An additional 37% did not know what type of involvement their health department had with Title III-D funding. About a fifth of SHDs (19%) reported participating in health promotion activities funded through Title III-D, such as conferences and training (data not shown)<sup>ii</sup>.*

*If additional monies were made available for health promotion for older adults, SUAs and SHDs would like the funding to address chronic disease prevention/control and risk reduction/behavior change (data not shown)<sup>iii</sup>. The majority of SUAs and SHDs selected risk reduction (SUA 61%, SHD 74%), with an emphasis on physical activity and nutrition. Almost half of respondents also selected the area of chronic disease (SUA 45%, SHD 43%), with cardiovascular disease being the most common specific health problem mentioned as needing additional funding. Many SUAs also identified mental and behavioral health as funding needs (SUA 39%, SHD 21%).*

## Promising programs

SUAs and SHDs were asked to provide examples, with brief descriptions, of *success stories<sup>iv</sup>* and *best practices<sup>v</sup>* in health promotion/disease prevention for older adults. A best practice was defined as being evidence-based, and respondents were asked to describe how they evaluated outcomes. SUAs and SHDs described a wide variety of programs, sometimes referencing the same program as both a success story and best practice. Few, however, stated specific outcomes or described an evaluation process. Some SUAs and SHDs from the same state described the same program. For this reason, the program types discussed below are based on the total number of responding states/territories (n= 51), rather than by type of state agency.

Seventeen states provided descriptions of physical activity programs. These were primarily walking and/or resistance training programs for the general population of older adults. Several programs targeted adults with general or specific disabilities, such as arthritis. Other programs mentioned with some frequency were osteoporosis screening, education, or awareness (ten states); immunization (seven states); medication management or access (six states); and fall or injury prevention (four states).

Programs that appeared to have evaluation components and that represented a cross-section of disease prevention and health promotion areas were contacted to collect additional information. Eight of these programs, representing a diversity of approaches, are described in the section entitled *Case Studies: Promising Programs*. These programs demonstrate that SUAs and SHDs are in fact addressing health promotion and disease prevention for older adults. Their efforts cut across diverse areas of health programming, including physical activity, fall prevention, immunization campaigns, health screening, disease management, and community provider training. Some programs are well funded while others started on a “shoestring.” Some have weathered state budget cuts, agency re-organizations, and mergers. More than one has faced an uncertain future in difficult fiscal times.

A common theme is the importance of collaboration in the successful development and maintenance of programs. One program is an explicit SHD-SUA collaboration. Others are local-level collaborations that include health departments, AAAs, hospitals, community service providers, and academic institutions.

These promising programs are presented to stimulate other SHDs and SUAs to consider partnerships and opportunities available in their states to develop similar programs. The experiences of the eight programs in *Case Studies: Promising Programs* demonstrate that there are many ways to begin to address the health promotion needs of older adults and many ways to structure effective collaborations that can result in successful programs.

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<sup>i</sup> Question 13 (SHD) of needs assessment.

<sup>ii</sup> Question 14 of needs assessment.

<sup>iii</sup> Question 18 of needs assessment.

<sup>iv</sup> Question 20 of needs assessment.

<sup>v</sup> Question 24/25 of needs assessment.

## Discussion

### Responding to the health needs of older adults

Most SUAs and SHDs recognized that chronic diseases are major health problems affecting older adults. In particular, cardiovascular disease (CVD), the leading cause of mortality among older adults, was the most common health problem identified by both SUAs and SHDs. However, the level of involvement in CVD programs was low for both agencies, with only six SHDs indicating that they currently have funding for comprehensive CVD programs.

This finding is consistent with the limited availability of federal or state funding for state CVD programs. Nationally, only 19 SHDs have CDC planning grants, which focus on policy and environmental approaches to CVD reduction. SHD involvement in this important health issue will likely increase in the future. However, SHDs are not currently mandated to collaborate with SUAs in these program-planning efforts or to target the older adult population.

SHDs reported moderate to high involvement in programming for several other chronic diseases. Most SHDs, for example, reported moderate to high involvement in breast cancer programs, a CDC-funded initiative in every state. This response may reflect the recent increased efforts by SHDs to deliver breast cancer screening services to women over age 50. More than half of SHDs also had moderate to high involvement in diabetes and arthritis programs—two areas funded by the CDC through cooperative agreements with selected states. Almost half of responding SUAs also had moderate to high involvement in arthritis programs. Although arthritis programs are not specifically referenced in the OAA, the aging services network serves many older adults with this condition through home care, case management, health promotion, transportation, and other community services. It is also possible that SUAs are collaborating with SHDs or local Arthritis Foundation chapters in their arthritis programming.

Many respondents identified the reduction of risk factors for chronic disease, particularly physical activity and nutrition, as top health concerns. More SUAs than SHDs reported moderate to high levels of involvement in risk reduction programs, with the exception that SHDs were somewhat more involved in obesity programs. The higher level of SUA involvement in nutrition probably reflects the extensive congregate and home-delivered nutrition programs funded through the OAA. Their higher level of involvement in physical activity coincides with the reported use of Title III-D health promotion programs on physical fitness and exercise by a majority of SUAs.

Tobacco use was rarely mentioned as a top health issue, despite its major contribution to cardiovascular disease and cancer. It is possible that tobacco prevention and cessation programs are not a priority per se, but may be a component, for example, of broader cardiovascular health programs. A lower prevalence of tobacco use among older adults may also help to explain this finding.

In addition to chronic disease and underlying risk factors, many SUAs and SHDs identified access to prescription medications and mental health services as top health issues for older adults. These important issues, which can affect overall health status, have received increased public attention in the past several years. Access to prescription medication was noted by both SUAs and SHDs to be the most common urgent, hot button issue receiving public attention in their states. While most SUAs reported moderate to high involvement levels in medication access programs, most SHDs did not. It may be that many state-funded programs that provide

coverage for prescription drugs are administered by SUAs and do not involve SHDs. Similarly, a majority of SUAs but few SHDs were involved at a moderate to high level in some aspect of mental health programming. SHDs may have valuable, untapped resources and capacity to contribute in addressing these health issues.

As expected, SHD efforts are less focused on older adults than are those of SUAs. For both agencies, levels of program-specific involvement appear to be dictated largely by current federal funding opportunities. SHDs rely primarily on limited CDC funding that is awarded on a competitive and often disease-specific basis to a limited number of states to support disease prevention and health promotion programming. This more limited funding likely impairs their ability to address healthy aging more broadly.

SUAs have high levels of involvement in programs that are funded through the Older Americans Act, which disburses funding to every state and territory on a formula basis. This funding approach and the corresponding structure of the aging services network, which directly reaches almost every community in the nation, ensures high levels of statewide involvement. While these OAA programs are directed predominately at maintaining the independence of older adults in the community, they do not necessarily emphasize disease prevention. Because of their OAA funding and community-based involvement with direct services, SUAs identified several issues that may be key to health promotion but were not widely recognized by SHDs. For example, SUAs reported transportation as a major concern and service barrier. This suggests that efforts to improve health promotion and disease prevention should address transportation barriers in order to ensure access to programs.

### **Program support needs**

SUAs and SHDs agree that they need more information on best practices, as well as practical assistance in developing, implementing, and evaluating effective programs that protect and improve the health of older adults. This finding was supported by the limited number of programs submitted as *best practices* that had a clearly defined evidence basis.

There was no single issue that the majority of respondents identified as a barrier to promoting health among older adults. In fact, SUAs' and SHDs' perceptions of barriers appeared to differ. SUAs selected individual behavior issues as barriers (such as lifestyle, consumer awareness, and perceptions of aging and illness) more frequently than health care system issues (such as lack of an organized service system

and Medicare restrictions). SHDs, conversely, selected these systemic issues more frequently. These differences may reflect their differing perspectives (e.g., services for individuals vs. population-based improvements) in approaching health issues.

