Background: The Aging States Project

Two distinct networks—public health and aging services—share similar goals in addressing the health needs of older adults but reach this population through different mechanisms. Developing an integrated system of health promotion and disease prevention programs and services for older adults will require stronger collaboration and cooperation between these two essential networks.

The goal of the Aging States Project is to bring together the respective strengths and expertise of the public health and aging services networks to better meet our shared responsibility for ensuring optimal health for our nation's rapidly aging society. Initiated in spring 2001, this project has been a cooperative effort between the Association of State and Territorial Chronic Disease Program Directors (ASTCDPD) and the National Association of State Units on Aging (NASUA), with support provided by the Centers for Disease Control and Prevention (CDC) and the Administration on Aging (AoA).

Just as CDC has long supported state health departments (SHDs), AoA supports a large network of state units on aging (SUAs) and over 650 local area agencies on aging that extend into virtually every community in the United States. The purpose of the Aging States Project is to systematically compile information on health-related needs, activities, and partnerships related to older adults in SUAs and SHDs. The information will provide an overview of health promotion and disease prevention efforts for older adults and will help identify opportunities for collaboration between the public health and aging services networks.

National health and aging organizations have now joined with federal and state government partners to use this innovative effort to integrate the expertise and capacity of both networks. We hope this information will help to define the critical next steps in addressing the health challenges of our growing population of older adults.

Gathering Critical Information

The assessment portion of the Aging States Project was guided by an advisory committee of ASTCDPD and NASUA representatives and selected outside experts. Initially, a pilot assessment instrument was sent to nine states through a Web-based format that allowed responses to be electronically submitted and easily analyzed. Based on feedback from the pilot, questions were refined and the full instrument was sent to identified SUA and SHD contacts in all 50 states, the District of Columbia, and seven territories in June 2001. Questions for SUAs (29) and SHDs (30) were identical or symmetrical except for one question asked only of SUAs and two questions asked only of SHDs. Follow-up contacts were made to states to encourage participants to respond. Overall response rates were 68% for SUAs (37 states, the District of Columbia, and Guam) and 75% for SHDs (43 states).

Responses from SUAs and SHDs were analyzed separately and characterized through descriptive statistics, including frequency distributions and cross-tabulations. Responses to selected questions from the 31 matched-pair states in which both the SUA and the SHD responded were also examined for consistency.

For further information or additional copies of this brochure, please contact Greg Case at the National Association of State Units on Aging, (202) 898-2578, gcase@nasua.org, or Elizabeth King at the Association of State and Territorial Chronic Disease Program Directors, (703) 538-1798, king@chronicdisease.org.

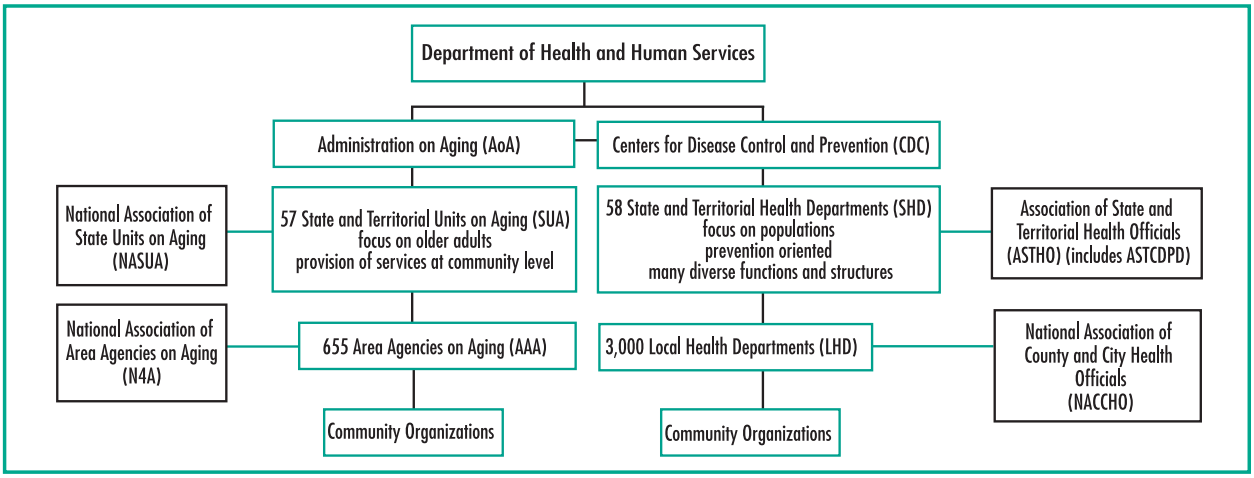
Public Health and Aging Services Networks

