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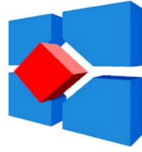

# HEALTH AND AGING

## CONCEPT MAPPING SUMMARY REPORT

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# HEALTH AND AGING

BUILDING THE CONCEPTUAL FRAMEWORK: SUMMARY REPORT

## EXECUTIVE SUMMARY

Last year, State Health Departments and State Units on Aging completed The Aging States Project: Promoting Opportunities for Collaboration Between the Public Health and Aging Services Networks. This needs assessment identified many opportunities for the public health and aging networks to work together to improve the health of older adults. The assessment provided valuable information about what state health departments and state units on aging require to address healthy aging effectively, and what barriers exist.

As a next step, the Chronic Disease Directors and its partner organizations sought to understand what characteristics and features programs geared toward improving the health of older adults should have. The annual Health and Aging retreat, held in October, provided an opportunity for these partner organizations to discuss such programming efforts. To make the most of participants' time at the retreat, Concept Systems assisted them by asking a number of stakeholders in the field what they think are key elements to health and aging programs, in advance of the retreat.

What follows is a summary of the results of that assessment project. The Concept Mapping project described here provides a summary of what key stakeholders in the health and aging field see as healthy aging programming and research priorities. It provides a conceptual framework which both Aging and Public Health agencies can build a relationship upon. This report also summarizes the action steps discussed at the Health and Aging Retreat, and shows how these action steps reinforce and complement The Aging States Project's "Recommendations to Improve the Health of Older Adults."

## PROJECT DESIGN

The purpose of this project was to gather, aggregate, confirm and integrate the specific knowledge and opinions of key members of communities of interest in the issues of public health and healthy aging. The Steering Committee identified three levels of participation to ensure that the project would benefit from appropriate involvement from individuals with experience, knowledge and commitment to the issue at hand.

The Steering Committee itself acted as the client group and design team for the project. The Steering Committee consisted of representatives from various aspects of the health and aging field, including CDC, CDD, NASUA and AoA. The Steering Committee's major responsibilities included

- the logistics and timing of the project
- identifying participants with knowledge and experience relevant to the issue
- drafting and approving communications with participants
- planning for presentation of results and additional data collection
- assisting in the successful completion of each phase of the project.

The Core participants were pre-selected as invitees to the annual Healthy Aging Retreat, scheduled for October 2002. Core participants included those on the Steering Committee and others with a high degree of current involvement in issues of health and aging. Core members were asked to participate in three activities: the initial brainstorming, the individual sorting, or categorizing of the subsequent set of statements, and the rating on value scales defined by the Steering Committee. These activities are described in more detail below, under Procedures.

The Invitees were identified by the Steering Committee as individuals with valuable knowledge and information gained from their work in the field. Invitees were asked to participate in both brainstorming and the rating of the subsequent list of statements on value scales identified by the Steering Committee.

## METHODOLOGY

To accomplish the desired result, planners utilized The Concept System planning and facilitation methodology. Key components are concept mapping and action planning. Concept mapping is a mixed methods planning and evaluation approach that integrates familiar qualitative group processes (brainstorming, categorizing ideas, and assigning value ratings) with multivariate statistical analyses to help a group describe its ideas on any topic of interest and represent these ideas visually through a map.[1] The process typically requires the participants to brainstorm a set of statements relevant to the topic of interest, individually sort these statements into piles of similar ones, rate each statement on one or more dimensions, and interpret the maps that result from the data analyses. The analyses includes multidimensional scaling (MDS) of the sort data, hierarchical cluster analysis of the MDS coordinates to create a two dimensional XY plot of the points. The result shows the individual statements in two-dimensional (x,y) space with more similar statements located nearer each other and grouped into clusters. Additionally, the ratings provide the data to compute an average for each individual item and for each cluster of items. These rating results can then be added to the map as third dimension (height). The result is multiple maps that are then interpreted by stakeholders in a facilitated session(s). Participants are actively involved in interpreting the results to ensure that the maps are understandable and labeled in a meaningful way.

[1] References and articles on the Concept System can be obtained by calling 607-272-1206 or by emailing infodesk@conceptsystems.com

## PROCEDURES

### ESTABLISHING THE FOCUS

To facilitate the collection of meaningful input, the Steering Committee for the project, with guidance from Concept Systems, Inc., developed this focus prompt to which stakeholders responded:

*"If new resources were made available to state public health programs to improve the health of older adults, a specific thing that program should be able to do or provide is..."*

### IDEA GENERATION

248 stakeholders were asked to provide input on health and aging issues or needs, using the prompt above as the focus for the structured responses. Each participant was asked to generate or brainstorm approximately five to ten ideas. Recognizing that the stakeholders' locations and access to technology varied, the project enabled multiple methods for submitting ideas. Stakeholders were contacted and provided with a web address for a project-specific website on which participants could submit their ideas online. Additionally, participants could choose to submit ideas using a fax back form. Participants could also return forms by mail.

### STATEMENT REDUCTION

The preliminary statement set for this project numbered 489. The Steering Committee used the following criteria to produce a final set of statements:

- Relevance to the stated focus question or within the scope of the question at hand
- Redundancy or duplication
- Clarity of meaning
- Relative appropriateness for the sorting and rating tasks to be completed

Appendix I shows the final list of ideas, which numbered 98. A large number of statements that were generated addressed either specific diseases or issues beyond the scope of state public health programs. These were removed from the list for the concept mapping project. Because of the obvious value of such aggregated information to the field, these statements were collected and made available for discussion. They are included as Appendix II.

### STRUCTURING THE IDEAS

Following the completion of the idea generation or brainstorming phase, participants were contacted again and asked to participate in tasks to structure the information.

*Sorting.* In the sorting task, each individual organizes or sorts the entire database of ideas into groups or themes based on similarity of the ideas. Specifically, each person who had been invited to attend the Health & Aging retreat in October 2002 was asked to identify themes among the ideas by

completing a sorting task. Concept Systems, Inc.[2] provided a dedicated website for those participants to complete the task online.

*Rating.* In the rating task, the stakeholders that participated in the idea generation were again contacted and asked to evaluate or rate on a five point scale each of the final ideas. Participants were asked to rate along two dimensions: *Importance* and *Potential Impact on Health*. Retreat participants completed these ratings at the retreat; the remainder of the original stakeholders were invited to submit these ratings after the retreat.

COMPUTING THE MAPS

The Concept System [3] uses multi-dimensional scaling and hierarchical cluster analysis to integrate the sorting information from each individual and develop a series of easily readable concept maps and reports. These maps show the perspective of the entire group of participants as well as sub groups. In effect, the Concept System represents the unique perspectives of a diverse group of individuals, preserves the best thinking of each individual and integrates the individual detail to construct and produce a coherent picture of the entire group.

The analysis uses the sort information to construct an NxN binary, symmetric matrix of similarities, for all sorting participants.

The total similarity matrix was analyzed using non-metric multi-dimensional scaling (MDS) analysis with a two-dimensional solution. The two-dimensional solution yields a configuration in which statements grouped together most often are located more closely in two-dimensional space than those grouped together less frequently. The x,y configuration resulting from the MDS analysis was the input for the hierarchical cluster analysis. To determine the best fitting cluster solution the analysts examined a range of possible cluster solutions suggested by the analysis, and took into account the fit of the contents within clusters as well as the specific desired uses of the results in planning and action development.

MAP INTERPRETATION

The maps and reports produced by the Concept System reflect and summarize the work of the stakeholders during the idea generation and structuring (sorting and rating) phases. The next step in the process requires interpretation and discussion by the stakeholders in this project. Two tasks were undertaken in this step. First, the resulting data were reviewed with the Steering Committee to ensure the reasonableness of the solution. This review also involved a preliminary discussion of the meaning, relevance and potential uses and implications of the results. Second, the results were presented at the Health & Aging retreat, where stakeholders had the opportunity to name the categories, or clusters, of issues; they then discussed the results at length, examining how they as a group viewed and organized the ideas, reviewing the rating data collected at the retreat, and discussing implications for action planning. A more detailed description of the retreat results appears below.

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[2] The Concept System© computer software (Concept Systems, 2000) was used to perform all analyses and produce all of the maps and statistical results. Most of the data was collected over the Worldwide Web using the Concept System Global© software to allow for participation from any location with access to the Worldwide Web.

[3] The Concept System© and Concept System Global© software are licensed through Concept Systems Incorporated, Ithaca, New York (http://www.conceptsystems.com).

## RESULTS

### RESPONSE RATE

The brainstorming activity is open to all identified stakeholders who were invited to participate in the project, about 248 people in all. Brainstorming is confidential and anonymous, thus limiting CSI's ability to identify with certainty the number of people who participated. Nevertheless, some key reliable indicators provide the estimate of about 123 for this project.

40 stakeholders were identified to complete sorting task. 28 completed the sorting phase of the project.

To engage a broader group of people in the rating task, all who were invited to participate in brainstorming were again contacted and asked to complete the rating task. This group included the retreat participants (who completed the rating task at the retreat) as well as others the participants (who completed it after the retreat). 40 retreat participants and 208 other participants were again invited to complete ratings. 28 retreat participants and 79 other participants completed the ratings.

Although it is difficult to estimate the ratio of public health to aging participants in the brainstorming activity, the sorting and rating activities showed relatively even involvement: 48 people identified themselves as working within public health and 52 people identified themselves as working within aging agencies. 7 participants identified themselves as "other."

## MAPS

In concept mapping, several different maps are typically generated based on the same underlying data structure, the arrangement of the statements by MDS. The foundation for all maps is the point map. The point map shows the relation of each idea to each other idea in a two dimensional Euclidean space. Distance between points is meaningful: the closer two points are on the map, the more frequently those two ideas were sorted together by the people who took part in this project. Therefore, on the point map, points that are closer together are more similar in meaning and points that are distant are more dissimilar.

**Figure 1** shows the arrangement of points for the Health & Aging Project. This point map can be used to illustrate the location of ideas in relation to each other. In Appendix I: List of statements used in the concept mapping project,

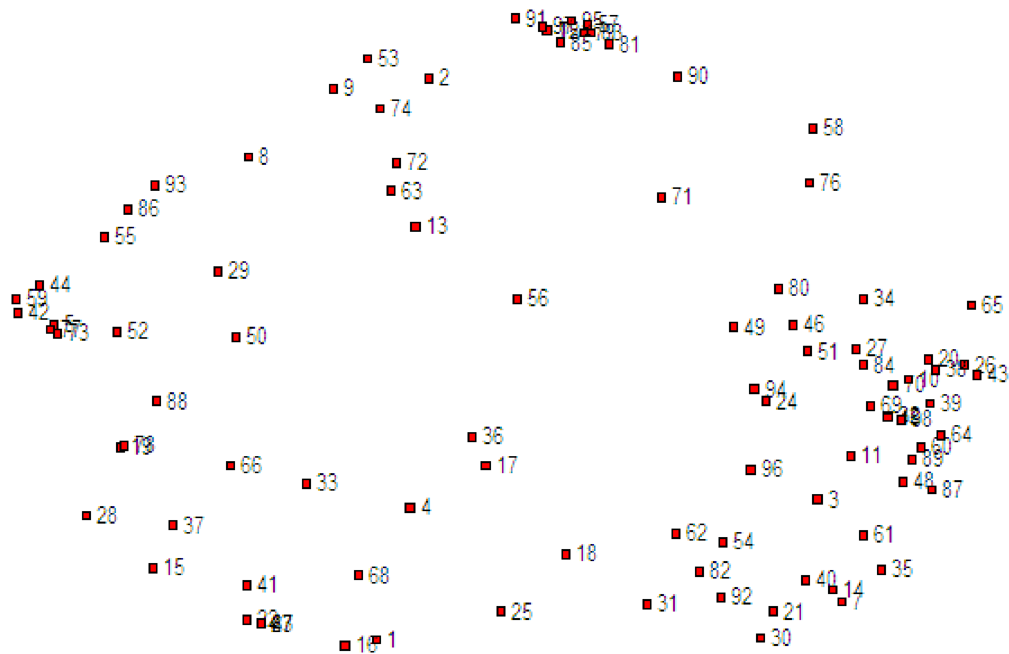


**Figure 1.** Point Map, indicating the array of all statements and their relationship to each other.

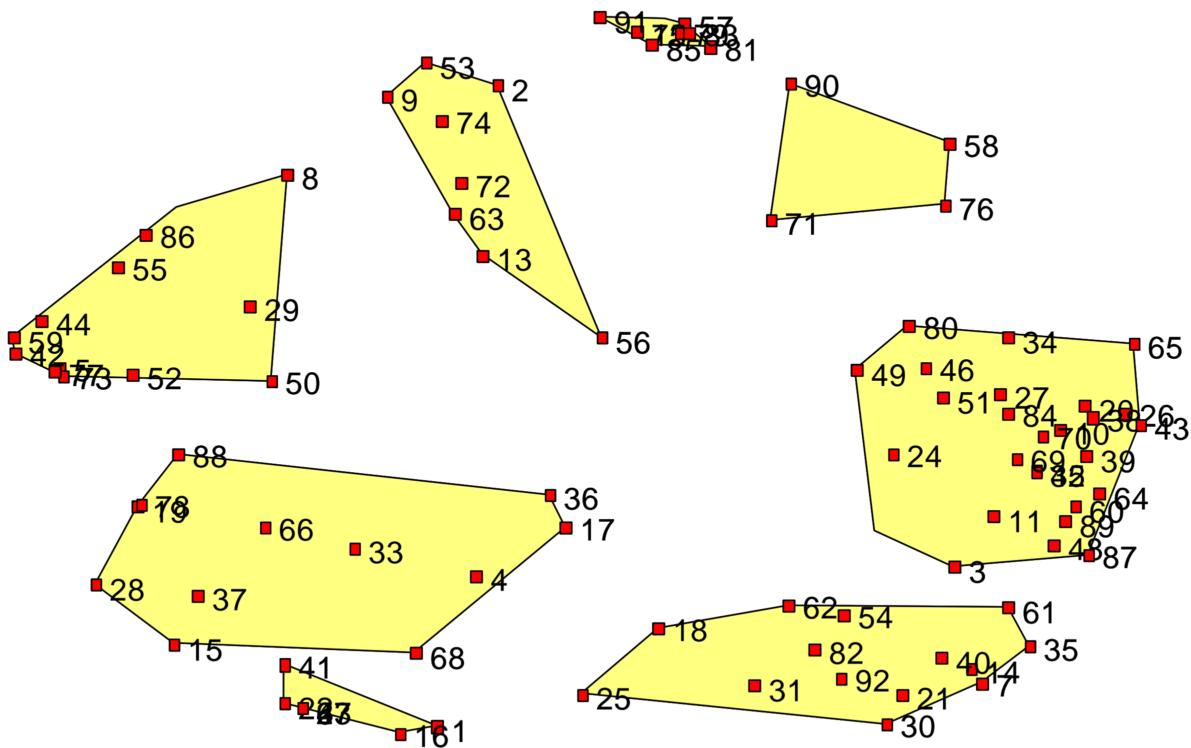


**Figure 2.** Point Cluster Map

While the arrangements of ideas and their relationships in the point map are interesting, the level of detail is useful primarily as a means of introducing stakeholders to the results and for laying the foundation for the additional maps and other analyses. The application of cluster analysis parses the map's space into groups, or clusters, of key ideas. In this case, the optimal solution was an eight-cluster solution (**Figure** 2). The compelling value of the cluster map graphic is to enable the recognition of a shared conceptual framework for discussing and planning for progress on a broad topic such as healthy aging. Establishing agreement among constituents and key participants on the reasonableness and utility of the cluster map as a frame of reference, discussion and action is a major element in the process.