No single program support need was identified by a majority of SUAs or SHDs. The most frequent needs identified by both SUAs and SHDs were public education material, media, and social marketing. Agencies may see development of skills and resources in these areas as particularly important for implementing chronic disease prevention and risk reduction programs.

Responses to questions about programmatic and data expertise yielded mixed messages. When asked about their access to and use of research expertise, fewer than half of SUAs and SHDs reported regular use of research expertise for program planning and implementation. Yet in response to another question, only about a quarter of respondents identified programmatic expertise, program evaluation, and data expertise as unmet program needs. Similarly, while few reported regular access to research expertise for program evaluation, just one-quarter of respondents selected program evaluation as an unmet program support need.

Responding to an open-ended question about technical assistance and training needs, the most frequent need, stated by almost half of all respondents, was in the general area of program planning and evaluation. About a quarter identified data and surveillance issues, and almost a third made broad statements related to needs in research or best practices.

While many SUAs and SHDs identified expertise in data, research, program implementation, and evaluation as needs, there appear to be others that, while lacking such expertise, do not perceive it as an unmet need.

### **Collaboration and organizational issues**

While most SUAs and SHDs collaborate to varying degrees with their counterpart agency, the extent of this collaboration is limited in many states. About one-half reported collaborating on the joint planning or development of programs; three-fourths of SHDs and two-thirds of SUAs reported collaborating less than once a month.

Meaningful collaborations appear to be hindered by the lack of staff specifically assigned to health promotion efforts for older adults. This limitation more frequently arises from the SHD side of the potential partnership, with only about a third of SHDs reporting a designated individual or unit. In addition to affecting cross-agency

collaborations, lack of designated staff appears to influence SHD internal planning for health promotion for older adults; only SHDs with designated staff indicated they had a formal plan.

Because SHDs do not typically have funding specifically dedicated to services and programs for older adults, the lack of a designated individual or unit is not surprising. Unfortunately, without a unit or staff person responsible for this program area, missed opportunities for collaboration and the development of more focused, funded programmatic initiatives are inevitable.

There appears to be widespread confusion about which agency in a state has lead responsibility for health promotion and disease prevention among older adults. This may hinder efforts to further develop programs since it is unclear who would take the lead role in these efforts. In general, both SUA and SHD responses shifted lead responsibility to the other agency, leaving a void in perceived leadership.

Despite these limitations, SUAs and SHDs recognize strengths in their own agencies and in their counterpart agencies that could form the core of stronger partnerships. The SUAs' lead role in the comprehensive aging services network was widely recognized, and skills in health programming were frequently mentioned for SHDs. While it may be surprising that SHDs were not widely recognized as having expertise in chronic disease prevention and control, this gap may be due to their acknowledged lack of activity specifically for older adults in this area.

## Funding

As noted above, funding availability drives program priorities for both SUAs and SHDs. The categorical nature of funding for chronic disease prevention and control, in particular, may force SHD programs to be more narrow than is desirable for a broad risk reduction approach that addresses older adults. Given the limited funds available for chronic disease prevention and control efforts, as well as the lack of any specific requirement to target older adults, SHDs usually do not include this population in their programmatic initiatives.

Several SUAs stated in narrative comments that they would like to be eligible to apply directly for CDC chronic disease funding to address the needs of their target population. Such flexibility in funding criteria, as well as enhanced SUA-SHD collaborations, could improve the ability of existing programs to address healthy aging. Increased funding would allow states to expand and more directly affect health promotion and disease prevention for older adults.

## Summary

The results of the Aging States Project needs assessment indicate that state units on aging and state health departments have very similar perspectives on a variety of issues. For example, they identify the same top health needs of older adults, although their programs to address these needs differ, consistent with their policy priorities, funding mandates and histories. The unique areas emphasized in programs conducted by public health departments and state units on aging may also influence differences in how barriers to promoting health are assessed and how program support needs are identified.

SUAs and SHDs each recognize strengths in their counterpart agencies. These strengths are often complementary to identified needs and are potential resources. However, SUA-SHD coordination and collaboration is limited in many states and may restrict the opportunity to develop shared resources. A major barrier to collaboration, particularly for SHDs, is the lack of staff specifically assigned to health promotion for older adults. The results also indicate that there is a particular need for information and assistance in the development of science-based programs in the area of health promotion for older adults. Finally, there is limited availability of funding that specifically targets health promotion and disease prevention for older adults, which may impose constraints on states' abilities to develop comprehensive healthy aging initiatives.

## Next Steps

These results point to a range of possible interventions to improve the capacity of SUAs and SHDs to address the health promotion and disease prevention needs of older adults. NASUA and CDD, together with the Ad Hoc Health and Aging Advisory Committee, developed the recommendations in the following section as next steps in this effort.

These recommendations identify a range of activities and initiatives that are intended to promote collaboration and coordination across agencies and to support the further development of effective health promotion and disease prevention programs for older adults. Recommendations are addressed to public agencies at both the federal and state level as well as to NASUA and CDD, as partners in this project.

Our hope is that the results and recommendations of the Aging States Project will be useful tools for stakeholders to help advance our collective efforts to improve the health of older Americans.

## Recommendations to Improve the Health of Older Adults

### For the Centers for Disease Control and Prevention (CDC) and the Administration on Aging (AoA)

#### ***Promote improved collaboration between state health departments and state units on aging:***

- Support active networking among state health departments and state units on aging around older adult health issues, e.g., through list-serves, conference calls, regional networking meetings and national conferences.
- Reward evidence of inter-agency collaboration between state units on aging and state health departments in competitively funded programs.
- Encourage state units on aging to involve state health departments in planning, implementing, and evaluating health promotion/disease prevention programs for older adults.
- Encourage state health departments to involve state units on aging in planning, implementing, and evaluating projects and programs that target older adults.
- Support development of state healthy aging plans that are jointly developed by state units on aging and state health departments.

#### ***Support health promotion/disease prevention programs for older adults:***

- Develop the scientific evidence needed to determine the most effective approaches to health promotion/disease prevention programs for older adults.
- Develop mechanisms to disseminate and promote “best practices” and effective and innovative program models.
- Reward applicants that can document an evidence base in competitively funded programs.
- Provide technical assistance and support to conduct rigorous evaluations of promising programs.
- Develop and promote data standards and guidelines to encourage shared program planning and evaluation.
- Assure that current and future funded programs address older adults and draw on strengths and outreach capabilities of the aging and public health networks.

#### ***Provide needed training and technical assistance:***

- Develop training materials for use at the state level to achieve visibility for healthy aging issues.
- Develop and promote training materials and educational opportunities for practitioners about evidence-based health promotion and disease prevention strategies for older adults.
- Provide technical assistance and support to replicate, adapt, and evaluate successful evidence-based health promotion/disease prevention programs.

## **For State Health Departments and State Units on Aging**

### ***Promote collaboration and communication across agencies:***

- Designate a “point person” for communication with the counterpart agency around health promotion/disease prevention for older adults.
- Clarify state organizational relationships related to lead roles and joint planning for healthy aging programs.
- Enlist health department collaboration in the design, implementation and evaluation of state unit on aging programs.
- Enlist state unit on aging assistance in the design, implementation and evaluation of health department programs for older adults.
- Include a focus on older adults in all appropriate health promotion and disease prevention initiatives directed by the state health department.
- Foster development and expansion of community-level partnerships between area agencies on aging, local public health departments, and their respective provider organizations.
- Share available data and analytic resources.

### ***Support health promotion/disease prevention programs for older adults:***

- Assure current and future programs use evidence-based interventions and evaluations where available.
- Enlist state health department collaboration in the use of Older Americans Act Title III-D (disease prevention/health promotion) funding within the state unit on aging.
- Enlist state unit on aging collaboration in the use of funds for chronic disease prevention and control activities within the state health department.
- Jointly seek additional funds for new collaborative initiatives targeting older adults.