The Public Health Network

The U.S. public health network protects and promotes the health and well-being of all Americans across their life span through efforts at the national, state, and local levels. The primary functions of the public health network include developing policies, prioritizing health problems, establishing a system to provide services to prevent disease and promote health, and collecting health information. The public health network relies on partnerships between the Centers for Disease Control and Prevention and other federal agencies, state and local health departments, voluntary and professional organizations, academic institutions, community-based organizations, and others.

The Aging Services Network

State aging networks provide a range of nutrition and supportive services for older adults aimed at promoting independent living in the community. Among those services are congregate and home-delivered meals, transportation, health insurance counseling, adult day care, and elder abuse prevention. The aging services network also implements a variety of health promotion/disease prevention programs for older adults. Designated by the SUA, area agencies on aging—which may be municipal/county governments, regional councils, or nonprofit organizations—work to ensure that optimal health and social services are available to older Americans.



Opportunities for Closer Collaboration

Although SUAs and SHDs bring different resources, approaches, and partners to the table, many of these elements are complementary. The Aging States Project has highlighted areas of mutual interest that offer potential for collaboration. Both SUAs and SHDs identified similar top health problems among older adults, a need for best practices, and barriers to health promotion and disease prevention. In addition, both state agencies need consistent data sources, technical assistance, and increased awareness of resources available through the network infrastructure. The quality and availability of health promotion programs for older adults could be enhanced by measures that would not require substantial new resources, such as assigning a lead person or unit to bridge SUA and SHD activities. Collaborations that combine the prevention expertise of the SHDs with the community outreach capacity of the SUAs can build the momentum needed to address the needs of the rapidly expanding number of older adults in the United States.

The Aging States Project: Promoting Opportunities for Collaboration Between the Public Health and Aging Services Networks