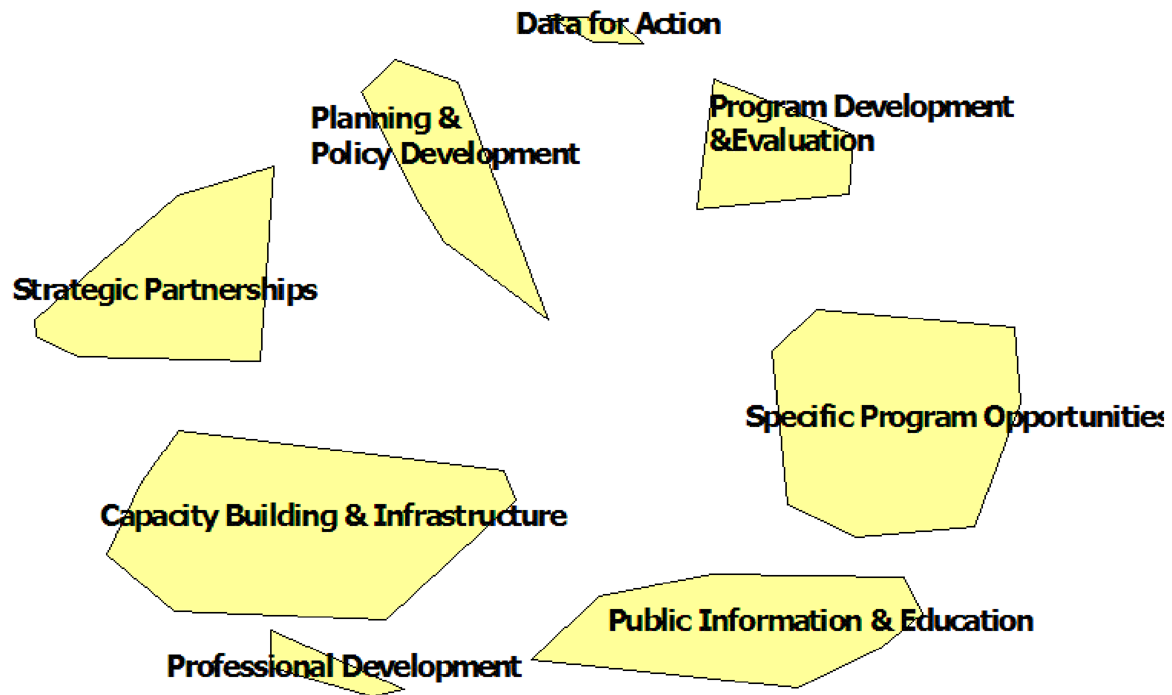


**Figure 3.** Concept Map. An eight-cluster concept map indicating the main topics, or concepts, that contain the 98 ideas that make up the content of the project. Small clusters like Data for Action and Professional Development suggest groups of closely related ideas, and areas like Capacity Building/Infrastructure are representative of a broader more encompassing concept.

Each of the clusters is comprised of items that, while specifically different, express a similar theme. An interpretive task is to determine the most appropriate label or title to express the theme in each of the clusters. While this is partly an analytical task and can be accomplished by an analyst, there is more value in engaging the stakeholders in reviewing the content and reaching consensus on the labels. There is a threefold value in this approach. First, this provides an opportunity for stakeholders to understand and internalize the deep structure of the map and, as a result, begin to consider the implications of these data. Second, the stakeholders are experts in the content and as such recognize and appreciate the nuances of meaning that may be missed by an analyst. Third, this provides stakeholders with a common framework with which to begin sharing ideas and begin the mutual construction of a shared framework.

As Figure 3 shows, this map is an eight-cluster solution, with the following conceptual categories:

- Professional Development,
- Capacity Building & Infrastructure,
- Strategic Partnerships,
- Planning & Policy Development,
- Data for Action,
- Program Development & Evaluation,
- Specific Program Opportunities, and
- Public Information & Education.

The analyses described above applied the data only from the sorting exercise; thus, no implications of relative value exist in these graphics. Value on whatever scales the project has used is represented below, in the Ratings discussion. Rather, the shape and size of the categories reflects the distribution of the points within that cluster, with large clusters typically covering more conceptual area than smaller clusters.

Appendix V shows the complete list of statements per cluster.

## RATINGS

Identifying the issues is a critical first step for a needs assessment. The rating data then provides additional information to answer four questions.

- First, while all of the ideas are important, which ideas are most important? In other words, among all of the ideas, are there a smaller number of clear priorities?
- Second, what ideas have the most potential to impact health?
- Third, what is the relationship of importance and impact on health among the concepts?
- Fourth, do public health professionals and aging professionals have different priorities?

### CLUSTER RATINGS MAPS

Using the specific statements as the data points, the analysis computes the average rating of each item and then the average of all items within a cluster or concept. The resulting value for each cluster is shown in two different graphical representations. One graphical representation of the ratings is shown in the Cluster Rating Map (Figure 4).

In this graph, the greater the height dimension, the higher the average rating for the cluster. The rating data, when coupled with the concept map, provides the means to facilitate discussion of these important questions. Again, in order to make the data accessible to all stakeholders, the data represented by the cluster rating map was also converted into two types of graphs: Pattern Matches of concept level results and Go-Zone analyses of item level results.

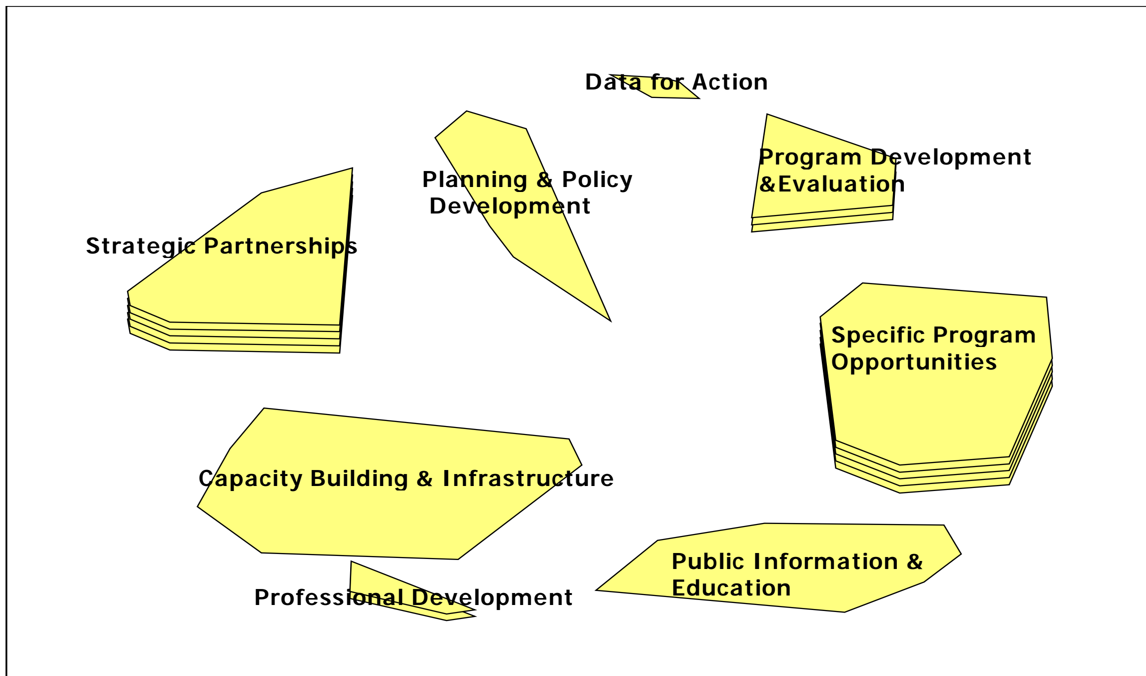


**Figure 4.** Cluster Rating Map, indicating the relative *importance* of the contents of each cluster. This suggests that Strategic Partnerships and Specific Program Opportunities are considered relatively more important than, for example, Planning And Policy Development or Public Information and Education.

PATTERN MATCHES

The pattern match graph enables the presentation of two values on the map contents in comparison to each other. In this project, each cluster is arrayed on a vertical number line for *importance*, and on another vertical number line for *potential impact on health*. Figure 4 shows the Cluster Rating Map and Figure 5 shows the number line graph, or Pattern Match, for these variables. To facilitate interpretation by groups of stakeholders, these number lines are joined to compare the pattern of results for importance to the pattern for potential impact; hence the term "pattern matching."

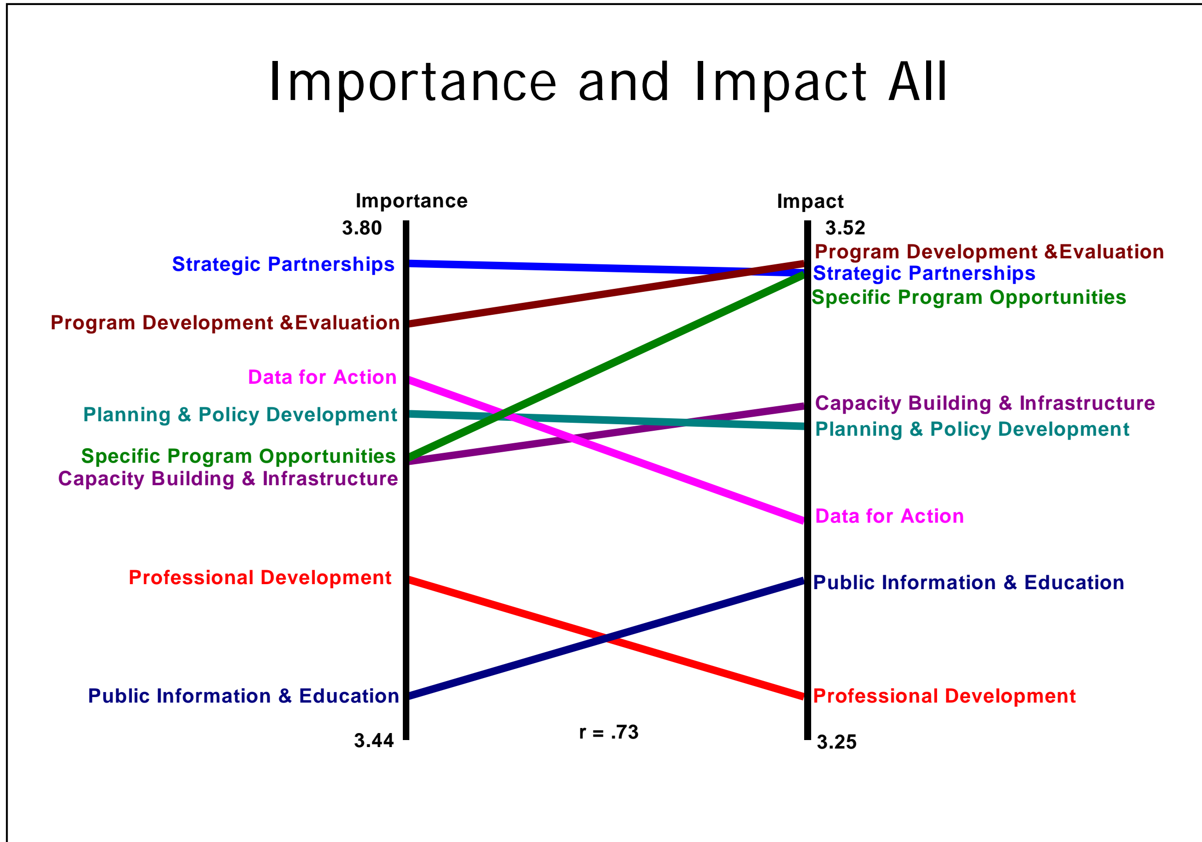


**Figure 5.** Importance and Potential Impact on Health Pattern Match

The pattern match shows that the relationship between Importance and Potential Impact on Health is strongly positively correlated (r = .73). This suggests that participants did not distinguish much between Importance and Potential Impact. Therefore, the Steering Committee chose to focus on Importance ratings only.

Pattern matches can also compare the value ratings of two different groups. Figure 6 compares the Importance ratings of participants affiliated with public health agencies with those affiliated with aging agencies. According to this graph, Aging and Public Health participants prioritize the issues quite differently. Top priorities for Aging participants are Strategic Partnerships and Specific Program Opportunities. For Public Health participants, it is Program Development & Evaluation, Data for Action, and Strategic Partnerships. That both groups rated Strategic Partnerships so high is good news for collaboration between the two.