### ***Provide needed training:***

- Provide and promote participation in training opportunities related to healthy aging for both the aging and public health networks.

## **For the Association of State and Territorial Chronic Disease Program Directors (ASTCDPD) and the National Association of State Units on Aging (NASUA)**

### ***Promote collaboration and communication:***

- Continue the associations’ collaborative activities at the national level to enhance relationships and partnerships between state units on aging and state health departments.

### ***Support health promotion/disease prevention programs for older adults:***

- Explore legislative changes that would ensure the inclusion of older adults as a priority target population in relevant health promotion/disease prevention programs.
- Identify new opportunities to gain support for resources that enhance healthy aging.

## Promising Programs: Case Studies

### California Department of Health Services *Preventive Health Care for the Aging Program*

#### Project Description

Preventive Health Care for the Aging (PHCA) was first enacted and funded by the California State Assembly in 1975 to provide preventive health services for seniors. Over the last 25-plus years, the program has expanded and developed to meet the preventive health needs of California's older adults, ages 55 and over. PHCA's goals are to promote healthy lifestyles, increase access to health services, and to improve quality of life. Its major objectives include assisting older adults in managing chronic health conditions and promoting healthy behaviors.

The core service of PHCA is a comprehensive individual assessment and development of a health plan conducted by a public health nurse. The assessment includes a health history, assessment of physical activity and nutritional status, and basic physical screening tests. The individualized health plan is a written, signed contract, jointly developed by the nurse and client, that reflects the client's commitment to take steps to improve his or her health. Steps may include behavior change, scheduling medical or other care, and seeking other needed community services. Follow-up visits are scheduled to check progress and to provide focused health education or counseling as indicated by the assessment and plan. While program outreach is directed at seniors who are under-served, low-income, and ethnically diverse, all seniors may receive services and participate. PHCA services are offered free of charge. In some locations, small fees or donations are requested for special laboratory screening tests.

The Department of Health Services contracts with 16 county and city health departments, covering about one-third of California, to implement PHCA. The state allocates approximately \$1.2 million to PHCA (fiscal year 2002) and requires that participating health departments provide at least a 50% match of funds or in-kind services for implementation. Public health nurses from the health departments conduct assessments and visits in a variety of community settings, including senior centers, congregate meal sites, senior housing complexes, and churches.

In addition to individual client services, PHCA nurses

provide an array of broader community-based services. For example, they typically conduct lectures and write articles for local senior publications on issues such as fall prevention, osteoporosis, and medication management. They work to improve the quality of life for seniors while collaborating with local aging networks and commissions. PHCA collaborates closely with local AAAs in referring clients to service programs and in sponsoring health fairs and educational events. All but one PHCA program is contracted and managed by the local public health department; the other is managed by the local AAA.

PHCA reaches a broad cross-section of California elders. Almost half (47%) are more than 75 years old, 62% live in rural areas, 59% are low-income, and 29% are minorities (with Hispanic clients being the predominant group). One-third have more than six chronic conditions, with cardiovascular disease (54%) and arthritis (48%) being the most commonly reported chronic conditions.

In fiscal year 2000, PHCA nurses served more than 8900 clients, with an average of 1.8 visits per client. More than 5200 medical referrals were made, of which 64% resulted in a new diagnosis or treatment.

#### Lessons Learned

PHCA has incorporated process and outcome evaluation into its program model to improve its efficacy. Among the range of research that has been done, a 1995 study found that a written, signed health plan significantly increased the likelihood of client behavior change. This component is now a standard part of PHCA assessments. Thirteen Healthy People 2010 objectives are now being tracked using computerized encounter forms.

Effective outreach has been the key to the success of PHCA in identifying under-served older adults. Each local health department uses multi-lingual outreach workers and senior volunteers who are familiar with their communities' older adult populations.

#### Contact

Laurie Vazquez, Chief  
PHCA Program  
California Department of Health Services  
601 North 7th St., MS-253  
P.O. Box 942732  
Sacramento, CA 94234-7320  
(P) 916-324-1323  
(F) 916-445-7100  
lvazquez@dhs.ca.gov

## Delaware Division of Services for Aging and Adults with Physical Disabilities

### Millennium March to Wellness

#### Project Description

The Millennium March to Wellness is a comprehensive wellness initiative for older adults begun in 1999 by the Division of Services for Aging and Adults with Physical Disabilities. In developing the project as a specific health promotion effort for older adults, the Division took its guidance from the national Healthy People 2010 and Healthy Delaware 2010 plans. The major objectives of the Millennium March to Wellness are to encourage older adults to increase physical activity, to increase their consumption of fruits and vegetables, and to adopt health-sustaining behaviors and lifestyles. Its major components are described below.

1. Walk Delaware promotes physical activity by challenging older adults to walk the equivalent of the length (96 miles) or width (35 miles) of Delaware during one year.

– In Walk Delaware’s initial stages, the Division sponsored a kick-off event for organizations in the state’s aging network to develop an advisory council and seek partners in forming local walking groups and promoting the program. This was a critical and successful outreach effort that led to multiple partnerships that have contributed to the growth and success of the project. The Division then kept in touch with its partners through monthly correspondence as the Millennium March developed.

– The Delaware Senior Olympics adopted Walk Delaware as their major non-competitive effort to promote physical activity. The Senior Olympics recently applied for and received a Healthy Delaware 2010 mini-grant from the SHD to continue its development of walking groups.

– Many additional partners, including local senior centers, also promote the program and have developed walking groups. The Division provides training to community partners.

– The Division developed and distributed a free Walking Logbook for participants to use to record their progress. Participants are asked to complete a registration form with basic demographic data prior to receiving a logbook.

– The Division developed *First State Fitness Certificates*, which are awarded to everyone who sends in a completed logbook documenting their achievement in walking the prescribed distance.

In 2000, more than 500 individuals registered for Walk Delaware and approximately 300 certificates were award-

ed. Some participants in their 80s and 90s have sent in walking logs to receive certificates for the past three years. Many people send in logs that record walking hundreds of miles each year.

2. *5 a Day for Better Health* is the Division’s effort to implement the national *5 a Day* program to increase consumption of fruits and vegetables and to focus on nutrition education for older adults. The Division is currently sponsoring a pilot program to increase fruit and vegetable consumption at Title III congregate and home delivery meal programs. A nutritionist and diabetes educator have developed an education module based on the stages of change model. The module was presented at a quarterly Title III directors’ meeting this fall, and they were asked to use it as their required quarterly consumer nutrition education program. The Division is currently evaluating its impact on two levels: a) its usefulness for nutrition education, and b) whether the intervention resulted in changes in participant eating habits. If the evaluation shows positive outcomes, they hope to replicate it statewide.

The overall budget within the Division for health promotion is about \$80,000 annually, all OAA Title III-D funds. The start-up costs for Walk Delaware were about \$20,000. This included developing and printing the logs and certificates, and bringing in outside experts for guidance. The public health educator, who oversees the Division’s health promotion program, is paid with state funds.

#### Next steps

The Division is now using the registration forms and completed logbooks to develop a participant database, and has contracted with the University of Delaware to develop an evaluation component examining health outcomes and quality of life measures for participants.

The Division is also developing a five-year strategic plan for its health promotion programs in conjunction with the University of Delaware, the Senior Olympics, the Governor’s Council on Physical Activity, the Department of Health and Social Services, and input from its community partners. With the success of the Millennium’s efforts in the past two years as a base, the Division hopes to increase its health promotion infrastructure, to widen its range of physical activity programs, and to incorporate into their initiatives greater focus on adults with physical disabilities.

#### Lessons learned

– The Division found that developing and sustaining key community partnerships has been critical to the success of



the Millennium March to Wellness.

– The sustainability of the project was an initial consideration that has proven to be important, as the March to Wellness has become a base upon which additional projects can be built.

– Division staff acknowledge that, in retrospect, it would have been preferable to involve experts in outcomes and evaluation earlier in the development of the project.