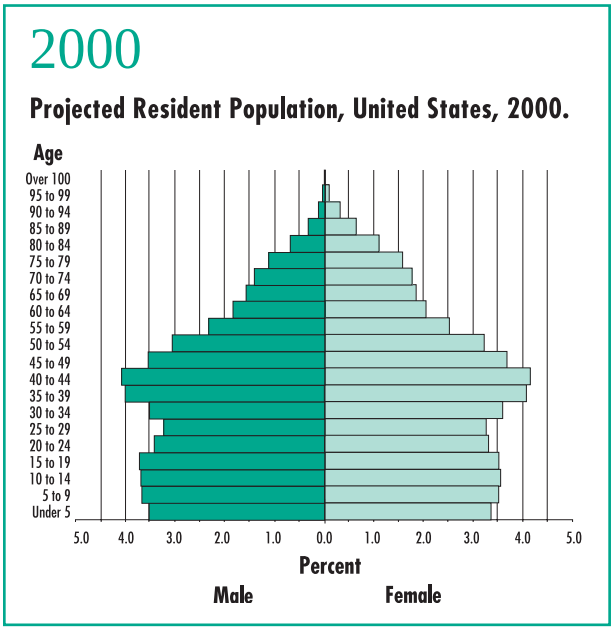
AN OVERVIEW

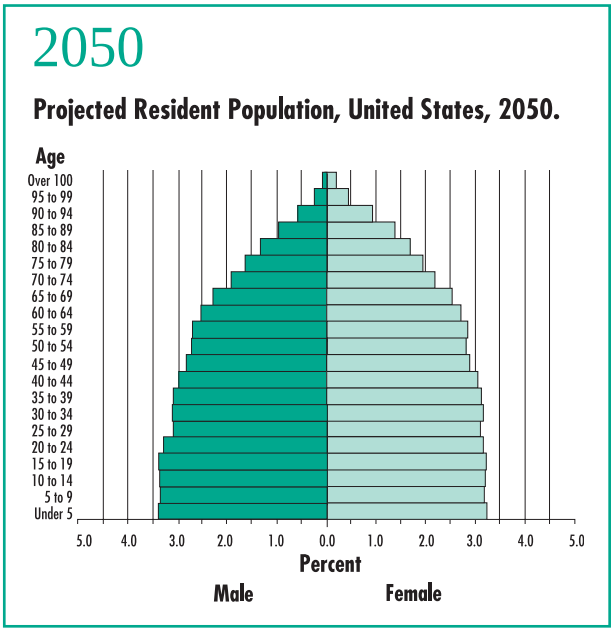
The Importance of Healthy Aging

The gain in U.S. life expectancy during the 20th century was a major victory for public health. The challenge of the 21st century will be to make these added years quality years. The number of adults age 65 years and older will more than double to over 70 million by 2030. The growing number of older adults places increasing demands on the public health system and on medical and social services. Currently, almost one-third of total U.S. health care expenditures, or $300 billion each year, is spent on older adults. Without greater emphasis on prevention, health care spending will increase by 25% by 2030 simply because the population will be older; this figure does not account for inflation or the cost of new technology.

Poor health is not an inevitable consequence of aging. 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. Given the demographic revolution under way, we have no time to lose in learning how to help older adults lead healthier, more independent, and more satisfying lives.

The Demographic Revolution: From Pyramid to Rectangle





Source: National Projections Program, Population Division, U.S. Census Bureau, Washington, D.C. 20233

Highlights of Key Findings

Health Promotion Needs, Priorities, and Barriers

- **The greatest health concern identified by both state health departments (SHDs) (81%) and state units on aging (SUAs) (72%) was chronic diseases.** Cardiovascular disease was the single most common health issue listed (SHD 55%, SUA 46%). Prescription drug access/coverage was the second most common area of concern (SUA 41%, SHD 38%). About a third of respondents from both agencies listed mental and behavioral health as a top issue.

- **Both agencies have limited involvement in addressing the top health issues of older adults.** Although cardiovascular disease was the health concern mentioned most frequently, fewer than half of the responding agencies reported moderate to high involvement in this area. Although most SUAs (74%) were significantly involved in promoting prescription drug access/coverage, the second top issue identified, only 15% of SHDs had programs in that area.

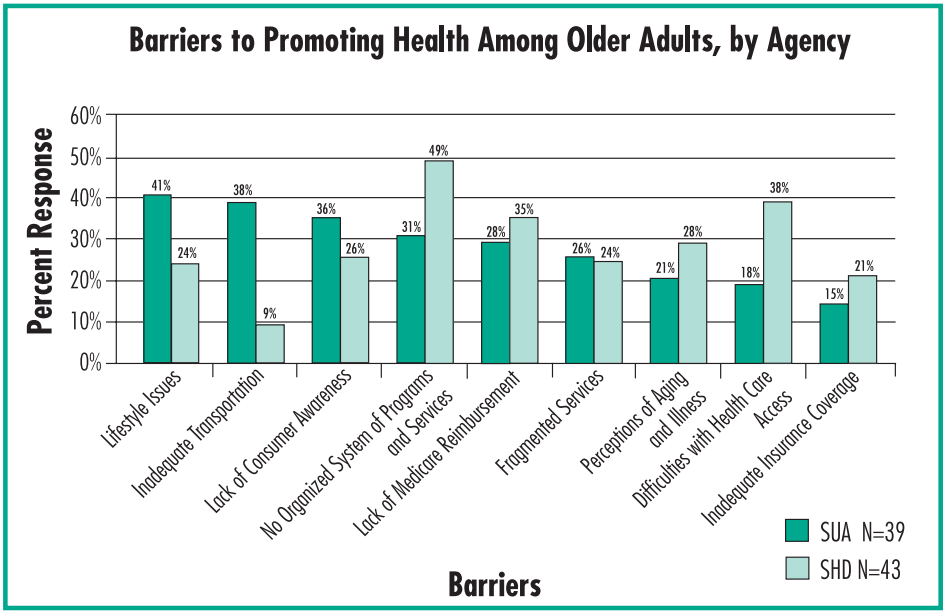
- **Both agencies identified a range of important barriers to promoting health among older adults.** No single barrier was identified by a majority of SUAs or SHDs (see figure). The range of barriers identified by SUAs focused more heavily on the individual (lifestyle issues, inadequate transportation, and lack of consumer awareness), which is consistent with their direct access to older adults and with their focus on social services. In contrast, the greatest barriers perceived by SHDs were systems barriers to providing programs and services on a population basis: lack of an organized system of programs and services, difficulties with health care access, and fragmented services.