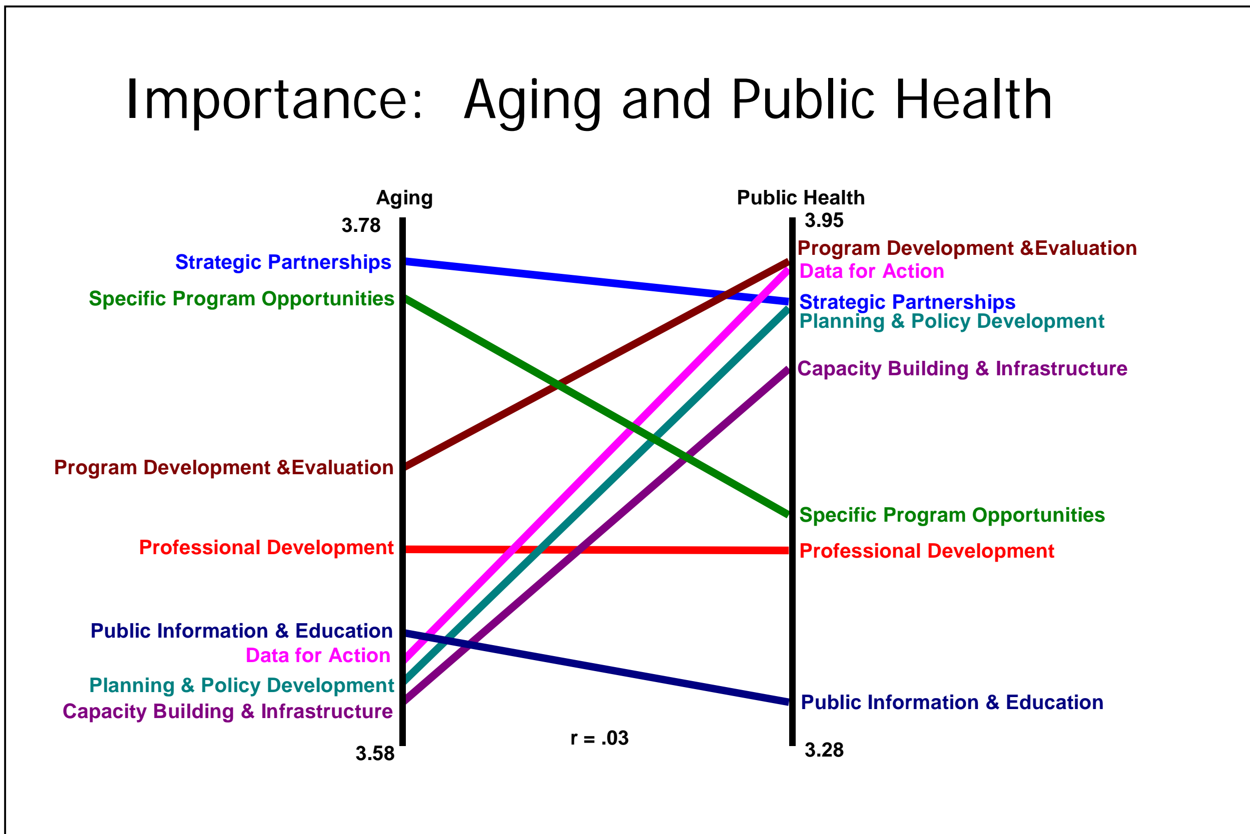


**Figure 6.** Aging and Public Health Importance Pattern Match

However, the purpose of these graphs is not to provide a specific data driven answer about actions. Rather, the point is use the data to show decision makers what their stakeholders are thinking. The goal of this presentation is to elicit and even provoke a discussion, based on evidence, of what this result means and what responses might logically emerge. The discussion can be focused on the issues that seem to need the most attention.

One final point must be made. The range on the scales is somewhat small due to the fact that the cluster mean is the mean of item scores, and the item scores are the mean values across raters. In effect, the pattern match is a mean of means and the deviation among scores is quite small. However, the results are not meant to be extrapolated from a sample to some other population. Rather, the results are intended to show what a group of selected key informants think about an issue. As such,

while the dispersion may be small the fact remains that items within some clusters were systematically rated higher [or lower] than items in other clusters. This systematic pattern represents information that should be noted by stakeholders.

"GO-ZONE" ITEM ANALYSES

A further graphical result based upon participant-provided data is the Go-Zone Analysis. Just as the concept map cluster levels and the pattern match enable decision makers to observe, understand and agree upon the relationship and relative value of concepts, the go-zone analysis enables stakeholders to keep the larger conceptual view in mind, while returning to the contents of each cluster to answer questions in more detail within each concept. As an example, consider the pattern match (figure 6) and look at the line between Public Health and Aging for the concept of "Data for Action." If this were an area of interest and discussion it would be useful to revisit the detail for this conceptual cluster. Are there items within this concept that both Public Health and Aging believe to be important? To examine this, a plot of all of the items that comprise the Data for Action cluster is graphed along the two dimensions of Public Health and Aging (Figure 7). A line was drawn on the vertical at the mean to divide high and low importance for Aging affiliates; and a horizontal line was drawn at the mean to divide high and low importance for Public Health affiliates. The result is that items in the upper right quadrant have the highest mean ratings for both groups; that is, above the mean on importance for both Public Health and Aging. These items might suggest issues that ought to be addressed first, given that they are high for both groups. Certainly there are other interpretations that could be added to understand this graph. The key point is that this provides a way for all stakeholders to view the data and to then engage in assisted dialogue about implications. Go-Zone analyses comparing Importance for Public Health and Aging affiliates for all clusters are located in Appendix III.

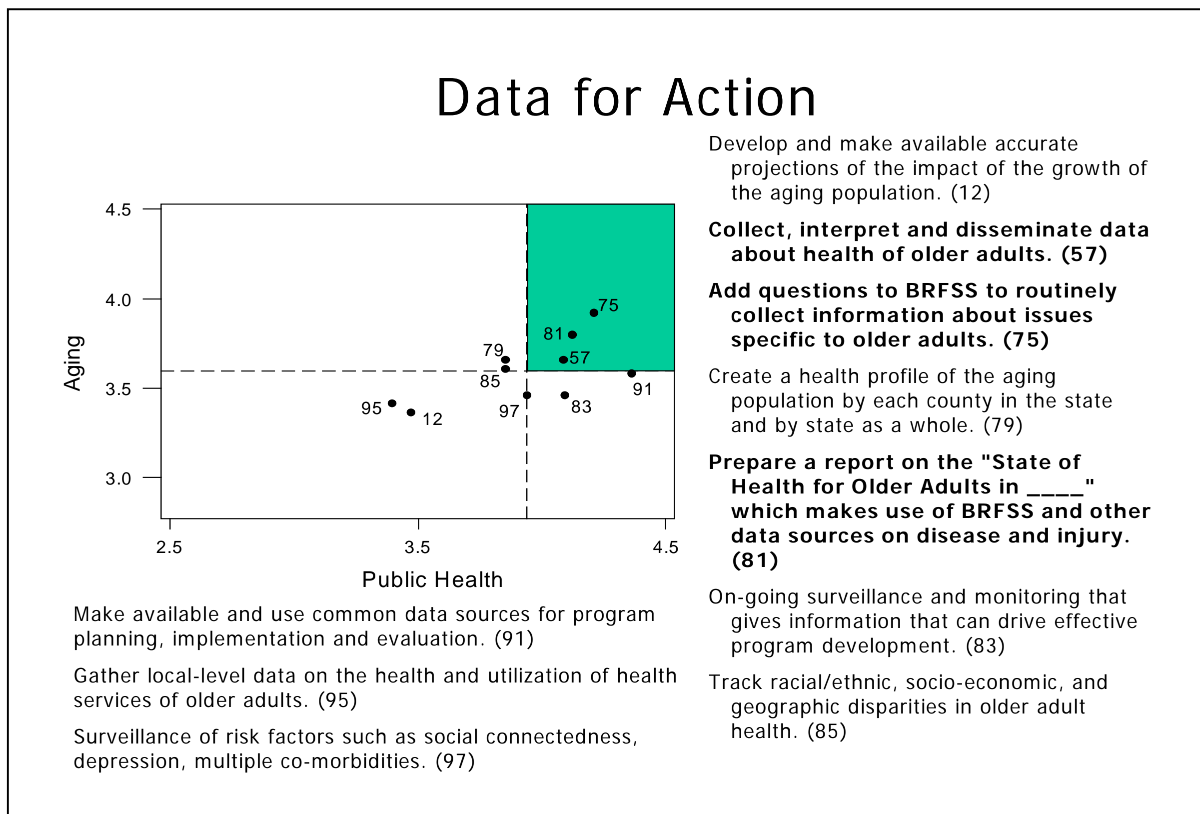




**Figure 7.** Sample Go-Zone Analysis

## ACTION PLANNING

With the information provided through the pre-retreat process, participants were able to focus on identifying where groups and interest positions agree on options and what steps to take next. Participants defined action steps for each cluster or area of the concept map.

Participants found it helpful to combine some of the clusters for action planning, so action plans were created for six categories: Professional Development, Capacity Building & Infrastructure, Strategic Partnerships/Planning & Policy Development, Data for Action, Program Development & Evaluation/ Specific Program Opportunities, Public Information & Education.

### ACTION RECOMMENDATIONS

#### PROFESSIONAL DEVELOPMENT

Key statements in the area of the map labeled Professional Development were:

- Seek gerontology and geriatric *training* for state public health staff and public health professionals. (6)
- *Train the public health staff* at both the state and local levels about aging and HPDP for older populations. (23)
- Disseminate and translate *best practices; technical assistance* in application. (41)
- Ensure that DPH *staff has knowledge* and experience in health promotion & aging. (67)

Major recommendations of the group were summarized into the following high-priority recommendation:

**Develop and conduct "Public Health & Aging 101", which would include:**

- Identifying the nature and extent of the problem of relevant training for both groups
- Identifying and disseminating reliable learning on best practices in healthy aging
- Training on evaluation methods and tools for local and state programs
- Ensuring cultural competency of staff and resulting services

in addition to other elements that arise during the needs assessment/planning stages of training development

Target populations: Training and learning opportunities would be planned and presented for Public Health, Aging and health care providers to take part in together, to enable both learning and partnership development.

Responsible agencies: Public health agencies, with CDC assistance, will conduct needs assessment, plan and deliver training with partner input. Lead: CDC.

Timeline: The group indicated that this effort should begin within one year.

CAPACITY BUILDING & INFRASTRUCTURE

Key statements in the area of the map labeled Capacity Building and Infrastructure were:

- Sponsor *mini grants to local collaborative (public health & aging services)* to conduct health promotion projects. (17)
- *Coordinate state level technical assistance* and consultation for local program development and evaluation. (28)
- Encourage use of *evidence-based program models* at state and local levels. (36)
- *Develop/build the network of (existing) specialists* in public health and aging issues. (37)
- Identify one *state health department person* whose primary responsibility is aging. (78)

Major recommendations of the group were summarized into the following high-priority recommendation:

**Develop health & aging network and working relationships, with centralized planning, by:**

- Identifying points of contact in state health departments; and sending letters from CDC and AoA leadership, with follow-up from NASUA
- Nurturing the network, through scheduled conference calls and meetings,
- Providing support with mini-grants for collaborative programs,
- providing technical assistance and training in grant writing, evaluation
- Creating links to the Prevention Research Centers, especially those with emphasis on issues related to health aging.

Target populations/appropriate participants: state health and aging staff, local and regional healthy and aging staff, advocates, federal program staff.

Responsible agencies: CDC, AoA, NASUA. The lead agencies are CDC and AoA. CDC would lead the PRC contact effort, and NASUA would be involved as a partner.

Timeline: The group indicated that this effort should begin within one to two years.

STRATEGIC PARTNERSHIPS/PLANNING AND POLICY DEVELOPMENT

Retreat participants indicated that these two areas provide common or complementary ideas on similar themes, so considered them together. Key statements that emerged as very important to both state health participants and aging agency participants were the following:

- Establish *collaborative relationships* and research programs with SUA and CDC's Prevention Research Centers. (5) (also addressed in *Capacity Building,* above)
- *Partner with other groups* within the community with resources such as churches, colleges and Universities. (42)
- Contribute to *coordination of initiatives* across SHD/SUA/AAAs and LHDs. (44)

- *Integrate healthy aging into existing categorical grants* for a focus on this specific age group. (50)
- Establish mutually logical and beneficial *linkages between the SHD and SUA* (III-D). (77)
- Conduct a *needs assessment and develop a strategic plan*. (9)
- Support *systems change* to improve effectiveness of community health promotion efforts. (13)
- Make *policy recommendations* based on the best available science. (74)

The group identified the following high-priority action recommendations:

**Develop a Healthy People-like initiative focused on aging by**

- Using evidence-based ideas,
- Identifying issue-based partners.

**Build a political constituency to** identify and provide strategic partners who embrace (and advocate for) healthy aging issues and who can identify or provide funding.

Target populations/appropriate participants: state health and aging leaders, local and regional healthy and aging staff, advocates.

Responsible agency: NASUA.

Timeline: The group indicated that this effort should begin within one to two years.

**Develop relationships with AARP, to**

- Identify appropriate avenues for collaboration on healthy aging issues at the state level and
- Involve AARP on these issues at the national policy level.

Target populations/appropriate participants: state health and aging leaders, local and regional healthy and aging staff, advocates.

Responsible agencies: Not identified

Timeline: No timeline was indicated, but the reporting group described this as appropriate to begin in the short term.

**Identify contact people** within states and nationally meet regularly to identify similar interest and opportunities for collaboration.

Target populations/appropriate participants: state health and aging leaders, local and regional healthy and aging staff, advocates, national level program staff.

Responsible agencies: Not identified

Timeline: No timeline was indicated, but the reporting group described this as appropriate to begin in the short term.

**Develop a joint strategic plan for healthy aging:**

- Focus on disease prevention and health promotion
- Ensure state and local involvement
- Include stakeholders (AARP, PRCs, etc.)
- Review evidence-based strategies and Review Aging States report
- Develop written Memo of Understanding/Agreement based on planning outcomes.

Target populations/appropriate participants: state health and aging leaders, local and regional healthy and aging staff, advocates, with support from federal agencies.

Responsible agencies: state health departments and state offices on aging

Timeline: No timeline was indicated, but the reporting group described this as appropriate to begin in the short term.

**Based on a collaborative state plan, provide funding to state health departments** to support academic-community partnerships to develop, translate, and disseminate evidence-based health promotion programs in aging.

Target populations/appropriate participants: state health and aging program staff and leaders

Responsible agencies: CDC support to state health departments and state offices on aging

Timeline: Immediately after collaborative plan is developed for a state.