**Contact:**

Chris Oakes, Public Health Educator  
Delaware Division of Services for Aging  
and Adults with Physical Disabilities  
(P) 302-577-4791, x 53  
(F) 302-577-5793  
coakes@state.de.us  
Web site: <http://www.dsaapd.com>

## Maine Bureau of Elder and Adult Services *A Matter of Balance*

### Project Description

In 2000, the Maine Bureau of Elder and Adult Services (BEAS) was contacted by its sister agency, the Bureau of Health (BoH), to request assistance in developing a collaborative response to a CDC grant program announcement for a fall and fire prevention program. Recognizing that these are two significant issues for the older adult population that it serves, BEAS readily agreed, and the two agencies jointly developed and submitted the grant proposal.

In the course of researching fall prevention programs for the CDC application, BEAS and BoH learned that an evidence-based curriculum, *A Matter of Balance*, was already in use in several counties in southern Maine. This curriculum, developed at Boston University's Roybal Center for the Enhancement of Late-Life Function, had been purchased by a major health system in Maine, MaineHealth, for use in their Gerontology Program. MaineHealth, through its network of community providers, supported the implementation as part of its goal of promoting physical activity to enhance the functioning of older adults. The curriculum focuses on managing the fear of falling, developing goals for improving balance and strength, and self-evaluating risk

factors in one's daily environment.

Although Maine did not receive a CDC grant, the process of developing the proposal had sown seeds of interest. Several of the five AAAs in Maine had expressed interest in a fall prevention program. The Bureau of Elder and Adult Services thought this was an important initiative and agreed to fund a pilot program using *A Matter of Balance*. BEAS funded three AAAs in rural northern, eastern, and western Maine (areas of the state where the curriculum was not being implemented by MaineHealth) to implement the program on a pilot basis. AAAs trained selected staff at their agencies to present the program. Seven classes have now been completed and several others are underway. BEAS' goal is to reach 250-300 older adults in this pilot phase, running through 2002.

The curriculum, which includes pre- and post-test evaluations, has been extensively evaluated for its effectiveness. Trainers re-contact participants after six months to collect data on whether they have had falls, and whether they've continued to engage in the exercises and activities taught in the program.

The costs of the program are relatively modest. A total of \$50,000 of state funds was provided to the three AAAs to pilot the program. Major costs include training time and purchase of the curriculum. Volunteers are recruited to assist with training, and collaborations have been formed with community providers such as housing, hospitals, and home health agencies. As part of the program, participants receive free exercise bands as well as safety devices such as grab bars. Volunteer handymen from the AAAs' home improvement programs install the devices. Additional resource materials related to health and safety are also offered in the form of printed handouts and videos. The program is free to participants.

At this time, BEAS is uncertain about continued funding of the program beyond the pilot stage. The AAAs report interest and potential funding from various community providers who recognize the benefit to the population they are serving as well.

**Contact:**

Doreen McDaniel, Community Program Specialist  
Bureau of Elder and Adult Services  
11 State House Station  
Augusta, ME 04333  
(P) 207-624-5335  
doreen.mcdaniel@state.me.us

## Massachusetts Department of Public Health

### Keep Moving Program

#### Project Description

Keep Moving, the name of Massachusetts' statewide walking program for older adults, is also an apt motto for the strategy used to keep a good program alive despite the ebbs and flows of public funding.

The goal of the Keep Moving Program is to improve the lives of people over age 50 by promoting physical activity to prevent and postpone chronic disease, build healthy bodies and minds, and keep individuals socially connected. The program functions through a network of about 150 local walking clubs with more than 2500 participants.

Started in 1985 as a project of the Massachusetts SUA, the Executive Office of Elder Affairs (EOEA), Keep Moving established walking clubs across the state for older adults. During funding cutbacks in the recession of the late 1980s, state support was no longer available. An ad hoc group of participants and supporters recognized the value of Keep Moving and assumed responsibility for it, staying in touch as an advisory group and doing private fundraising to sustain a part-time coordinator. The advisory committee included, and continues to include, participants from the state's aging network, business, academia, health care, the state legislature, the SUA, the SHD, and the Governor's Committee on Physical Fitness and Sports. From the late 1980s through the mid-1990s, the Keep Moving Program sustained its activities through a private funding base.

As the economy improved, opportunities for state funding arose through programs based at the Massachusetts Department of Public Health (MDPH). Massachusetts is one of relatively few SHDs with a dedicated organizational unit for older adults, the Office for Elder Health in the Division of Community Health Promotion. In 2000, EOEA and MDPH agreed that the organizational responsibility for Keep Moving should shift to this office at MDPH, while still maintaining the inter-agency collaborative nature of the program.

The core programmatic activity has remained stable throughout Keep Moving's evolution: to recruit older adults to join local walking clubs, each coordinated by a trained volunteer leader from the community, and to encourage them to take at least three 30-minute walks weekly. Most local clubs function through the auspices of a community organization such as a senior center,

housing site, municipal parks and recreation department, or church. Walkers receive a walking manual and a logbook, in which they can record their activity and progress. Each local club takes on a unique identity. Many have club names, and local sponsoring organizations frequently provide club tee shirts and other incentives. Several times a year, Keep Moving sponsors regional walks, where local clubs come together for an event. An annual statewide event brings clubs together and recognizes volunteer leaders.

Keep Moving conducts regional leader training programs throughout the year. Marketing to identify potential leaders and develop new clubs has traditionally been done through the state's aging network. In keeping with a recently developed strategic plan, Keep Moving has made several changes. It has identified target populations of older adults—communities of color and men in urban neighborhoods—who have not been adequately enrolled through previous efforts. Keep Moving has hired a part-time outreach worker and organizer, through the help of a foundation grant, to specifically establish clubs and recruit these target populations in Boston. Training also has been modified to focus on men's health issues and to meet the learning styles of a predominantly male audience.

In 2001, MDPH contracted with Tufts University to evaluate Keep Moving. Evaluators have completed an extensive survey of participating walkers and are now surveying participants in leader training programs. By contacting everyone who has completed a leader training in the past five years, they hope to learn more about what causes individuals to act on the health information gained, and what barriers keep individuals from applying the information and forming local walking clubs.

Keep Moving has an annual budget of about \$70,000 and currently receives funding from Blue Cross/Blue Shield of Massachusetts and the Robert Wood Johnson Foundation, with additional in-kind support from MDPH and the Governor's Committee on Physical Fitness and Sports. Funding supports two part-time staff, materials development and printing, special events, leadership training, and evaluation. Staff emphasize that Keep Moving has been able to exist in the past with much less funding and that walking clubs can be sustained at differing funding levels.

#### Next Steps and Lessons Learned

Now in its 17th year, Keep Moving continues to adapt and grow to meet the challenge of promoting physical fitness among older adults. Future plans for Keep Moving include the expansion of physical activity choices to encourage senior walkers to add strength, bal-

ance, and flexibility training to their walking routines. Staff identified several key issues that have contributed to past successes and that will inform future program changes:

- The importance of local infrastructure: being part of a community organization gives walking clubs invaluable support, adds resources to local activities, and sustains community-based physical activity programs.
- Targeting under-served and hard-to-reach populations is crucial to achieving overall state goals for the program, but also requires additional resources to support local leaders and community organizations.
- Identifying and training a minimum of two leaders for each club increases the sustainability of local clubs.
- Last, but not least, collaboration works. Throughout the life of Keep Moving, the SUA and SHD have collaborated—with each other and with a broad array of private partners. As one staff person put it, “We never let turf issues interfere with the value of the program to seniors.”