Program Support Needs

- **Both SUAs and SHDs reported a need for best practices for promoting health and preventing disease among older adults.** Most frequently mentioned by both SHDs (59%) and SUAs (37%) was a need for best practices in the area of risk reduction/behavior change. Within this area, physical activity and nutrition were the topics most frequently cited. Chronic disease prevention and control was the second most frequent area mentioned as requiring best practices by both SHDs (31%) and SUAs (23%). Cardiovascular disease and diabetes were the most common specific conditions cited in this area.

- **Apart from funding and staffing, public education materials, media, and social marketing were identified by both SUAs (54%) and SHDs (40%) as the most important program support needs.** SHDs also chose advocacy for older adults with the same frequency. Roughly one-third of respondents in both networks cited programmatic expertise and leadership continuity as top unmet needs.

- **Other than 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 public health programs.** All but one



SHD (98%) use BRFSS, while 64% of SUAs use the system. SUAs most frequently use U.S. census data (74%) as well as their own internal data (72%) for planning and evaluation. Apart from BRFSS data, SHDs most often depended on vital statistics (88%) and cancer registry (77%) data. Fifty-three percent of SHDs use data from the federal Administration on Aging.

A Program in Action: *Keep Moving*

Keep Moving, a statewide walking program for older adults, was started in 1985 as a project of the Executive Office of Elder Affairs in the Massachusetts SUA to improve the lives of people age 50 and older by promoting physical activity. The program functions through a network of 140 local walking clubs with more than 2,000 participants. The program has continued to play an important role among older adults largely because of collaborations between the Executive Office of Elder Affairs (SUA), the Massachusetts Department of Public Health (SHD), and other partners, including the Governor's Committee on Physical Fitness and Exercise and the Robert Wood Johnson Foundation. Despite fluctuations in funding, these strategic collaborations have enabled the program to continue recruiting older adult walkers and training local leaders to coordinate the community-based walking clubs.

Funding Sources for Health Promotion and Disease Prevention

- **Funding sources drive priorities in SUAs and SHDs.** SUAs are funded through the Older Americans Act (Title III-D) 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%). 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 cooperative agreements (72%) and prevention block grants (65%). Cooperative agreements are generally categorical; that is, they address a specific disease or public health issue. Neither public health funding source usually requires older adults to be a priority population and hence they are often overlooked.

- **Fifty percent of SHDs are unfamiliar with Title III-D of the Older Americans Act.** Thirty-seven percent of SHDs reported not knowing what type of involvement they had with Title III-D funding. Nineteen percent of SHDs reported participating in health promotion activities funded by Title III-D, such as conferences and training, though they did not receive these funds directly.

Organizational and Collaboration Issues

- **Most SUAs and SHDs collaborate to some extent with their counterpart agency.** 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%) and joint planning/development of programs (SUA 56%, SHD 47%). A major barrier to coordinated and complementary efforts is the lack of a designated lead unit or person for older adults. When a lead unit or person for older adult health is clearly identified in either agency, the two agencies are more likely to collaborate on health promotion programming and activities (see figures at right). SUAs (74%) were more likely to have an organizational unit or staff person designated for health promotion and disease prevention for older adults than were SHDs (37%).