DATA FOR ACTION

Key statements in the area of the map labeled Data for Action were:

- Collect, interpret and disseminate data about health of older adults. (57)
- Add questions to BRFSS to routinely collect information about issues specific to older adults. (75)
- Prepare a report on the "State of Health for Older Adults in ____" which makes use of BRFSS and other data sources on disease and injury. (81)

Based upon the group discussion, the following emerged as priority recommendations:

**Make the BRFSS data and reporting more useful for aging and health issues by**

- providing BRFSS data for older adults to local aging agencies
- Increasing BRFSS sample size, increasing representation of older adults and adding aging-specific questions to BRFSS.
- Preparing a report on “the State of Health” which makes use of BRFSS and other data sources on disease and injury.

Target populations/appropriate participants: aging agencies, advocacy and care groups

Responsible agencies:  State health departments

Timeline:  not specified.

**Provide electronic access to health data for local aging agencies and**

- Organize the data by aging boundaries
- Provide training and technical assistance for data users.

Target populations/appropriate participants:  aging agencies, advocacy and care groups

Responsible agencies:  State health departments

Timeline:  not specified.

**Ensure aging and public health professionals are knowledgeable about existing and future data sources, and how to access them by**

- Providing needed training and technical assistance to public health and aging professionals in effectively using data for action.
- Tailor data to the needs of varied and specific target audiences, e.g. policy makers, media, health & aging professionals.

Target populations/appropriate participants:  aging agencies, advocacy and care groups

Responsible agencies:  State health departments

Timeline:  not specified.

**Develop and publish regularly scheduled "Report on the Health Status of Older Adults" that includes national and comparable state level data.**

Target populations/appropriate participants:  aging agencies, advocacy and care groups

Responsible agencies:  State health departments

Timeline:  not specified.

**Plan and conduct a Surveillance Summit in 2003.**

Target populations/appropriate participants:  aging agencies, advocacy and care groups

Responsible agencies:  State health departments

Timeline:  not specified.

PROGRAM DEVELOPMENT AND EVALUATION

The key statements in the Program Development and Evaluation cluster are:

- Develop *practical evaluation tools* for use in the field. (58)
- Include *impact measures*, such as quality of life and disability, in surveillance data. (90)

The following action items correspond to one or both of those items:

- Identify existing evidence-based program models for dissemination.
- Supplement existing models by developing program specific tool kits to assist professionals in program development and evaluation.
- Disseminate program and evaluation models widely, via the web, hard copy, conferences and other avenues.

SPECIFIC PROGRAM OPPORTUNITIES

This cluster contains specific examples of programs in place or required, and eleven items emerged from this cluster as important to both Aging and Public Health participants. Few action items associated with this group, possibly because the items in this cluster give specific program examples while the action items are broader in their intent. The key statements in this cluster are:

- Develop self-management programs, empowering elderly to take charge of their own health needs. (10)
- Integrate messages for seniors into existing DOH programs. (24)
- Improve injury and falls prevention program in older population. (32)
- Support pilot demonstration programs & promote their replication where need & capacity exist. (34)
- Improve injury and falls prevention program in older population. (32)
- Support pilot demonstration programs & promote their replication where need & capacity exist. (34)
- Facilitate broader use of covered preventive health services by older adult, incl immunizations. (64)
- Address the health of caregivers--spouses and adult children, who themselves may be older. (87)
- Keep in mind rural area elderly as well as those in urban areas and support programs and initiatives accordingly. (89)

Major action recommendations of the participants included the following:

**Create state plans to address quality of life and disease prevention.**

Target populations/appropriate participants: state health departments, aging agencies, advocacy and care groups, research community

Responsible agencies: State health departments

Timeline: not specified.

**Conduct participatory research to identify communities** to target for action.

Target populations/appropriate participants: aging agencies, advocacy and care groups, community groups, state agencies

Responsible agencies: State health departments

Timeline: not specified.

**Engage the community** throughout program development, implementation, and evaluation phases.

Target populations/appropriate participants: community groups, aging agencies, advocacy and care groups

Responsible agencies: Partnerships of agencies

Timeline: not specified.

PUBLIC INFORMATION AND EDUCATION

The final cluster contains six items in the Go-Zone:

- Run statewide media campaigns on health topics to reach seniors through a variety of channels. (7)
- Provide resources to address needs of the various racial/ethnic and/or immigrant populations (18)
- Fund train-the trainer model for health promotion activities in community, health care & institutional settings. (25)
- Develop large print, low literacy and culturally appropriate education materials. (30)
- Support an effort to train seniors to train their peers on health topics so more seniors could be reached. (54)
- Support creation of information that would reach the homebound client. (61)
- Provide information and training on medication management. (82)

The following action items are associated with this cluster:

**Develop a national awareness campaign.**

Target populations/appropriate participants: aging agencies, advocacy and care groups, community groups, state agencies

Responsible agencies: CDC support of state and partner efforts.

Timeline: not specified.

**Develop and resource social marketing capacity.**

Target populations/appropriate participants: aging agencies, advocacy and care groups, community groups, state agencies

Responsible agencies: State health departments

Timeline: not specified.

In general, many action recommendations focused on creating and sustaining partnerships between Aging and Public Health agencies, as well as other private and not-for-profit groups. Retreat participants also recommended that both Aging and Public Health professionals be educated about available resources (including data), existing programs, and methods for needs assessment and evaluation. Finally, participants expressed an interest in having Public Health and Aging create joint strategic plans on both the national and state levels.

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## TYING ACTION PLANS TO AGING STATES RECOMMENDATIONS

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The action steps described above were based on the concept map and the 98 statements that comprise it. But many of these actions also echoed recommendations made by the State Units on Aging in the report titled "Recommendations to Improve the Health of Older Adults," which came out of the Aging States Project.[4] This link was an encouraging one, as it confirmed the importance of the Aging States Report and supported the recommendations contained within the report.

Many of the action steps developed at the retreat link to the Aging States Report recommendations on collaboration, shared resources, and centralized planning for state units on aging and public health departments. In addition, both the Report and the retreat action steps address professional development and education for both aging services and public health networks, so they might encourage and support each other and become familiar with the subject matter traditionally within the other's purview.

Details on how the retreat action steps link to the Aging States Report recommendations are located in the tables in Appendix IV. Each table in Appendix IV represents one category of the "Recommendations," and lists the specific recommendations from the Aging States Report in that category. The table also lists which statements on the concept map relate to that recommendation, and what action steps (if any) were suggested at the retreat.

The retreat participants also created action recommendations that are unrelated to the material in the Aging States Report. This is due partially to the different emphases of the two projects: the focus of the Aging States Project was to discover ways to promote collaboration between the public health and aging services networks, while the focus of the concept mapping project was to discover what public

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[4] "The Aging States Project: Promoting Opportunities for Collaboration Between the Public Health and Aging Services Networks." This report was created by the Chronic Disease Directors and the National Association of State Units on Aging for the benefit of the Centers for Disease Control & Prevention and the Administration on Aging (United States Department of Health & Human Services).

health programs should be able to do or provide. Therefore some recommendations from the Aging States project do not correspond to anything on the concept map, just as some action steps that emerged from the retreat do not pertain to the Aging States project recommendations. The Aging States Report provides detail on those recommendations that are unique to its focus. What follow here are the recommendations that were unique to the work of the retreat, using the concept mapping and action planning approach:

- Create state plans to address quality of life and disease prevention.
- Conduct a National Awareness Campaign.
- Conduct participatory research to identify communities to target for action. Community should be engaged throughout entire program development, implementation, and evaluation phases.
- Develop and resource social marketing capacity.

Again, action recommendations that refer to both projects are summarized in the tables in Appendix IV.

## CONCLUSION AND RECOMMENDATIONS

The Concept Mapping project described in this report provides a summary of what key stakeholders in the health and aging field see as healthy aging programming and research priorities. It provides a conceptual framework which both Aging and Public Health agencies can build a relationship upon. It highlights and recognizes the appropriate differences between the two functions, but also points to areas in which there is some overlap and potential for synergistic collaboration. In addition, it reinforces and confirms the value of the "Recommendations to Improve the Health of Older Adults" report by The Aging States Project. Both efforts provide valuable information to those who are working toward improving the health and well-being of older adults. Together they provide a roadmap and recommendations for action, some of which Public Health and Aging will undertake as separate units, and some of which they will choose to take collaboratively.

To continue the work summarized in this report, it will be beneficial to convene a national group of representatives from Aging and Public Health to engage in a follow up conversation. This will provide the opportunity to prioritize the action steps described here, establish timelines for those actions, and determine which agencies might appropriately take responsibility for bringing those action steps to life.

## Appendix I: List of statements used in the concept mapping project

| # | Statement |
|---|---|
| 1 | Develop or expand cultural competence training for health care professionals. |
| 2 | Set up a process through which local aging & public health staff review incidence rates & concerns of the aging. |
| 3 | Support the development of health resource manual(s) for men which would influence older men's wellness & change behavior regarding their health. |
| 4 | Identify and utilize content experts on various health issues of interest to older adults. |
| 5 | Establish collaborative relationships and research programs with SUA and CDC's Prevention Research Centers. |
| 6 | Seek gerontology and geriatric training for state public health staff and public health professionals. |
| 7 | Run statewide media campaigns on health topics to reach seniors through a variety of channels. |
| 8 | Facilitate policy development at the state and local level to support healthy aging. |
| 9 | Conduct a needs assessment and develop a strategic plan. |
| 10 | Develop self-management programs, empowering elderly to take charge of their own health needs. |
| 11 | Develop a program with "leaders," older adults who will communicate/promote chronic disease prevention programs. |
| 12 | Develop and make available accurate projections of the impact of the growth of the aging population. |
| 13 | Support systems change to improve effectiveness of community health promotion efforts. |
| 14 | Develop social marketing campaign for older adults. |
| 15 | Develop capacity to write grants or do other funding raising to gain more funds for healthy aging. |
| 16 | Author articles and publications to share with others in the aging network related to their challenges and accomplishment. |
| 17 | Sponsor mini grants to local collaborative (public health & aging services) to conduct health promotion projects. |
| 18 | Provide resources to address needs of the various racial/ethnic and/or immigrant populations. |
| 19 | Fund a position in department of health in aging, and fund a position in aging unit to relate to DOH. |
| 20 | Programs to enhance patient provider communication. |
| 21 | Develop a State Wide Website to link older adults to health information. |
| 22 | Develop training to reduce barriers and bridge the gap between public health and aging cultures. |
| 23 | Train the public health staff at both the state and local levels about aging and HPDP for older populations. |
| 24 | Integrate messages for seniors into existing DOH programs. |
| 25 | Fund train-the trainer model for health promotion activities in community, health care & institutional settings. |
| 26 | Improved access to services with transportation. |
| 27 | Enhance disease management and self-management initiatives by incorporating geronotological principles. |

| # | Statement |
|---|---|
| 28 | Coordinate state level technical assistance and consultation for local program development and evaluation. |
| 29 | Collaborate with communities to assess/improve environment and community design for older citizens. |
| 30 | Develop large print, low literacy and culturally appropriate education materials. |
| 31 | Provide public health expertise to informal elder caregivers. |
| 32 | Improve injury and falls prevention program in older population. |
| 33 | Provide technical assistance on program design, implementation and evaluation. |
| 34 | Support pilot demonstration programs & promote their replication where need & capacity exist. |
| 35 | Support public education to debunk stereotypes/myths about aging. |
| 36 | Encourage use of evidence-based program models at state and local levels. |
| 37 | Develop/build the network of (existing) specialists in public health and aging issues. |
| 38 | Place emphasis on sex and aging issues including HIV/AIDS education, prevention, counseling; men's/women's health. |
| 39 | Create community-based safety programs for older pedestrians that include education, environmental adaptation and enforcement. |
| 40 | Facilitate development of integrated health communications campaigns across disease and injury programs. |
| 41 | Disseminate and translate best practices; technical assistance in application. |
| 42 | Partner with other groups within the community with resources such as churches, colleges and Universities. |
| 43 | Increase number of health screenings that are specific to cultural/ethnic groups. |
| 44 | Contribute to coordination of initiatives across SHD/SUA/AAAs and LHDs. |
| 45 | Increase awareness and capacity for screening for depression and substance abuse. |
| 46 | Target the specific and different aging issues of young old populations (65-75) and old (75+). |
| 47 | Facilitate mutual interest HPDP training for staff of health and aging departments. |
| 48 | Use techniques to reach out to diverse populations (i.e. minorities, gay and lesbian community, rural populations). |
| 49 | Encourage development of community-based programs that integrate many of the available programs. |
| 50 | Integrate healthy aging into existing categorical grants for a focus on this specific age group. |
| 51 | Identify effective community interventions able to prevent or forestall chronic health problems common to aging. |
| 52 | Provide funds to contract w/ academic institutions to develop collaborative health promotion programs in aging. |
| 53 | Analyze state and community policies that affect the health and quality of life of older adults. |
| 54 | Support an effort to train seniors to train their peers on health topics so more seniors could be reached. |
| 55 | Develop state plans in collaboration with other state agencies to address the HP/DP needs of older persons. |
| 56 | Coordinate a public health response to mental health issues in elderly with other stakeholders. |
| 57 | Collect, interpret and disseminate data about health of older adults. |
| 58 | Develop practical evaluation tools for use in the field. |
| 59 | Collaborate with AARP chapters, union retiree groups, veterans groups, etc. on health promotion initiatives. |
| 60 | Develop programs to educate older adults and their families about the importance of health screenings. |
| 61 | Support creation of information that would reach the homebound client. |