**Contact:**

Jan Marble, Project Coordinator  
Keep Moving Program  
Office of Elder Health  
Massachusetts Department of Public Health  
250 Washington St.  
Boston, MA 02108  
(P) 617-994-9808  
(F) 617-624-5075  
jan.marble@state.ma.us

**Missouri Department of Health and Senior Services (MDHSS)**

*The Missouri Arthritis and Osteoporosis Program*

**Project Description**

The Missouri Arthritis Program was established by the Missouri state legislature in 1984, the result of an eight-year, broad-based citizen coalition of health care professionals, policy makers, and community leaders that produced a major report on the burden of arthritis in the state. This initial grassroots effort developed out of concern for the high prevalence of arthritis among adult Missourians: 37% report having arthritis. In 1996, after the legislature enacted an osteoporosis program with similar programmatic objectives to the Arthritis Program, the two programs joined to become the

Missouri’s Arthritis and Osteoporosis Program (MAOP). The goal of MAOP is to reduce the burden of chronic disease and promote healthy aging by providing education and community-based services. The program is implemented through seven Regional Arthritis Centers (RACs), which serve as local resources for arthritis and osteoporosis professional and public education, medical referrals, and services. RACs are situated within larger hosting institutions, such as teaching hospitals, that can provide comprehensive arthritis care.

A state-level, 25-member advisory board with health professional and consumer and community representatives provides ongoing consultation to the program. Each RAC has a local advisory board, many of which have representation from the state’s aging network. RACs also partner with many local organizations that are part of the state’s aging network, including AAAs, senior centers, and independent living centers.

MAOP has developed specific, measurable objectives for increasing physical activity, decreasing the prevalence of overweight, decreasing functional limitations due to arthritis, and increasing osteoporosis counseling among menopausal women. The program uses the state’s Behavioral Risk Factor Surveillance Systems (BRFSS) to collect statewide data on these indicators. MAOP has also contracted with St. Louis University School of Public Health to conduct a program evaluation.

Funding for MAOP comes from a combination of state and federal sources, which are used to create a continuum of services. In addition to the state-specific arthritis and osteoporosis appropriations, MDHSS receives funding for arthritis from the CDC through a cooperative agreement as well as a Special Interest Project research contract. In total, MAOP receives approximately \$880,000 annually.

**Contact:**

Mary Ellen Ankeney, Manager  
Arthritis and Osteoporosis Program  
Division of Chronic Disease Prevention  
and Health Promotion  
Missouri Department of Health and Senior Services  
920 Wildwood, P.O. Box 570  
Jefferson City, MO 65102-0570  
(P) 573-522-2800

**New Jersey Department of Health and Senior**

## Services

### *Health Promotion Initiative*

#### **Project Description**

In 1997, the New Jersey Department of Health and Senior Services (NJDHSS) was contacted by the New Jersey Geriatric Education Center (NJGEC) at the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine Center for Aging to propose the formation of a collaborative relationship. The NJGEC, one of more than 40 centers funded nationally by the federal Bureau of Health Professions to provide health professional education in geriatrics, had identified a need for accessible and coordinated education to community-based service providers from both the health and aging networks.

The Health Promotion Initiative (HPI) grew out of this initial overture. HPI has two major goals: to provide training on health promotion and aging to professionals in community-based health and aging programs, and to strengthen networking and coalition-building between those same community-level health and aging networks.

The NJDHSS conducted surveys of health and aging providers to assess their training needs. This resulted in the NJGEC developing three distinct training modules in mental health, fall prevention, and medication use/misuse. In addition to curriculum development, the NJGEC is responsible for identifying expert presenters and delivering training programs across the state. NJDHSS takes the lead role in identifying counties to participate in the program and in supporting and sustaining coalition-building efforts. NJDHSS staff and the NJGEC convene a meeting of key representatives from health and aging networks, including the county office on aging, the county or municipal health department, and the county mental health office. This core group identifies which of the three curriculum modules will meet a specific need in their region, selects representatives/agencies from their counties to participate in the training, and handles the logistics of the two-day training. The program is offered free of charge to trainees and the county. Each training workshop can accommodate 30 participants, equally representative of the health and aging networks.

Training workshops are provided at the county level and targeted to address local needs. The workshops include a session featuring local experts and provide an important opportunity for networking among the trainees. These two factors are critical to the success of

the overall initiative. Trainings are two full days, held a week apart. Participants are required to attend both days. Presenters of each module are specifically qualified in the topic and may include geriatricians, psychiatrists, nurse practitioners, pharmacists, and physical therapists. Trainings are designed to be interactive, with participants learning not just from the presenters, but from each other. Opportunities for networking and learning about community resources for health and aging are structured into the session.

Participants must also agree to join an ongoing coalition that will address community needs in the topic area. Everyone receives a homework assignment on the first day to identify gaps in local resources related to the training topic. NJGEC staff collect these assignments, compile the information, and present it to the group on the next day. The information is used as the starting agenda for the first follow-up meeting of the county coalition.

Since 1998, the Health Promotion Initiative has conducted 15 trainings with more than 400 participants. Participants have included visiting nurses, social workers, mental health counselors, local health officers, senior center coordinators, and police officers. The most requested training module has been mental health.

One HPI coalition focusing on mental health selected a common depression-screening tool for all sites to use in a depression screening campaign. The NJ DHSS worked with the coalition to secure a small grant to underwrite the campaign. The coalition also developed an insert for the local paper on mental health and stress.

Another county developed a “gatekeeper” training to assist first-responders and others to recognize symptoms of mental illness, including depression, and to be aware of referral resources when they are called to a situation involving an older adult. Police officers, emergency medical technicians, and clergy were among the community participants in the training.

NJGEC is able to provide these trainings free of charge to counties and participants as part of its grant from the HRSA Bureau of Health Professions. NJGEC estimates that the cost per training is approximately \$9400. Additionally, curriculum development for the three training modules was \$10,500.

#### **Next Steps and Lessons Learned**

Pre- and post-knowledge tests that are part of the curriculum indicate that participants learn substantial new information. NJDHSS staff indicate that the coalitions that grow out of the trainings have had mixed success.

As is typical with community coalitions, they require substantial staff support to nurture and maintain. Those with a community-based individual who takes the lead are most successful. Coalitions report that small amounts of funding to support community efforts would be of benefit. The availability of mini-grants of \$5000 to \$10,000, such as the grant the coalition secured in the example above, would support their efforts to implement activities.

Ideally, HPI staff would also like to expand the range of topics on which training is offered, and to more systematically involve local health departments in the planning process. NJGEC and NJDHSS will continue to offer the trainings for at least the two remaining years of the current grant cycle.

**Contact:**

Gerry Mackenzie, Supervisor  
Older Adult Health and Wellness  
Division of Senior Affairs  
New Jersey Department of Health and Senior Services  
P.O. Box 807  
Trenton, NJ 08625  
(P) 609-943-3499  
(F) 609-943-3487  
Geraldine.Mackenzie@doh.state.nj.us

**New York State Office for the Aging  
New York State Department of Health  
Adult Immunization Campaign**

**Project Description**

Four years ago, staff from the New York State Office for the Aging (NYSOFA) and the State Department of Health (DoH) began discussions around data showing that many high-risk older adults were not receiving recommended influenza and pneumococcal vaccinations. The DoH had CDC funding for immunization campaigns and had epidemiological expertise, while NYSOFA had both the access to the aging network and the knowledge base of social gerontology that the health department required.

The Health Department contracted with NYSOFA for outreach to older adults. NYSOFA then utilized its aging network, arranging flu clinics at senior centers, adult day health programs, and senior congregate housing sites, and also promoted the campaign to providers. Flyers were distributed at elder programs. NYSOFA also developed a comprehensive flu Web site page (<http://flu.state.ny.us>) as part of its comprehensive Aging Well Web site

(<http://agingwell.state.ny.us>).

In the past two years, outreach and vaccination programs have expanded to non-traditional settings and have targeted particularly high-risk groups such as the homeless and near-homeless. Staff from both the DoH and NYSOFA conduct outreach at off-track betting sites, bus depots, and train stations. They have developed an array of promotional give-aways, including pencils and cups. They have also focused on developing successful partnerships with the faith community. Immediately following a sermon including a health message about the benefits of vaccination, state staff offer vaccination clinics in the church or synagogue hall.