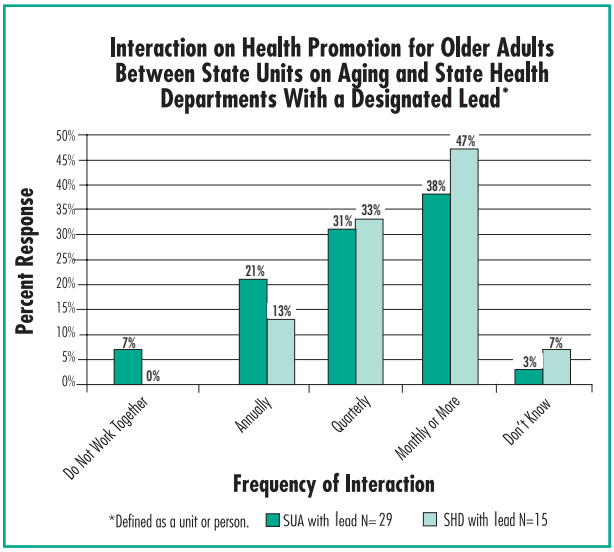
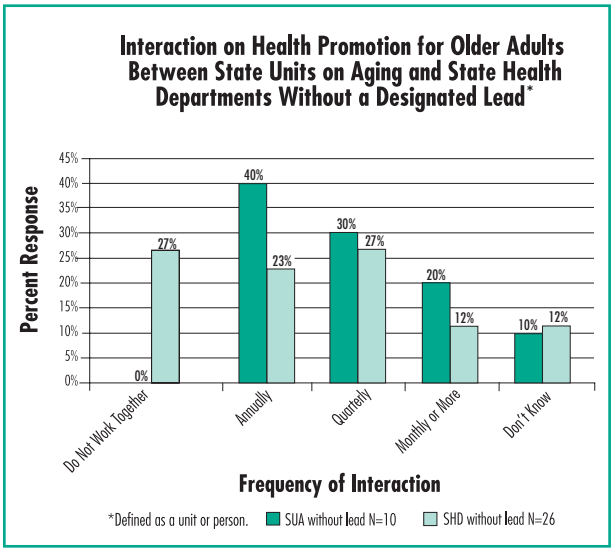
- **Respondents frequently did not agree on which state agency has the lead responsibility for health promotion and disease prevention for older adults**. SUAs (44%) most frequently stated the responsibility was shared, while the SHDs (40%) stated the responsibility was that of the SUAs.

Highlights (continued)

SUAs were more likely than SHDs to have a formal plan for health promotion and disease prevention for older adults (SUA 44%, SHD 9%). Only 6 (19%) of the 31 matched-pair states had internally consistent answers on lead responsibility, indicating a lack of clarity within state structures.

- **A majority of both SUAs (84%) and SHDs (57%) saw the Aging Services Network and its infrastructure as strengths of the SUAs.** Because of 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 groups ranked SHDs high on collaborations and partnerships.

- **Both agencies involve external partners in their health promotion and disease prevention activities.** Senior centers (SUA 95%, SHD 84%) and local health departments (SHD 79%, SUA 59%) were both frequently selected as partners. The most common governmental partners were the State Department of Mental Health for SUAs and State Peer Review Organizations for SHDs. Common nongovernmental partners included numerous nonprofit organizations dedicated to specific diseases, such as the Arthritis Foundation and the Alzheimer's Association.

A Program in Action: *Millennium March to Wellness*

In 1999, the Delaware Division of Services for Aging and Adults with Physical Disabilities launched the *Millennium March to Wellness*, a comprehensive initiative to encourage older adults to increase their physical activity and eat more fruits and vegetables. The physical activity component, *Walk Delaware*, challenges older adults to walk the length (96 miles) or width (35 miles) of the state of Delaware over the course of a year. In 2000, more than 500 older Delaware residents registered for *Walk Delaware*. The nutrition component implements the national "5-A-Day" program to increase fruit and vegetable consumption and provides nutrition education for older adults. The success of the *Millennium March to Wellness* is largely due to collaborations between state and local partners and to the designation of a public health educator within the state unit on aging to take lead responsibility for this program. Other health promotion and disease prevention programs are being built upon the success of this program.