| # | Statement |
|---|---|
| 62 | Disseminate healthy aging how-to materials and other resource materials to local agencies and communities. |
| 63 | Involve of older adults to assess & address the public health needs of their age group. |
| 64 | Facilitate broader use of covered preventive health services by older adult, incl immunizations. |
| 65 | Emphasize minority health issues. |
| 66 | Provide centralized support to state & local project staff in the design & eval. of health promotion programs in aging. |
| 67 | Ensure that DPH staff has knowledge and experience in health promotion & aging. |
| 68 | Hold a state healthy aging conference. |
| 69 | Find creative ways to provide multigenerational programs. |
| 70 | Support programs on end of life issues, e.g. advanced care planning and end of life choices. |
| 71 | Model policies that promote healthy behavior for older adults--health care, communities, institutional settings. |
| 72 | Support a consumer advisory group to provide direction/advocacy for health promotion strategies for older persons. |
| 73 | Have SUA and SHD collaborate on information for the national 211 system. |
| 74 | Make policy recommendations based on the best available science. |
| 75 | Add questions to BRFSS to routinely collect information about issues specific to older adults. |
| 76 | Enable the development of a user-friendly and current information database containing resources available to older adults in the state. |
| 77 | Establish mutually logical and beneficial linkages between the SHD and SUA (III-D). |
| 78 | Identify one state health department person whose primary responsibility is aging. |
| 79 | Create a health profile of the aging population by each county in the state and by state as a whole. |
| 80 | Identify and disseminate best practices for improving the health of older adults |
| 81 | Prepare a report on the "State of Health for Older Adults in _____" which makes use of BRFSS and other data sources on disease and injury. |
| 82 | Provide information and training on medication management. |
| 83 | On-going surveillance and monitoring that gives information that can drive effective program development. |
| 84 | Develop ideas and techniques to promote better physician and patient relationships (i.e. explain diagnoses and procedures). |
| 85 | Track racial/ethnic, socio-economic, and geographic disparities in older adult health. |
| 86 | Develop & execute strategic plans in collaboration with SUAs to address HP/DP among older persons. |
| 87 | Address the health of caregivers--spouses and adult children, who themselves may be older. |
| 88 | Support creation of an Office of Elder Health. |
| 89 | Keep in mind rural area elderly as well as those in urban areas and support programs and initiatives accordingly. |
| 90 | Include impact measures, such as quality of life and disability, in surveillance data. |
| 91 | Make available and use common data sources for program planning, implementation and evaluation. |
| 92 | Help older adults become more technology (i.e computer) savvy especially in regard to internet health information. |
| 93 | Encourage coordinated long range strategic planning for HPDP at local level. |
| 94 | Provide program materials for specific interventions in quantities adequate to meet community demand. |
| 95 | Gather local-level data on the health and utilization of health services of older adults. |
| 96 | Reach out to employers to include HP/DP activities for retirees and those who are close to retirement. |
| 97 | Surveillance of risk factors such as social connectedness, depression, multiple co-morbidities. |
| 98 | Develop a program to increase physical activity among older persons (implement National Blueprint). |

APPENDIX II: OTHER STATEMENTS

Note: Those statements that are marked in bold are also on the list of statements of other agencies because the Steering Committee designated which agency would be responsible for focusing on that particular idea as well as recognized that these statements are disease specific.

*Disease Specific*

| If new resources were made available to state public health programs to improve the health of older adults, a specific thing that program should be able to do or provide is... | Disease Specific |
|---|---|
| Expand the age limits for ed. programs or Women's Health Month to focus on issues specific to older women | age limits |
| **Increase the availability of Alzheimer's Education programs for professionals serving/treating the elderly.** | Alzheimer's |
| **Increase support to community level programs to support family caregivers of patients with Alzheimers.** | Alzheimer's |
| **Support community level programs to coordinate medical, community, and social services for patients with Alzheimers.** | Alzheimer's |
| **Fund regional piloting of new screening methods for assesing Alzheimer's risk in younger elderly.** | Alzheimer's |
| To promote the reporting of early-stage Alzheimer's by neurologists to the NYS Alzheimer's & Other Dementias Registry. | Alzheimer's |
| Support arthritis self-help education programs to seniors at senior centers, retirement facilities and churches. | arthritis |
| cardiovascular disease programs | cardiovascular |
| Expanded, age-appropriate opportunities & resources for older adults to improve modifiable CVD risk factors. | cardiovascular |
| Women's Cardiovascular Awareness Education - Prevention and what are the symptoms. | cardiovascular |
| **Cognitive fitness programs to delay or prevent dementia (e.g. brain gyms)** | Cognitive fitness |
| Screening and treatment services related to colorectal cancer. | colorectal cancer |
| **Interface Public Health with Mental Health and substance abuse** | Coordination |
| provide incentives for collaborations between mental health, substance abuse and SUA's | Coordination |
| **Depression counseling** | depression |
| **Education and intervention regarding depression** | depression |
| **mental health consultation and programming for depression** | depression |
| Public awareness program targeting MDs to place more emphasis on treating and recognizing depression in elderly. | depression |
| Provide limited diabetes education on the ABCs and recommendations about foot and eye exams. | diabetes ed |
| Provide funding for diabetes education and foot care for diabetics age 65 or older. | diabetes ed - foot care |
| Techniques to reach out to diverse populations (i.e. minorities, gay and lesbian community, rural populations) | diversity techniques |
| program to increase awareness of domestic violence among older women | domestic violence |
| Develop & support training for service providers relating to elder abuse | elder abuse |
| Resources to address needs of the various racial/ethnic populations | ethnic |
| Increased number of health screenings that are specific to cultural/ethnic groups. | ethnic |
| **Revisit the Food Guide Pyramid to determine if original assumptions are still applicable today.** | food research |
| **in home foot care** | foot care |
| **Secondary health care services to persons in thier homes such as podiatry and opathalmology.** | foot care |
| Menopause, diabetes, cardiovascular disease and stroke | Health concerns |

| If new resources were made available to state public health programs to improve the health of older adults, a specific thing that program should be able to do or provide is... | Disease Specific |
|---|---|
| **Support community health education programs focused on nutrition and physical activity to senior farmer's markets.** | health ed |
| **Nutrition Education** | health ed |
| **Promote nutrition programs that go the USDA Pyramid with its overemphasis on meat and dairy.** | health ed |
| health education at senior centers, churches, mobile home parks, -- reaching multiple ethnicities | health ed |
| Educate families and elders to the steps for good nutrition and activity specific to their needs. | health ed |
| Implement a statewide campaign for promoting physical exercise and healthy nutrition. | health ed |
| Increased health promotion & disease prevention progs, including medication monitoring and alcohol treatment progs. | health ed |
| Reframe PH messages for older people with disabilities to encourage participation in exercise and nutrition programs. | health ed |
| statewide wellness programs including physical activity, nutrition and smoking cessation | health ed |
| Support culturally-sensitive programs in physical activity and nutrition | health ed |
| **Local agencies could partner with grocery stores and markets to promote being a smart healthy shopper** | healthy eating |
| **Real life health tips for eating healthy with very limited funds. (Such as which fast food is better)** | healthy eating |
| **Require meal programs to provide healthier meals,focusing on fruits, vegetables, and whole grains.** | healthy eating |
| **Resources for local programming to support healthy eating** | healthy eating |
| **Resources for state and local programming to support healthy eating** | healthy eating |
| **Develop a collaborative program for improved nutrition among older persons.** | healthy eating |
| **Research on prevalence or amount of money spent to market food product to age groups and its impact on health & obesity.** | healthy eating |
| support efforts to create environments where it is easier for all people to be active and make healthy food choices. | healthy eating |
| **Prevention of hearing loss.** | hearing loss |
| To help fund getting hearing aids for older adults. | hearing loss |
| funding for eyeglasses/hearing aids for low-income clients | hearing loss - eye |
| (improved health of) for older immigrants, linguistically appropriate programs. (and training in ethnic specific needs) | immigrants |
| Resources to address non-English speaking and immigrant populations | immigrants |
| Immunizations are not generally received. | immunizations |
| Provide funding for immunization programs for persons over age 65. | immunizations |
| Improve rates of adult immunizations. | immunizations |
| use district health office RD/RN staff to provide health promo, nutrition and disease prev information | Information |
| Injury prevention programs for community-based activities including process, impact and outcome evaluation | injury prevention |
| fall prevention programs offered at the local level | injury prevention |
| Home modification programs for falls prevention. | injury prevention |
| Provide funding for home injury prevention programs. | injury prevention |
| Fall prevention/fear of falling program at diverse local sites, e.g. housing, COAs | injury prevention |
| Falls prevention/injury prevention program | injury prevention |
| Home injury prevention progs to perform household inspections & make minor modifications using volunteers and donations. | injury prevention |
| Statewide falls prevention programs. | injury prevention |
| Improve injury and falls prevention program in older population. | injury prevention |

| If new resources were made available to state public health programs to improve the health of older adults, a specific thing that program should be able to do or provide is... | Disease Specific |
|---|---|
| **Memory assessment** | Memory |
| Support the development of health resource manual(s) for men which would influence older men's wellness & change behavior regarding their health. | men's health |
| **To coordinate local mental health service to be available at senior centers and/or primary doctors' offices** | mental health |
| **Mental health screening in senior centers - simple screening test that would encourage elderly to seek help.** | Mental health |
| **training and education for health providers around mental health issues, including depression, suicide** | Mental health |
| **Resources for state and local programming to support mental health** | mental health |
| **Community needs assessments related to dementia/mental health.** | mental health |
| **mental health issues and the elderly** | mental health |
| **Funding for one on one counseling for mal nourished clients.** | nutrition counseling |
| **individualized nutritional counseling** | nutrition counseling |
| **Nutrition counseling** | nutrition counseling |
| **Promote nutrition counseling programs and other nutrition interventions.** | nutrition counseling |
| **access to dietitians for nutrition counseling. Move Senior Nutrition Svcs. from SUA to SHD** | nutrition counseling |
| **Culturally appropriate nutrition education and counseling** | nutrition counseling |
| Develop health tips & marketing strategies that are designed for minorities that reach the local supermarket level. | Nutrition education - minorities |
| **Nutrition interventions to include screening for malnutrition due to poverty, depression, inability to shop, etc.** | nutrition interventions |
| Address oral health needs | oral health |
| Oral health/access to dental care | oral health |
| Develop a program to improve oral health in the long-term care setting. | oral health |
| resources for state and local progamming to address issues not currently funded like osteoporosis, fall prevention, | osteoporosis |
| Develop a collaborative program for osteoporosis prevention and screening. | osteoporosis |
| Early and regular screenings for osteoporosis. | osteoporosis |
| osteoporosis intervention program that would provide screening, education and referral | osteoporosis |
| Support osteoporosis education and referral advice to seniors at senior centers and retirement facilities. | osteoporosis |
| go beyond physical activity and nutrition. Acknowledge the roles of social support, mental stimulation, etc. | Other factors |
| Work with cooperative extension, pharmacists on educ & counseling about use of devices and meds for seniors w/asthma. | pharmacists |
| aggressive mobility and exercise fitness assessments and programs | physical activity |
| Aggressively promote physical activity programs geared to seniors. | physical activity |
| Community wellness/fitness centers where elders can exercise (free) on a routine basis - must include transportation. | physical activity |
| Coordinate linkages between community resources in physical activity with health care initiatives in physical activity | physical activity |
| Create an advertising campaign about physical activity. Include what happens to us when we are inactive. | physical activity |
| Create walking programs in neighborhoods for seniors. | physical activity |
| Develop, implement, and test physical activity programs in collaboration with SUAs | physical activity |
| Exercise activity programs in nursing homes (1 hr. 3 times/wk) - should include age appropriate exercise equipment. | physical activity |
| fitness assessments/accessible equipment/fitness programs | physical activity |

| If new resources were made available to state public health programs to improve the health of older adults, a specific thing that program should be able to do or provide is... | Disease Specific |
|---|---|
| Implement more physical activity programs for the elderly in rural areas. | physical activity |
| Prevention through Physical Activity and Health Promotion. | physical activity |
| Promote increased physical activity among older adults. | physical activity |
| promote local level media messages aimed at older adults (50+) to increase group physical activity. | physical activity |
| promote safe and appropriate physical activity as a mandatory program component. | physical activity |
| Provide discounts for joining health clubs | physical activity |
| Provide funding for programs to increase physical activity among persons over age 65. | physical activity |
| Resources for state and local programming to support regular physical activity | physical activity |
| Work with planning agencies to provide safe walking and biking areas. | physical activity |
| Strategies to promote physical activity among the elderly. | physical activity |
| To conduct age appropriate exercise programs | physical activity |
| Utilize the expertise of the fitness industry. | physical activity |
| Develop a program to increase physical activity among older persons (implement National Blueprint) | physical activity |
| **no cost or very low cost annual physical exams.** | physicals |
| **Provide funding for poly-pharmacy programs to evaluate medication problems experienced by persons over age 65.** | polypharmacy |
| **pharmacy consulting re: medication management and poly-pharmacy** | polypharmacy |
| **Polysubstance issues - unintentional misuse of medications (polypharmacy of misdosing)** | polypharmacy |
| **Address the issue of poly-pharmacy -** | polypharmacy |
| build programs to integrate different disease/condition area (ie phys act+falls prevention,nutrition+oral health) | program integration |
| **Coordinated referral system at the local level to meet needs identified in nutrition and health screening** | referral system |
| **routine nutrition screening and referral** | referral system |
| **Cardiac and stroke rehab program for rural communities (ex. traveling RV w/ equip)** | rural rehab |
| Community Awareness of Home Safety/Community Safety. | safety |
| home safety assessments/installation of safety equipment | safety |
| Improve screening programs (diabetes, hypertension, etc.) and access to care. | screening |
| Emphasis on sex and aging issues including HIV/AIDS education, prevention, counseling; men's/women's health | sex and aging |
| Info targeting older Americans on ways they can quit tobacco use & protect children from secondhand smoke | smoke - secondhand |
| Promote cessation in middle age adults; promote take it outside campaign (targeting grandparents) | smoking cessation |
| Provide limited smoking cessation advice/tips to seniors at senior centers, retirement facilities and churches. | smoking cessation |
| **To develop substance abuse awareness prgrams for older adults** | Substance abuse |
| **Resources for state and local programming to address substance abuse issues** | Substance abuse |
| Training for professionals regarding cultural competency issues | training - cultural |
| Closed head injury program - education for MDs and clients that concussions can be very dangerous. | training - head injury |
| Train home and community based services workers on exercise, fall prevention, and self-exam and screenings. | training - service workers |
| **Local transportation options for ambulatory older adults, which would require coordiation with MV sectors in state govt.** | transportation |
| **Create Fact Sheets on vitamin and/or herbal supplements on possible benefits/drawbacks of each.** | vitamins & herbs |

Note: Those statements that are marked in bold are also on the list of statements of Disease Specific because the Steering Committee recognized that some statements were disease specific as well as recognizing that there was a certain agency that would be responsible for focusing on that particular idea.