NYSOFA has worked with New York's AAAs to incorporate vaccinations into their Title III-D funding. All Title III-D funds are spent on specified priorities, of which vaccination is one. If the AAA chooses this priority, it receives guidance from NYSOFA in implementing a successful program.

These coordinated efforts have been extraordinarily successful. In three years, the immunization rates for influenza and pneumonia among New York residents ages 65 and older have improved by almost 24%, to 79% in the 2000/01 flu season.

**Lessons Learned**

As in many other states, New York's SUA and SHD are separate agencies, with many inherent obstacles to collaboration. Four years ago, there was little in the way of formal joint activities, with each agency regarding the other somewhat dubiously from a distance. However, some collegial relationships did exist, and from these, a group of DoH and NYSOFA staff began to talk informally, exploring in a general way how they could work together to better address the health needs of New York's older adults.

Recognizing that relationship-building was key, staff began extending mutual invitations to gerontology forums sponsored by the SUA. As a result of these contacts and discussions, opportunities arose for joint program development on a number of disease prevention and control initiatives. Today, the two agencies collaborate closely across a broad range of programs that are improving the health of the older adults of New York.

**Contact:**

Edward J. Kramer, Assistant Director for Operations  
New York State Office for the Aging  
Two Empire State Plaza  
Albany, NY 12223  
(P) 518-474-5478  
(F) 518-473-5177  
Ed.kramer@ofa.state.ny.us

## Pennsylvania Department of Aging

### *PrimeTime Health: Peer Exercise Program Promotes Independence*

#### **Project Description**

PrimeTime Health is the umbrella statewide health promotion and disease prevention program of the Pennsylvania Department of Aging. At the initiation of PrimeTime Health in 1993, the Department convened an advisory committee, which set priority areas for program development: exercise, nutrition, incontinence, mental health, chronic disease, alcoholism, injury prevention, and medication management. Pennsylvania's 52 AAAs are each required to use their Title III-D funds in one or more of these priority areas, overseen by a local designated PrimeTime Health coordinator. While the AAAs have discretion in their health promotion programming, the Department also develops programs that can be implemented by AAAs in their communities. One of PrimeTime Health's major programs, Peer Exercise Program Promotes Independence (PEPPI), is described below.

PEPPI was instituted in 1996. Drawing on research showing the efficacy of weight training in older adults, PrimeTime Health has developed a statewide model of local weight training classes led by volunteer older adults who receive initial training and ongoing technical assistance from a contracted exercise physiologist.

Volunteer class leaders participate in a one-day training led by a certified exercise physiologist. PEPPI sponsors about three to five classes per year for new trainers. There are approximately 30-40 people in each class and 75% go on to become leaders. Leaders are encouraged to hold class two to three times per week, for 30 to 60 minutes per class. Participants keep logs in which they document progress, such as the number of repetitions and size of weights used. In some classes, blood glucose and cholesterol testing has taken place. There are approximately 350 regular classes occurring across Pennsylvania, with about 3500 regular participants. While PEPPI is an optional program for AAAs to adopt, 36 of the 52 AAAs offer the program and each year more choose to become involved.

In the past year, PEPPI has developed supporting videos that can be used by leaders to reinforce proper techniques or can be used to lead a class if the leader is unavailable for a session. PEPPI also publishes a monthly newsletter for leaders and participants.

PEPPI is based on published research showing the effectiveness of strength training for older adults. Original research was conducted at Tufts University. The original program was based on the eight exercises in the book *Biomarkers*<sup>11</sup>, with the consultation of the book's primary author. With the help of the exercise physiologist, PEPPI has since modified some of the exercises to increase ease for older adults. To date, there is substantial anecdotal evidence of the program's effectiveness from adults who have, for example, given up walkers and canes, lost weight, and changed their lifestyles.

A year ago, PEPPI took the first steps to develop quantitative program outcomes, but found that there were internal inconsistencies in program implementation that made this difficult. Not all leaders were consistent in their class exercises. At that point, the program stepped back and developed some of the additional tools now available to leaders: a revised, more detailed manual, and the video. The Department of Aging is now in the process of doing a survey to benchmark success. Data is being collected on improvement in physical activities such as ability to walk, climb stairs, and rise from a seated position, as well self-reported improvement in overall health and social and emotional well-being.

The Department of Aging, a cabinet-level agency, funds a full-time PrimeTime Health coordinator who develops and promulgates PEPPI and other health promotion programs, which AAAs may implement at their discretion. Each AAA is required to have a local PrimeTime Health coordinator to oversee their health promotion programs, though not all are full-time staff.

The Department of Aging spends about \$18,000 per year on PEPPI's implementation. Major expenses include the contracted exercise physiologist, videos, in-state travel, purchase of weights, and production of the newsletter. Most classes are offered in senior centers or common areas in congregate housing developments. Training of leaders is free to AAAs.

#### **Contact:**

Linda Bowers, PrimeTime Health Coordinator  
Pennsylvania Department of Aging  
555 Walnut Street, 5th Floor  
Harrisburg, PA 17101-1919  
(P) 717-783-8975  
Lbowers@state.pa.us

## Glossary

**AAA** Area Agency on Aging. Public, governmental agencies or non-profit organizations serving the older adults in defined geographic regions within each state. Based on local needs and priorities, AAAs contract with local provider organizations for services and/or provide services directly.

**AoA** Administration on Aging. The federal agency within the United States Department of Health and Human Services responsible for overseeing the implementation of the Older Americans Act and for monitoring and responding to the needs of older adults.

**ASTCDPD** Association of State and Territorial Chronic Disease Program Directors. See CDD below.

**BRFSS** Behavioral Risk Factor Surveillance System. A random digit dial telephone survey of adults age 18 and older, conducted in all states as a joint collaboration between the CDC and SHDs. The BRFSS collects data on a variety of health characteristics, risk factors for chronic conditions and preventive behaviors.

**CDC** Centers for Disease Control and Prevention. The federal agency within the United States Department of Health and Human Services responsible for protecting the health of all Americans through disease prevention and control.

**CDD** Chronic Disease Directors. (Officially known as the Association of State and Territorial Chronic Disease Program Directors, or ASTCDPD). The national non-profit membership organization of state health departments' chronic disease programs.

**CVD** Cardiovascular disease

**NASUA** National Association of State Units on Aging. The national non-profit membership organization of state units on aging.

**OAA** Older Americans Act. Passed by Congress in 1965 and amended and reauthorized most recently in 2000, the Older Americans Act is the federal statute that mandates and funds a range of community-based services for older adults.

**SHD** State health department. The state agency in each state or territory responsible for overseeing public health programs, including health promotion and disease prevention programs.

**SUA** State unit on aging (also referred to as state agency on aging). The state agency in each state or territory designated by the governor and state legislature to be the focal point for all matters affecting older citizens in the state.

**Title III-D** The title, or section, of the Older Americans Act that directs states to provide health promotion and disease prevention services to older adults (See Appendix D for the full text of Title III-D).

