Elder Health Programs in State Health Agencies

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SYNOPSIS

DUE TO THE rapid rise in the population of those ages 65 and older, public health programs that target this group merit special attention. State health agencies can play leading roles in providing and coordinating elder health programs by identifying needs and formulating guidelines in collaboration with federal, local, and private organizations. The Massachusetts Department of Public Health initiated the Elder Health Programs Unit in 1988, with a mission to assist elders in maintaining their highest level of functional status in community settings and to provide opportunities for older adults to take greater responsibility for their own health. The extent of involvement in elder health programming of other state health agencies outside of Massachusetts is not well documented. Through the distribution of a national survey, we set out to determine how many state health agencies offer elder health services.

State health agencies (SHAs) can play a leading role in providing and coordinating elder health programs by identifying needs and formulating guidelines in collaboration with federal, local, and private organizations.[1,2] In 1988, the Massachusetts Department of Public Health created the Elder Health Programs Unit to provide a focus for activities targeting the growing number of elders in the state. In 1994, the state Department of Public Health undertook a national survey to document elder health activities in other state health agencies. Thirty-six of the 49 state health agencies contacted returned surveys.

Results

We found that specific elder health programs were reported to exist in half (18/36) of the state health agencies that returned the surveys. Program names of elder health units fell into three basic areas: advanced age, such as California's Center for Gerontology and Georgia's Older Adult Program; disease and dependency, as evidenced by Illinois's Alzheimer's Disease Program; and health promotion, such as Colorado's Elderly Health Promotion Initiative and Ohio's Elder Health Promotion Program.

Those in charge of the elder health programs typically possessed more than

Table 1. Reported database use for surveillance of elder health

(36 state health agencies reporting)	Number	Percent
Death certificates	27	75
Census data	26	72
Behavioral Risk Factor Surveillance Survey	26	72
Bureau of Census	21	58
Cancer Registries	20	56
National Center for Health Statistics	18	50
Uniform Hospital Discharge Data Set	17	47
Immunizations	15	42
Birth certificates	14	39
Communicable Disease Incidence	14	39
Medicaid (Program utilization)	14	39
Elder Abuse Statistics	14	39
National Health Information Survey	13	36
National Nursing Home Survey	11	31
Longitudinal Study of Aging	9	25
National Hospital Discharge Survey	8	22
National Ambulatory Care Survey	7	19
Lead Poisoning Incidence	7	19
National Health Professions Inventories & Surveys	7	19
National Mortality Followback Survey	5	14
National Nursing Home Survey Follow up	3	8

one advanced degree or other professional qualification and many years of experience. At least four had a doctorate, more than a dozen held one or more master's degrees, and three were registered nurses. Eight program directors mentioned 10 to 28 years of relevant experience.

As surveillance has been noted as a core public health function,[3] we attempted to identify databases used in surveillance of elder health status. Twenty-seven SHAs reported use of death certificates, 26 used census data, the same number reported using the Behavioral Risk Factor Surveillance Survey, 21 SHAs reported use of Bureau of Census statistics, while 20 SHAs used Cancer Registry data (Table 1).

Among the specific disease prevention and health promotion programs that were offered by SHAs (Table 2), 22 reported nutrition programs, 19 offered mammography and breast health programs, 18 offered group health education, and 17 offered cancer and hypertension screenings.

With regard to how direct care services were provided, 15 SHAs contracted with providers for services, while six states provided the services directly. SHAs reported receiving money from one or more of the following: state funding; federal block grants; third-party reimbursement; private foundations; and other sources, including federal grants, local contributions, casino revenues, fees collected for services, etc.

Fourteen SHAs provided education in gerontology and geriatrics for front-line workers and administrators in aging and health care, an activity funded by both state and federal dollars. Only five SHAs provided the services of senior advocates. Seven states provided Alzheimer's disease evaluation and referral, and three provided telephone reassurance. Services were provided in a variety of settings, primarily in senior centers, community health centers, nutrition sites, and homes.

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We found that most SHAs were involved in regulating nursing homes and to a lesser extent, adult day health centers. Fewer SHAs regulated assisted-living residences, but several states passed that responsibility off to the State Unit on Aging or Department of Welfare. Interestingly, in very few cases was the elder health program the unit of the SHA that was charged with regulatory activities. These activities were usually centralized in a regulatory entity.

Many of the SHAs that responded to our survey reported cooperation with Area Agencies on Aging (AAAs). AAAs, funded through the federal Administration on Aging as a result of the Older Americans Act, develop plans and administer funding for nutritional, home care, and other supportive services, as well as the establishment of senior centers. Through the senior centers, elders may receive a myriad of services including transportation, health education, health screenings, fitness programs, recreation, counseling, legal assistance, elder abuse prevention programs and the like.[4]

Discussion

It appears that many state health agencies are creating

Table 2. Disease prevention/health promotion programs

(36 state health agencies reporting)	*Number*	*Percent*
Nutrition	22	61
Mammography/breast health	19	53
Group health education	18	50
Cancer screening	17	47
Hypertension screening	17	47
Physical activity	14	39
Home safety	13	36
Immunizations	13	36
Smoking cessation	13	36
Injury prevention	12	33
Diabetes screening	12	33
Individual health counseling	10	28
Medication management	9	25
Abuse prevention	8	22
Oral health screening	8	22
Alzheimer's evaluation and referral	7	19
Stress management	6	17
Foot care referrals	6	17
Vision and hearing screening/care	6	17
Prostate screening	6	17
Senior advocates	5	14
Respite care for caregivers	4	11
Telephone reassurance	3	8
Sexuality	1	3

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organizational capacity to address the public health issues affecting older adults. Our survey found great variation in approach, but surveillance activities and health promotion activities were widely in place. We suggest that great opportunities exist for state health agency staff to share information regarding programs, organizational structure, and funding streams.

References

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