*Other Agencies*

| If new resources were made available to state public health programs to improve the health of older adults, a specific thing that program should be able to do or provide is... | Agency | Agency 2 | Agency 3 |
|---|---|---|---|
| Prepare materials and advocate for aging-related HPDP wor policy makers and legislators. | advocates | | |
| Assistance in finding quality palliative and/or end of life care & support services for their families when needed | AOA | HCS | |
| Coordination of health services for older adults. | AOA | HCS | |
| a system that is streamlined...get the services to the seniors! | AOA | HRSA | |
| Alternatives to nursing home placement. | AOA | HRSA | |
| **To coordinate local mental health service to be available at senior centers and/or primary doctors' offices** | AOA | SAMHSA | HCS |
| Increase support for the work of Alzheimer's Disease Assistance Centers in diagnosing & treating patients with Alz. | AOA | SAMHSA | |
| **Support community health education programs focused on nutrition and physical activity to senior farmer's markets.** | AOA | | |
| **Local agencies could partner with grocery stores and markets to promote being a smart healthy shopper** | AOA | | |
| **Real life health tips for eating healthy with very limited funds. (Such as which fast food is better)** | AOA | | |
| **Require meal programs to provide healthier meals, focusing on fruits, vegetables, and whole grains.** | AOA | | |
| **Resources for local programming to support healthy eating** | AOA | | |
| **Resources for state and local programming to support healthy eating** | AOA | | |
| **Funding for one on one counseling for mal nourished clients.** | AOA | | |
| **individualized nutritional counseling** | AOA | | |
| **Nutrition counseling** | AOA | | |
| **Promote nutrition counseling programs and other nutrition interventions.** | AOA | | |
| **Coordinated referral system at the local level to meet needs identified in nutrition and health screening** | AOA | | |
| **Nutrition interventions to include screening for malnutrition due to poverty, depression, inability to shop, etc.** | AOA | | |
| **access to dietitians for nutrition counseling. Move Senior Nutrition Svcs. from SUA to SHD** | AOA | | |
| **Culturally appropriate nutrition education and counseling** | AOA | | |
| **Develop a collaborative program for improved nutrition among older persons.** | AOA | | |
| **Nutrition Education** | AOA | | |
| **Promote nutrition programs that go the USDA Pyramid with its overemphasis on meat and dairy.** | AOA | | |
| **routine nutrition screening and referral** | AOA | | |
| **Increase the availability of Alzheimer's Education programs for professionals serving/treating the elderly.** | AOA | | |
| arrange training for aging network to gain expertise in health issues | AOA | | |
| provide referrals to programs and services housed outside the public health agency. | AOA | | |

| If new resources were made available to state public health programs to improve the health of older adults, a specific thing that program should be able to do or provide is... | Agency | Agency 2 | Agency 3 |
|---|---|---|---|
| Full-time person at the AAA level to deal only with health promotion - w/o that, there is no time to carry out programs. | AOA | | |
| identify one state unit on aging person whose primary responsibility is health | AOA | | |
| The Area Agencies on Aging could better utilize Title III-D funding. | AOA | | |
| Intensive case management to determine at risk behaviors of seniors participating in nutrition programs through AAAs. | AOA | | |
| Funding for Ombudsman progs for adequate asst living & nursing home visits to increase number of monthly visits. | AOA | | |
| Coordinate health promotion/disease prevention activities for older adults statewide | AOA | | |
| Develop coordinated transportation system for HP assessments, screening, immunizations and PA maintenance and follow-up | AOA | | |
| Provide support for caregivers of older adults. | AOA | | |
| Address the physical and emotional needs of caregivers | AOA | | |
| caregiver health issues | AOA | | |
| care providers to look after loved ones so seniors can access services | AOA | | |
| An effort to use libraries, other places seniors visit besides centers as portals of information. | AOA | | |
| Provide healthy lifestyle education programs to senior groups in the faith communities. | AOA | | |
| End of life care | AOA | | |
| educate older adults about existing health programs operated statewide or in local communities. | AOA | | |
| more money available for home repairs and modifications, so the older adults can stay in their own homes. | AOA | | |
| more money for share-a-home projects. | AOA | | |
| Support older adult access to companion animals in their homes and in institutional settings. | AOA | | |
| social and educational opportunities (transportation provided) for seniors who are isolated. | AOA | | |
| Instilling confidence in older adults to ask key questions of their physicians | AOA | | |
| Preventative medicine focus for caregivers. | AOA | | |
| Set standards of training and certification for ombudsmen. | AOA | | |
| A guide to community resources for older adults and their families, service providers and health professionals | AOA | | |
| Develop a resource listing of community-based organizations serving older adults | AOA | | |
| Independent living skills maintenance | AOA | | |
| Sponsor programs that help seniors maintain independence in their homes. | AOA | | |
| Both State Health and State Aging Units have a specific person with responsibility for HPDP. | AOA | | |
| change the stereotype of aging (ie, if you're old you're sick, disabled frail, etc.) to healthy aging. | AOA | PH | HCS |
| Development of standard chronic care protocols for doctors/consumers to use when managing chronic disease. | ARHQ | | |
| Technical assistance to states in setting up statewide infrastructure and developing state plans | CDC | AOA | CDD |
| guidelines for priority setting - to ensure that public health and aging organizations are on the same page | CDC | AOA | CDD |
| Require state agencies that serve older adults to work cooperatively to maximize limited resources. | CDC | AOA | |
| Explain the basic principles of public health to its partner organizations and understand their missions. | CDC (?) | | |
| Medicare education- use of benefits | CMS | AOA | |
| **no cost or very low cost annual physical exams.** | CMS | HCS | HRSA |
| program to educate providers and seniors on preventive health benefits under Medicare | CMS | HRSA | |

| If new resources were made available to state public health programs to improve the health of older adults, a specific thing that program should be able to do or provide is... | Agency | Agency 2 | Agency 3 |
|---|---|---|---|
| Be able to provide low/no cost Medicare covered prevention services (i.e flu shots) | CMS | HRSA | |
| Clinical preventive services (immunizations, breast and cervical cancer screenings) | CMS | | |
| Facilitate broader use of covered preventive health services by older adult, incl immunizations | CMS | | |
| appropriate transportation to services and services provded in home for homebound | DOT | AOA | |
| Transportation to medical appointments, delivery of prescriptions and better access to care in general. | DOT | AOA | |
| Transportation. | DOT | AOA | |
| **Local transportation options for ambulatory older adults, which would require coordiation with MV sectors in state govt.** | DOT | TRANS | |
| **Improved access to services with transportation.** | DOT | | |
| **Revisit the Food Guide Pyramid to determine if original assumptions are still applicable today.** | FDA | | |
| **Research on prevalence or amount of money spent to market food product to age groups and its impact on health & obesity.** | federal role? | NIH | |
| to support systems which empower consumers and allow consumer direction in care | HCS | AOA | |
| **in home foot care** | HCS | home health | |
| **Secondary health care services to persons in their homes such as podiatry and opathalmology.** | HCS | home health | |
| no charge in-home medication set-up | HCS | home health | |
| **Cardiac and stroke rehab program for rural communities (ex. traveling RV w/ equip)** | HCS | HRSA | |
| To have mobile health care team which includes mental helath workers to reach out to older adults in rural areas | HCS | HRSA | |
| an increased number of mobile clinics available to communities. | HCS | HRSA | |
| **Create Fact Sheets on vitamin and/or herbal supplements on possible benefits/drawbacks of each.** | HCS | | |
| Education about chronic disease management | HCS | | |
| dedicated case managers to assist in the frustrating system of health care paperwork | HCS | | |
| in-home: CompuMed machines | HCS | | |
| (Decrease gap between skilled Medicare and Medicaid services to) Assist people who do not meet criteria for either Medicare or Medicaid program requirements. | HRSA | CMS | |
| Improved certification and monitoring mechanisms of in-home service providers. | HRSA | HCS | home health |
| more resources available to provide skilled care on a more than once a day basis for certain populations. (diabetics) | HRSA | HCS | home health |
| Adequate in home health care services | HRSA | HCS | |
| Medication Management | HRSA | HCS | |
| medication management programs in conjuntion with health conditions and substances, e.g. alcohol | HRSA | HCS | |
| Medication management vs over the counter medication education programs. | HRSA | HCS | |
| Better access to pharmaceuticals | HRSA | HCS | |
| availability of free or lower cost prescription drugs | HRSA | HCS | |
| Fund infrastructure for comprehensive health promotion programs in community, health care and institutional settings. | HRSA | HCS | |
| Better medication assessment and management | HRSA | HCS | |
| Provide program funding to promote persons age 65 or over receiving age & gender specific clinical preventive services. | HRSA | | |
| Increase capacity at area agencies to do healthy lifestyle education, promotion | HRSA | | |

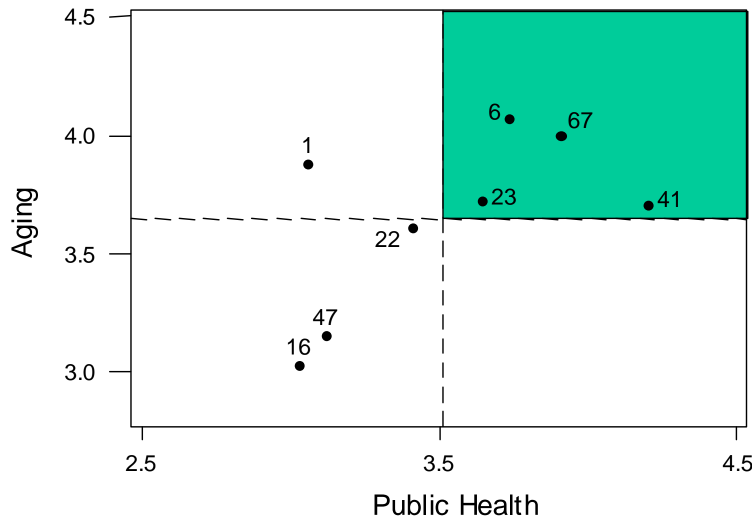
| If new resources were made available to state public health programs to improve the health of older adults, a specific thing that program should be able to do or provide is... | Agency | Agency 2 | Agency 3 |
|---|---|---|---|
| contractual arrangements with local providers for low/no cost health improvement/maintenance activities | HRSA | | |
| incorporate focused effort to raise visibility of crucial need to more fully apply prevention measures | HRSA | | |
| Preventive health education, training and testing | HRSA | | |
| Addressing risk factor reduction in people aged 60 plus. | HRSA | | |
| information about medication management. | HRSA | | |
| Introduce medication tracking and alert systems. | HRSA | | |
| Encourage health practitioners, caregivers and older adults themselves to review medications and rid unnecessary meds. | HRSA | | |
| Navigation services for seniors so they have help knowing what clinical services are available & how to access them | HRSA | | |
| Recruitment efforts for geriatricians to work outside the nursing home | HRSA | | |
| Educate decision makers regarding the need for universal health care for all older adults. | Legislature | advocates | |
| Promote natl replication of senior prescription/pharm assistance programs to those states which still do not have them. | Legislature | HRSA | advocates |
| Educate decision makers regarding the need for coverage for drug prescriptions for seniors. | Legislature | HRSA | advocates |
| Explore cost of providing generic drugs and pharmaceuticals to seniors. | Legislature | HRSA | HCS |
| Low or no cost prescription coverage for low to moderate income seniors. | Legislature | HRSA | HCS |
| Legislative language that articulates the public health responsibility of SHDs for older persons. | Legislature | | |
| **Provide funding for poly-pharmacy programs to evaluate medication problems experienced by persons over age 65.** | NIH | | |
| **pharmacy consulting re: medication management and poly-pharmacy** | NIH | | |
| **Polysubstance issues - unintentional misuse of medications (polypharmacy of misdosing)** | NIH | | |
| **Address the issue of poly-pharmacy -** | NIH | | |
| conduct research to be able to quantify the financial savings/costs of specific health activities/non-activities. | NIH | | |
| More frequent & specific information about access to clinical trials in their geographic areas. | NIH | | |
| Identify and develop effective community-based interventions relevant to the lives of older adults | NIH | | |
| Conduct socio/cultural studies of beliefs and attitudes regarding chronic disease among different groups. | NIH | | |
| Research to evaluate what community supports are available to effectively maintain elders in their own homes. | NIH | | |
| **Prevention of hearing loss.** | occupational health | | |
| Make certain the print size of medications is sufficiently large that it can be read by people with vision problems | pharmaceutical cos | | |
| **Increase support to community level programs to support family caregivers of patients with Alzheimers.** | SAMHSA | AOA | |
| **Support community level programs to coordinate medical, community, and social services for patients with Alzheimers.** | SAMHSA | AOA | |
| **Cognitive fitness programs to delay or prevent dementia (e.g. brain gyms)** | SAMHSA | AOA | |
| **Mental health screening in senior centers - simple screening test that would encourage elderly to seek help.** | SAMHSA | AOA | |
| **Memory assessment** | SAMHSA | AOA | |
| **To develop substance abuse awareness prgrams for older adults** | SAMHSA | | |
| **Depression counseling** | SAMHSA | | |

| If new resources were made available to state public health programs to improve the health of older adults, a specific thing that program should be able to do or provide is... | **Agency** | **Agency 2** | **Agency 3** |
|---|---|---|---|
| **Education and intervention regarding depression** | SAMHSA | | |
| **training and education for health providers around mental health issues, including depression, suicide** | SAMHSA | | |
| **support for grief issues** | SAMHSA | | |
| **Interface Public Health with Mental Health and substance abuse** | SAMHSA | | |
| **Resources for state and local programming to address substance abuse issues** | SAMHSA | | |
| **Fund regional piloting of new screening methods for assesing Alzheimer's risk in younger elderly.** | SAMHSA | | |
| **Resources for state and local programming to support mental health** | SAMHSA | | |
| **Community needs assessments related to dementia/mental health.** | SAMHSA | | |
| **mental health consultation and programming for depression** | SAMHSA | | |
| **mental health issues and the elderly** | SAMHSA | | |

APPENDIX III: GO-ZONE ANALYSES

The next pages show Go-Zone reports for each cluster. The ideas in bold indicate those within the cluster that are located in the Go-Zone; that is, important to both state health department participants and aging agency participants. These ideas were used as the discussion and planning foundation for the action recommendations included in this document.