## Appendix A Needs Assessment Questionnaire

**1. Please list the top 5 health issues affecting older adults in your state.**

**2. Within your agency, is there an organizational unit or person specifically designated for health promotion/disease prevention activities related to older adults?**

Yes \_\_\_ No \_\_\_

**3. Does your agency have a plan for serving older adults that addresses health promotion/disease prevention? Please check ALL that apply.**

- Yes. Formal plan developed
- No, no formal plan developed
- No, BUT mission statement developed
- No, BUT goals, objectives and priorities identified
- No, BUT activities and programs identified
- Other, please specify

**4. In your state, which state agency has LEAD (or primary) responsibility for health promotion/disease prevention activities for older adults?**

- Health department (SHD)
- State unit on aging (SUA)
- Shared between SHD & SUA
- None
- Don't know

**5. Please identify other state agencies/public programs involved in (or responsible for) health promotion/disease prevention activities for older adults.**

- Department of Mental Health
- Department of Mental Retardation
- Department of Substance Abuse
- Department of Medical Assistance (Medicaid)
- Department of Food & Agriculture (5-a-Day, Farmer's Market Nutrition Program)

- State Peer Review Organization (State PRO)
- Department of Veterans Affairs (VA)
- Other, please specify

**6. Please identify OTHER partners you work with around health promotion/disease prevention activities for older adults. Please check ALL that apply.**

- Faith-based organizations
- YWCA/YMCA
- Social Clubs (e.g., Elks, Kiwanis)
- Women's Groups (e.g., Older Women's League, Junior League)
- Senior centers
- Councils on Aging
- Visiting Nurse Associations (VNAs)
- Hospital networks
- Local health departments
- Health Maintenance Organizations (HMOs)
- AARP
- Arthritis Foundation
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Lung Association
- National Osteoporosis Foundation
- Alzheimer's Association
- Pharmacists
- Other, please specify

**7. Describe the ORGANIZATIONAL relationship between the state health department and the state unit on aging in your state.**

- Located within the same agency
- Separate agencies
- Don't know
- Other, please specify

**8. What are the collaborative activities engaged in by the state unit on aging and the state health department? (Please check top 3)**

- Joint programs/activities at the state level
- Joint programs/activities at the community level
- Joint planning/development of programs
- Joint contracts
- Joint training
- Conference attendance/planning
- Participation on committees/boards



- Joint grant writing
- Advocacy
- None
- Don't know
- Other, please specify

**9. On average, how often do you engage in health promotion/disease prevention activities for older adults with your counterparts in the other state agency?**

- Do not work together in this area
- Annually
- Quarterly
- Monthly
- Two times or more per month
- Don't know

**10. What do you see as the strengths of your agency in health promotion/disease prevention activities for older adults?**

**11. What do you see as the strengths of your counterpart agency in health promotion/disease prevention activities for older adults?**

**12. Choose the three most important organizational, programmatic, geographic, or political BARRIERS OTHER THAN FUNDING that limit or prevent coordination with your counterpart agency:**

- Low priority given to services for older adults within the SHD
- No individual designated as the lead for aging issues in SHD
- Organizational culture differences
- Lack of knowledge of opportunities for coordination
- Non-overlapping planning & service areas
- Complexity & fragmentation of delivery services
- Lack of access to adequate computer technology & support
- Staff has too many other work responsibilities
- Physical distance between SHD and SUA offices
- Don't know
- Other, please specify

**SHD 13. Are you aware of the health promotion/disease prevention provisions of Title III-D of the Older Americans Act?**

Yes\_\_\_ No\_\_\_

**SUA 13. Please identify the 3 types of activities for which your OAA Title III-D funds have been used most frequently.**

- Senior Center
- Speakers
- Physical fitness/exercise programs
- Health screening
- Consumer education & training
- Provider training
- Materials production & dissemination
- Nutrition screening & assessment
- Nutritional education & counseling
- Mental health screening
- Programs targeting specific chronic diseases
- Educational health programs
- Intergenerational programming
- Support groups
- Medication management, screening & education
- Falls/injury prevention & home safety
- Purchase & distribution of health/safety-related aids
- Other, Please Specify

**14. Does the state health department participate in any health promotion/disease prevention activities funded under Title III-D of the Older Americans Act?**

- No
- Yes, we receive Title III-D funds for contracted health promotion/disease prevention activities
- Yes, we participate through conferences, trainings, programmatic efforts, etc.; but receive no Title III-D funds
- Don't know
- Other, please specify

**15. Aside from funding, what are the 3 main BARRIERS to fully promoting health and preventing disease among older adults in your state?**

- Life-style issues
- Inadequate transportation
- Housing
- Language
- Literacy
- Lack of culturally competent providers
- Educational limitations of providers/recipients
- Inadequate insurance coverage
- Fragmented services
- Medicare requirements/lack of reimbursement for preventive services

- Lack of organized system of programs & services
- Geography
- Difficulties with health care access
- Lack of caregiver support
- Frailty & mobility issues
- Lack of consumer awareness/perceptions
- Perceptions of aging & illness
- Lack of supportive environments & safe communities
- Don't know
- Other, Please specify

**16. What are the funding sources used for health promotion/disease prevention for older adults by your agency? Check ALL that apply.**

- Centers for Disease Control and Prevention Cooperative Agreement Funds
- Preventive Health Services Block Grant
- Social Services Block Grant
- Community Services Block Grant
- Older Americans Act Funds
- Maternal and Child Health Block Grant
- Other federal funds
- State tobacco settlement funds
- Casino/lottery funds
- Other state funds
- None
- Don't know
- Private grants, please specify

**17. Other than funding or staffing, what are the 3 TOP UNMET PROGRAM SUPPORT NEEDS for health promotion/disease prevention for older adults in your state?**

- Caregiver assistance
- Leadership continuity
- Advocacy for older adults
- Public education materials, media, social marketing
- Programmatic expertise
- Grant writing expertise
- Staff development/training
- Data expertise
- Access to target populations
- Program evaluation
- Other, please specify

**18. If greater funding were available, what 3 health promotion/disease prevention issues for older adults would you address?**

**19. The following is a list of health problems affecting older adults. Please indicate the current level of involvement of your agency.**

1= None 2= Limited 3= Moderate 4= High

- Arthritis \_\_\_
- Asthma \_\_\_
- Cancer-colorectal \_\_\_
- Cancer-breast\_\_\_
- Cancer-prostate\_\_\_
- Cancer-lung\_\_\_
- Cancer-other malignancy\_\_\_
- Cardiovascular disease\_\_\_
- Caregiver issues\_\_\_
- Compassionate care/end of life issues\_\_\_
- Dementia (including Alzheimer's disease)\_\_\_
- Depression\_\_\_
- Diabetes\_\_\_
- Domestic violence/elder abuse\_\_\_
- Falls/injury prevention\_\_\_
- Financial resources inadequacy/poverty\_\_\_
- HIV\_\_\_
- Housing\_\_\_
- Hunger/food security\_\_\_
- Hypertension\_\_\_
- Immunizations\_\_\_
- Incontinence\_\_\_
- Legal assistance/advocacy\_\_\_
- Medication management\_\_\_
- Menopause\_\_\_
- Nutrition\_\_\_
- Obesity\_\_\_
- Oral health/access to dental services\_\_\_
- Osteoporosis\_\_\_
- Patient/provider communication\_\_\_
- Physical inactivity/sedentary lifestyle\_\_\_
- Prescription drug access/coverage\_\_\_
- Senior employment\_\_\_
- Social isolation\_\_\_
- Smoking\_\_\_
- Suicide prevention\_\_\_
- Transportation\_\_\_
- Vision and hearing problems\_\_\_

**20. Please describe one health promotion/disease prevention success story in your state that you would like others to know. How do you define success?**

**21. What data sources do you use to identify, plan, monitor, or evaluate the health needs of older adults in your state? Please check ALL that apply.**

- Behavioral Risk Factors Surveillance Survey (BRFSS)
- State aging unit data
- State aging unit plan
- Mortality/death (vital statistics)
- Medicare claims data
- Cancer registry
- Census data
- Nursing home data
- Health plan data/report cards
- National Center for Health Statistics/Centers for Disease Control Healthy Aging Web site
- Local program data
- Other, please specify

**SHD 22. What Administration on Aging resources do you use?**

- Publications
- Data
- Conferences
- Direct contacts
- Web site
- Don't know
- Don't use
- Other, please specify

**SUA 22. / SHD 23. What are the 3 TOP AREAS where you could benefit most from technical assistance and training to more effectively address the health promotion/disease prevention needs of older adults?**

**SUA 23. / SHD 24. Do you have access to up-to-date research expertise for health promotion/disease prevention program planning, implementation, and evaluation for older adults? Please check ALL that apply.**