## Professional Development




Develop or expand cultural competence training for health care professionals. (1)

**Seek gerontology and geriatric training for state public health staff and public health professionals. (6)**

Author articles and publications to share with others in the aging network related to their challenges and accomplishment. (16)

Develop training to reduce barriers and bridge the gap between public health and aging cultures. (22)

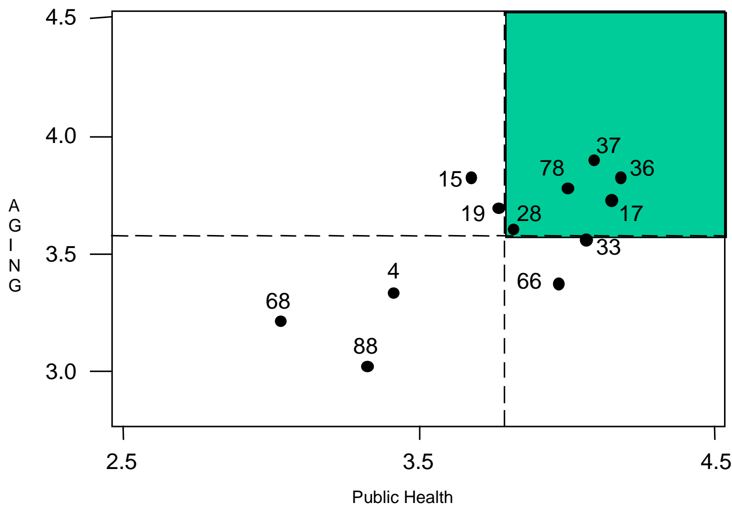
**Train the public health staff at both the state and local levels about aging and HPDP for older populations. (23)**

**Disseminate and translate best practices; technical assistance in application. (41)**

Facilitate mutual interest HPDP training for staff of health and aging departments.(47)

**Ensure that DPH staff has knowledge and experience in health promotion & aging. (67)**

## Capacity Building & Infrastructure




Identify and utilize content experts on various health issues of interest to older adults. (4)

Develop capacity to write grants or do other funding raising to gain more funds for healthy aging. (15)

**Sponsor mini grants to local collaborative (public health & aging services) to conduct health promotion projects. (17)**

Fund a position in department of health in aging, and fund a position in aging unit to relate to DOH. (19)

**Coordinate state level technical assistance and consultation for local program development and evaluation. (28)**

Provide centralized support to state & local project staff in the design &eval. of health promotion programs in aging. (66)

Hold a state healthy aging conference.(68)

**Identify one state health department person whose primary responsibility is aging. (78)**

Support creation of an Office of Elder Health(88)

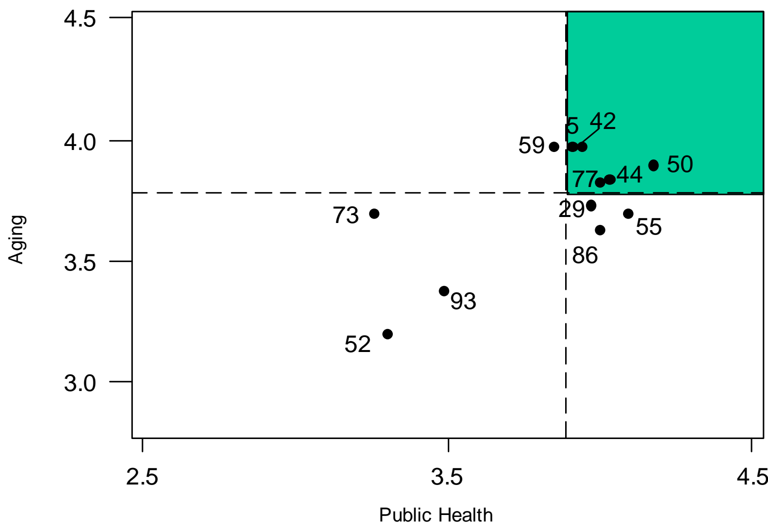
Provide technical assistance on program design, implementation and evaluation. (33)

**Encourage use of evidence-based program models at state and levels. (36)**

**Develop/build the network of specialists in public health and issues. (37)**

Integrate healthy aging into categorical grants for a focus on this specific age group. (50)

## Strategic Partnerships




**Establish mutually logical and beneficial linkages between the SHD and SUA (III-D). (77)**

Develop & execute strategic plans in collaboration with SUAs to address HP/DP among older persons. (86)

Encourage coordinated long range strategic planning for HPDP at local level. (93)

**Establish collaborative relationships and research programs with SUA and CDC's Prevention Research Centers. (5)**

Collaborate with communities to assess/improve environment and community design for older citizens. (29)

**Partner with other groups within the community with resources such as churches, colleges and Universities. (42)**

**Contribute to coordination of initiatives across SHD/SUA/AAAs and LHDs. (44)**

**Integrate healthy aging into existing categorical grants for a focus on this specific age group. (50)**

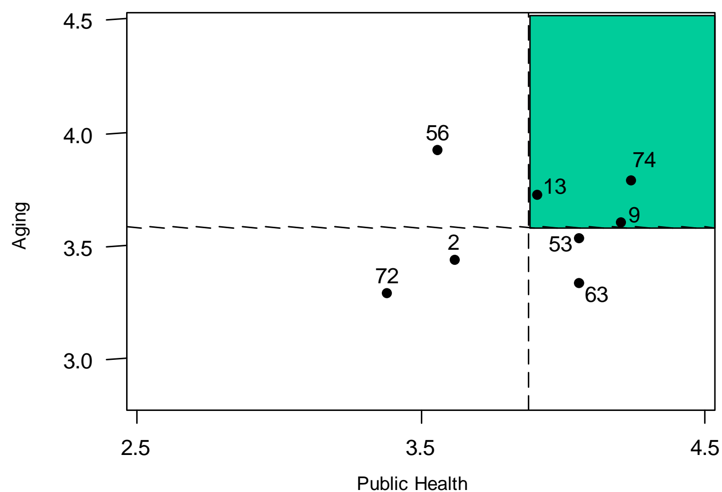
Provide funds to contract w/ academic institutions to develop collaborative health promotion programs in aging. (52)

Develop state plans in collaboration with other state agencies to address the HP/DP needs of older persons. (55)

Collaborate with AARP chapters, union retiree groups, veterans groups, etc. on health promotion initiatives. (59)

Have SUA and SHD collaborate on information for the national 211 system. (73)

## Planning & Policy Development




Set up a process through which local aging & public health staff review incidence rates & concerns of the aging. (2)

Facilitate policy development at the state and local level to support healthy aging. (8)

**Conduct a needs assessment and develop a strategic plan. (9)**

**Support systems change to improve effectiveness of community health promotion efforts. (13)**

Analyze state and community policies that affect the health and quality of life of older adults. (53)

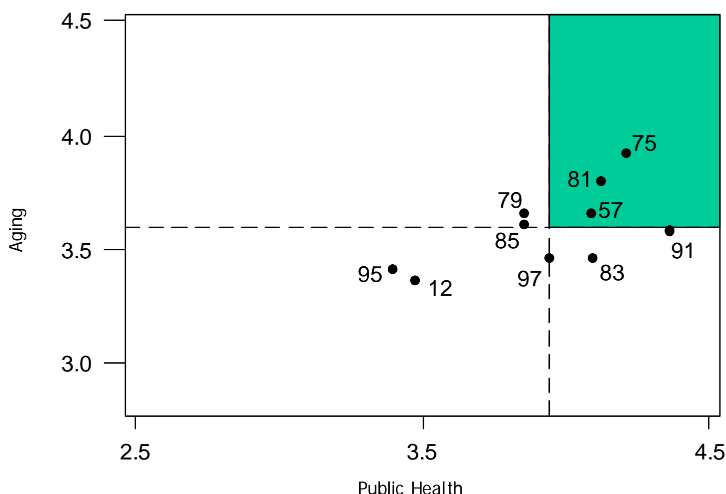
Coordinate a public health response to mental health issues in elderly with other stakeholders. (56)

Involve of older adults to assess & address the public health needs of their age group. (63)

Support a consumer advisory group to provide direction/advocacy for health promotion strategies for older persons. (72)

**Make policy recommendations based on the best available science. (74)**

**Data for Action**




Develop and make available accurate projections of the impact of the growth of the aging population. (12)

**Collect, interpret and disseminate data about health of older adults. (57)**

**Add questions to BRFSS to routinely collect information about issues specific to older adults. (75)**

Create a health profile of the aging population by each county in the state and by state as a whole. (79)

**Prepare a report on the "State of Health for Older Adults in _____" which makes use of BRFSS and other data sources on disease and injury. (81)**

On-going surveillance and monitoring that gives information that can drive effective program development. (83)

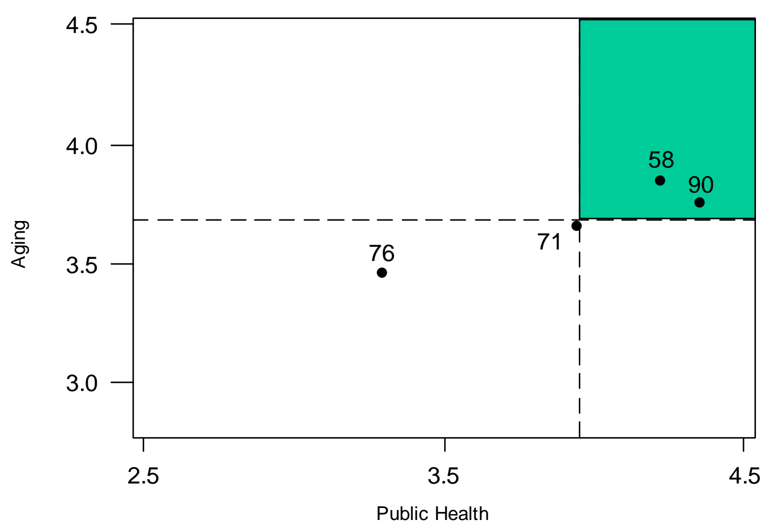
Track racial/ethnic, socio-economic, and geographic disparities in older adult health. (85)

Make available and use common data sources for program planning, implementation and evaluation. (91)

Gather local-level data on the health and utilization of health services of older adults. (95)

Surveillance of risk factors such as social connectedness, depression, multiple co-morbidities. (97)

**Program Development & Evaluation**




**Develop practical evaluation tools for use in the field. (58)**

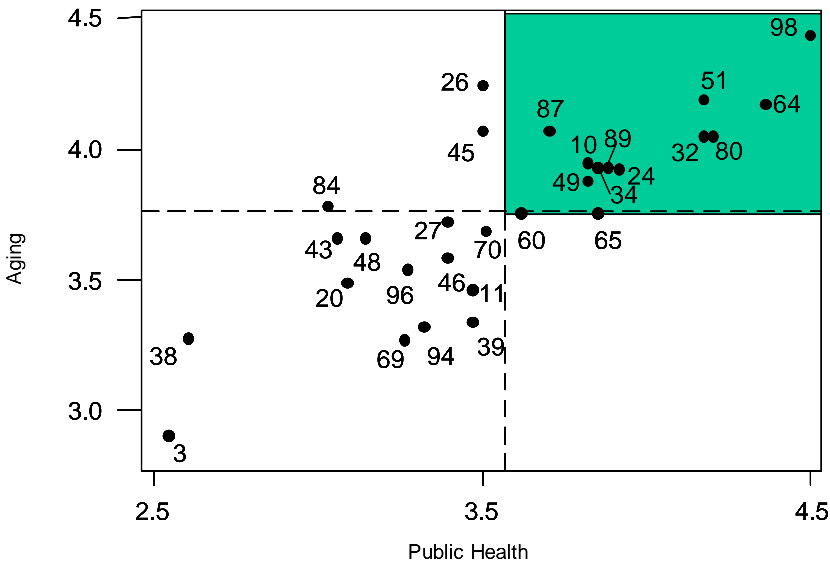
Model policies that promote healthy behavior for older adults--health care, communities, institutional settings. (71)

Enable the development of a user-friendly and current information database containing resources available to older adults in the state. (76)

Identify and disseminate best practices for improving the health of older adults. (80)

**Include impact measures, such as quality of life and disability, in surveillance data. (90)**

## Specific Program Opportunities




Support the development of health resource manual(s) for men which would influence older men's wellness & change behavior regarding their health. (3)

Develop a program to increase physical activity among older persons implement National Blueprint). (8)

**Develop self-management programs, empowering elderly to take charge of their own health needs. (10)**

Develop a program with "leaders," older adults who will communicate/promote chronic disease prevention programs. (11)

Programs to enhance patient provider communication. (20)

**Integrate messages for seniors into existing DOH programs. (24)**

Improved access to services with transportation. (26)

Enhance disease management and self-management initiatives by incorporating gerontological principles. (27)

**Improve injury and falls prevention program in older population. (32)**

**Support pilot demonstration programs & promote their replication where need & capacity exist. (34)**

Place emphasis on sex and aging issues including HIV/AIDS education, prevention, counseling; men's/women's health. (38)

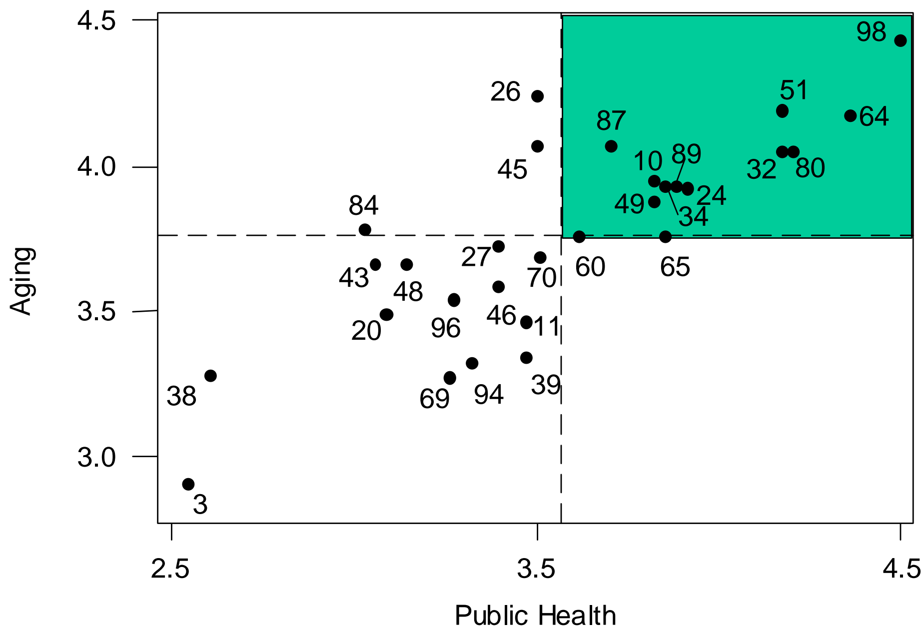
Create community-based safety programs for older pedestrians that include education, environmental adaptation and enforcement. (39)