- None
- Generally available in our state but difficult to access for program planning & implementation
- Generally available in our state but difficult to access for program evaluation
- Yes, have resources we regularly use for program planning & implementation
- Yes, have resources we regularly use for program evaluation

- Don't know
- Other, please specify

**SUA 24. / SHD 25. Give one example of a health promotion/disease prevention program in your state that you would nominate for BEST PRACTICES FOR OLDER ADULTS. Provide the name of the program, a description, and how outcomes were evaluated, if they were.**

**SUA 25. / SHD 26. In what areas of health promotion/disease prevention would you most like to see best practices (evidence-based programs) developed?**

**SUA 26. / SHD 27. What do you perceive as the Center for Disease Control and Prevention's current role in health promotion/disease prevention for older adults?**

**SUA 27. / SHD 28. If additional funds were made available to the Centers for Disease Control and Prevention, what would be the priorities for state-based programs targeting health promotion/disease prevention for older adults?**

**SUA 28. / SHD 29. What are the urgent hot button issues in your state related to older adults (e.g., interests of the governor, the legislature, media, or advocates)?**

**SUA 29. / SHD 30. Is there anything else you would like to tell us regarding gaps in health promotion/disease prevention programs/services/activities related to older adults at your agency?**

## Appendix B Respondents to Needs Assessment

States for which both agencies responded are shaded

State	SUA	SHD
Alabama	X	X
Arkansas		X
Arizona	X	X
California	X	X
Colorado	X	X
Connecticut	X	X
Washington DC	X	
Delaware	X	
Florida	X	X
Georgia	X	X
Guam	X	
Hawaii	X	X
Iowa	X	X
Idaho		X
Illinois	X	X
Indiana	X	X
Kentucky	X	X
Kansas	X	
Louisiana		X
Massachusetts	X	X
Maryland	X	
Maine	X	X
Michigan	X	X
Minnesota	X	X
Missouri	X	X
Mississippi	X	X
Montana		X
North Carolina	X	X
North Dakota		X
Nebraska	X	
New Hampshire	X	X
New Jersey	X	X
New Mexico		X
Nevada	X	
New York	X	X
Ohio	X	X
Oklahoma	X	X
Oregon		X
Pennsylvania	X	X
Rhode Island	X	X
South Carolina	X	X
Tennessee	X	
Texas	X	X
Utah	X	X
Virginia		X
Vermont	X	X
Washington		X
Wisconsin		X
West Virginia	X	X
Wyoming	X	

## Appendix C

### Coding Categories for Open Response Questions

(#1, 10, 11, 18, 22, 25, 26, 27, 28)

#### Chronic disease prevention & control

General - not disease-specific  
 Cardiovascular disease and stroke  
 Diabetes  
 Osteoporosis  
 Arthritis  
 Cancer  
 Chronic obstructive pulmonary disease (COPD)  
 HIV  
 Asthma  
 Vision & hearing problems  
 Incontinence  
 Other

#### Mental health, behavioral health & dementia

General mental health  
 Depression  
 Suicide prevention  
 Alcohol and substance abuse  
 Dementia & Alzheimer's  
 Other

#### Risk reduction/behavior change

General health promotion/wellness/healthy lifestyles  
 Exercise/physical activity/sedentary lifestyle  
 Nutrition/diet/eating habits  
 Tobacco cessation  
 Obesity/weight control  
 Fall & injury prevention  
 Assistive technologies/home & environmental modifications  
 Other

#### Concrete services

Financial resources

Housing  
 Hunger/food security  
 Transportation  
 Legal assistance/advocacy  
 Senior employment  
 Medication management  
 Caregiver issues, including support & respite  
 Support services & case management  
 Long-term care  
 Home care  
 Domestic violence/elder abuse  
 Other

#### Health care - access, coverage & quality

Access to health care, including rural & minority issues  
 Health insurance coverage  
 Oral health/access to dental care  
 Prescription drug access/coverage  
 Patient/provider communication  
 Immunizations  
 Other

#### Quality of life

Functional disabilities  
 Independence  
 Social isolation  
 Compassionate care/end of life  
 Mobility  
 Other

#### Systems & program management

Leadership/advocacy  
 Policy development & legislation  
 Data & surveillance

Collaboration between state agencies (SUA-SHD)  
Other collaboration, coalition-building & partnerships  
Funding - levels, grant availability  
Marketing, outreach & education (to public, not staff)  
Cultural competency/addressing disparities  
Aging provider network  
Infrastructure

### **Staffing issues**

Development, expertise, training issues  
Numbers/too much work, too few people  
Lack of designated/lead individual  
Other staff issues

### **Training/knowledge issues**

Research & best practices  
Technical assistance  
Conferences, trainings, special meetings  
Grant writing  
Other training/knowledge issues

### **Program implementation & evaluation issues**

General program expertise  
Needs assessment  
Program development & implementation  
Outcome measures/program implementation  
Intergenerational models  
Other program issues  
**Other (not any of above)**

**Don't know**

**None**

**Limited**

**Blank**

**Appendix D**  
**Older Americans Act,**  
**Title III-D**  
**Disease Prevention and Health**  
**Promotion Services**

**Title 42, Chapter 35, Subchapter III, Title F (amended to D, 2000)**

Sec. 3030m. - Program authorized

(a) Grants to States

The Assistant Secretary shall carry out a program for making grants to States under State plans approved under section 3027 of this title to provide disease prevention and health promotion services and information at multipurpose senior centers, at congregate meal sites, through home delivered meals programs, or at other appropriate sites. In carrying out such program, the Assistant Secretary shall consult with the Directors of the Centers for Disease Control and Prevention and the National Institute on Aging.

(b) Community organizations and agencies

The Assistant Secretary shall, to the extent possible, assure that services provided by other community organizations and agencies are used to carry out the provisions of this part.

Sec. 3030n. - Distribution to area agencies on aging

The State agency shall give priority, in carrying out this part, to areas of the State -

- (1) which are medically underserved; and
- (2) in which there are a large number of older individuals who have the greatest economic need for such services

Sec. 3030o. - "Disease prevention and health promotion services" defined

As used in this part, the term "disease prevention and health promotion services" means -

- (1) health risk assessments;
  - (2) routine health screening, which may include hypertension, glaucoma, cholesterol, cancer, vision, hearing, diabetes, and nutrition screening;
  - (3) nutritional counseling and educational services for individuals and their primary caregivers;
  - (4) health promotion programs, including programs relating to chronic disabling conditions (including osteoporosis and cardiovascular disease) prevention and reduction of effects, alcohol and substance abuse reduction, smoking cessation, weight loss and control, and stress management;
  - (5) programs regarding physical fitness, group exercise, and music, art, and dance-movement therapy, including programs for multigenerational participation that are provided by -
    - (A) an institution of higher education;
    - (B) a local educational agency, as defined in section 8801 of title 20; or
    - (C) a community-based organization;
  - (6) home injury control services, including screening of high-risk home environments and provision of educational programs on injury prevention (including fall and fracture prevention) in the home environment;
  - (7) screening for the prevention of depression, coordination of community mental health services, provision of educational activities, and referral to psychiatric and psychological services;
  - (8) educational programs on the availability, benefits, and appropriate use of preventive health services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);
  - (9) medication management screening and education to prevent incorrect medication and adverse drug reactions;
  - (10) information concerning diagnosis, prevention, treatment, and rehabilitation of age-related diseases and chronic disabling conditions, including osteoporosis, cardiovascular diseases, and Alzheimer's disease and related disorders with neurological and organic brain dysfunction;
  - (11) gerontological counseling; and
  - (12) counseling regarding social services and followup health services based on any of the services described in paragraphs (1) through (11).
- The term shall not include services for which payment may be made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)

(Source: <http://www4.law.cornell.edu/uscode/42/ch35schIIIpF.html>)

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