Increase number of health screenings that are specific to cultural/ethnic groups. (43)

Increase awareness and capacity for screening for depression and substance abuse. (45)

Target the specific and different aging issues of young old populations (65-75) and old old (75+). (46)

Specific Program Opportunities (2)




Use techniques to reach out to diverse populations (i.e. minorities, gay and lesbian community, rural populations). (48)

**Encourage development of community based programs that integrate many of the available programs. (49)**

**Identify effective community interventions able to prevent or forestall chronic health problems common to aging. (51)**

Develop programs to educate older adults and their families about the importance of health screenings. (60)

**Facilitate broader use of covered preventive health services by older adult, incl immunizations. (64)**

Emphasize minority health issues. (65)

Find creative ways to provide multigenerational programs. (69)

Support programs on end of life issues, e.g. advanced care planning and end of life choices. (70)

**Identify and disseminate best practices for improving the health of older adults. (80)**

Develop ideas and techniques to promote better physician and patient relationships (i.e. explain diagnoses and procedures). (84)

**Address the health of caregivers--spouses and adult children, who themselves may be older. (87)**

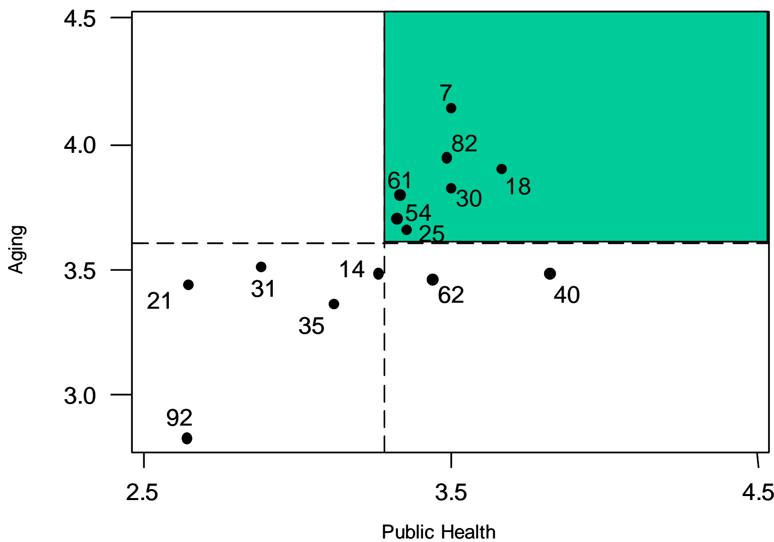
**Keep in mind rural area elderly as well as those in urban areas and support programs and initiatives accordingly. (89)**

Provide program materials for specific interventions in quantities adequate to meet community demand. (94)

Reach out to employers to include HP/DP activities for retirees and those who are close to retirement. (96)

**Develop a program to increase physical activity among older persons (implement National Blueprint). (98)**

## Public Information & Education




**Support creation of information that would reach the homebound client. (61)**

Disseminate healthy aging how-to materials and other resource materials to local agencies and communities. (62)

**Provide information and training on medication management. (82)**

Help older adults become more technology (i.e computer) savvy especially in regard to internet health information. (92)

**Run statewide media campaigns on health topics to reach seniors through a variety of channels. (7)**

Develop social marketing campaign for older adults. (14)

**Provide resources to address needs of the various racial/ethnic and/or immigrant populations. (18)**

Develop a State Wide Website to link older adults to health information. (21)

**Fund train-the trainer model for health promotion activities in community, health care & institutional settings. (25)**

**Develop large print, low literacy and culturally appropriate education materials. (30)**

Provide public health expertise to informal elder caregivers. (31)

Support public education to debunk stereotypes/myths about aging. (35)

Facilitate development of integrated health communications campaigns across disease and injury programs. (40)

**Support an effort to train seniors to train their peers on health topics so more seniors could be reached. (54)**

APPENDIX IV: RETREAT ACTION ITEMS BY "AGING STATES" REPORT CATEGORY

## A. Recommendations for the Centers for Disease Control & Prevention (CDC) and the Administration on Aging (AOA)

Table A1: Promote improved collaborations between state units on aging and state health departments.

| Aging States Project Recommendation | Concept Map Cluster | Concept Map Statements | Action Steps |
|---|---|---|---|
| Supporting active networking among state units on aging and state health departments around older adult health issues. This might include supporting list-serves, informational conference calls, and regional networking meetings. | Strategic Partnerships, Planning & Policy Development, Capacity Building & Infrastructure, Professional Dev't | 2, 28, 37, 44, 47, 68 | (1) Develop health & aging network and working relationships, with centralized planning:<br>• Identify points of contact in state health departments; send letters from CDC and AoA (follow-up from NASUA)<br>• Nurture the network, by holding conference calls and meetings, giving mini-grants, providing technical assistance and training (grant writing, evaluation, using evidence base)<br>• Create links to the PRCs<br>(2) Develop training for health and aging network. |
| Rewarding evidence of inter-agency collaboration between state units on aging and state health departments in competitively funded programs. | Capacity Building & Infrastructure | 17 | |
| Encouraging state units on aging to involve state health departments in planning, implementing, and evaluating health promotion/ disease prevention programs for older adults. | Strategic Partnerships, Planning & Policy Development, Capacity Building & Infrastructure | 17, 44, 73, 77 | |
| Encouraging state health departments to involve state units on aging in planning, implementing, and evaluating projects and programs that target older adults. | Strategic Partnerships | 17, 44, 73, 77, | |
| Endorsing state health aging | Planning & | 9, 55, 86, 93 | (1) Create a national plan for healthy |

| | | | |
|---|---|---|---|
| plans that are jointly developed by state units on aging and state health departments. | Policy Dev't, Strategic Partnerships | | aging, to lead to committed support. |

Table A2: Support health promotion/ disease prevention programs for older adults

| **Aging States Project Recommendation** | **Concept Map Cluster** | **Concept Map Statements** | **Action Steps** |
|---|---|---|---|
| Developing the scientific evidence needed to determine the most effective approaches to health promotion/ disease prevention programs for older adults. | Capacity Building & Infrastructure, Data for Action, Planning & Policy Dev't | 57, 74, 97 | |
| Developing mechanisms to disseminate and promote best practices and effective and innovative program models. | Data for Action, Professional Dev't, Specific Program Opportunities | 12, 41, 62, 80 | (1) Develop a Healthy People –like initiative focused on aging:<br>• Use evidence-based ideas<br>• Identify issue-based partners |
| Rewarding applicants that can document an evidence base in competitively funded programs. | Capacity Building & Infrastructure | 36 | |
| Providing technical assistance and support to conduct rigorous evaluations of promising programs. | Program Dev't and Evaluation | 58 | |
| Developing and promoting data standards and guidelines to encourage shared program planning and evaluation. | Data for Action, Program Dev't and Evaluation | 12, 81, 85, 90, 91 | (1) Provide needed data analysis on existing and future data sources.<br><br>(2) Tailor data to the needs of varied and specific target audiences, e.g. policy makers, media, health & aging professionals.<br><br>(3) Develop and publish regularly scheduled "Report on the Health Status of Older Adults" that includes national and comparable state level data.<br><br>(4) Surveillance Summit 2003 |
| Assuring that current and future funded programs address older adults and | Specific Program Opportunities, | 24, 50 | |

| | | | |
|---|---|---|---|
| utilize the existing strengths of the aging and public health networks. | Strategic Partnerships | | |

Table A3: Provide needed training and technical assistance

| Aging States Project Recommendation | Concept Map Cluster | Concept Map Statements | Action Steps |
|---|---|---|---|
| Developing training materials for use at the state level to achieve visibility for healthy aging programs. | Public Information & Education | 62 | |
| Developing and promoting training materials and educational opportunities for practitioners about evidence-based health promotion and disease prevention strategies for older adults. | Professional Development, Data for Action | 23, 41, 91 | (1) Ensure aging and public health professionals are knowledgeable about existing and future data sources, and how to access them.<br><br>(2) Provide needed training and technical assistance to public health and aging professionals in effectively using data for action. |
| Providing technical assistance and support to replicate, adapt, and evaluate successful evidence-based health promotion/ disease prevention programs. | Capacity Building & Infrastructure, Specific Program Opportunities, Strategic Partnerships | 5, 28, 33, 34, 36, 41, 52, 66, 80, 94 | (1) Provide funding to support academic-community partnerships to develop, translate, and disseminate evidence-based H.P. programs in aging. These activities should flow from state plan.<br><br>(2) Identify existing evidence-based program models for dissemination.<br><br>(3) Supplement existing models by developing program specific tool kits to assist professionals in program development and evaluation.<br><br>(4) Disseminate widely, via the web, hard copy, conferences and other avenues. |

## B. Recommendations for State Units on Aging and State Health Departments

Table B1: Promote collaboration and communication across agencies

| Aging States Project Recommendation | Concept Map Cluster | Concept Map Statements | Action Steps |
|---|---|---|---|
| Designating a "point person" for communication with the counterpart agency around health promotion/ disease prevention for older adults. | Capacity Building & Infrastructure | 19, 78 | |
| Clarifying state organizational relationships related to lead roles and joint planning for health aging programs. | Planning & Policy Dev't, Strategic Partnerships | 9, 77, 86, 93 | (1) Develop a Healthy People –like initiative focused on aging:<br>• Use evidence-based ideas<br>• Identify issue-based partners<br>(2) Develop a joint strategic plan for healthy aging:<br>• Focus on DP and HP<br>• State and local involvement<br>• Include stakeholders (AARP, PRC, etc.)<br>• Identify contact people and meet regularly<br>• Review evidence-based strategies<br>• Review Aging States report<br>• Develop written Memo of Understanding/ Agreement<br>(3) Conduct a needs assessment, including older adults, and develop a strategic plan with policy recommendations.<br>• Have an independent facilitator help to facilitate a shared vision;<br>• Organize appropriate work team to develop the plan. |
| Enlisting health department collaboration in designing and implementing health promotion programs directed by the state unit on aging. | Strategic Partnerships | 77 | |
| Including older adults in all appropriate health promotion | Specific Program | 11, 54, 63 | |

| | | | |
|---|---|---|---|
| and disease prevention initiatives directed by the state health department. | Opportunities, Planning & Policy Dev't, Public Info & Education | | |
| Enlisting state unit on aging assistance in the design and implementation of health department programs for older adults. | Strategic Partnerships | 77 | |
| Fostering development and expansion of community-level partnerships between area agencies on aging, local public health departments, and their respective provider organizations. | Public Info & Education, Strategic Partnerships, Specific Program Opportunities | 25, 29, 42, 44, 49, 59, 62, 96 | (1) Build a political constituency to<br>• Provide strategic partners who embrace (and advocate for) our issues and mission<br>• Identify funding sources<br>(2) Develop relationship with AARP, finding ways to get engaged and work together on healthy aging initiatives at the state level<br>(3) Identify contact people who meet regularly to identify similar interest and opportunities for collaboration in DP/HP:<br>• Aging states report<br>• Evidence-based strategies (e.g. PA)<br>• Commitment through MOA-MOU<br>(4) Encourage and facilitate state, regional, local, and community strategic partnerships. |
| Sharing available data and analytic resources. | Data for Action, Program Development & Evaluation | 76, 79, 83, 91, 95 | (1) State health departments should provide electronic access of health data to local aging agencies.<br>• Organize data by aging boundaries<br>• Provide training and technical assistance.<br>(2) Prepare a report on "State of Health" which makes use of BRFSS and other data sources on disease and injury. |

**Table B2: Support health promotion/ disease prevention programs for older adults**

| Aging States Project Recommendation | Concept Map Cluster | Concept Map Statements | Action Steps |
|---|---|---|---|
| Assuring that current and future programs utilize evidence-based interventions where available. | Capacity Building & Infrastructure | 36 | (1) Identify existing evidence-based program models for dissemination.<br><br>(2) Supplement existing models by developing program specific tool kits to assist professionals in program development and evaluation.<br><br>(3) Disseminate widely, via the web, hard copy, conferences and other avenues. |
| Enlisting state health department collaboration for utilizing Older Americans Act Title III-D (disease prevention/ health promotion) funding. | Strategic Partnerships | 77 | |
| Enlisting state unit on aging collaboration in the use of funds for disease control and prevention activities within the health department. | Strategic Partnerships | 77 | |
| Partnering to seek addition funding for new collaborative initiatives targeting older adults. | Capacity Building & Infrastructure | 15 | |

### Table B3: Provide needed training

| Aging States Project Recommendation | Concept Map Cluster | Concept Map Statements | Action Steps |
|---|---|---|---|
| Providing and promoting training opportunities related to healthy aging for both the aging and public health networks. | Professional Development, Capacity Building & Infrastructure | 22, 23, 47, 68 | (1) Develop and conduct "Public Health & Aging 101", which would include:<br>• Nature and extent of problem/ best practices/ evaluation methods/ cultural competency<br>• Public Health, Aging and health care providers together for sessions<br>• Public Health will organize and follow up |

## C. Recommendations for the National Association of State Units on Aging (NASUA) and Chronic Disease Directors (CDD)

Table C1: Promote collaboration and communication

| Aging States Project Recommendation | Concept Map Cluster | Concept Map Statements | Action Steps |
|---|---|---|---|
| Continuing the associations' collaborative activities at the national level to enhance relationships and partnerships between state units on aging and state health departments. | Capacity Building & Infrastructure | 37 | (1) Develop health & aging network and working relationships, with centralized planning:<br><br>• Identify points of contact in state health departments; send letters from CDC and AoA (follow-up from NASUA)<br>• Nurture the network, by holding conference calls and meetings, giving mini-grants, providing technical assistance and training (grant writing, evaluation, using evidence base)<br>• Create links to the PRCs<br><br>(2) Develop training for health and aging network.<br><br>(3) Develop relationship with AARP, finding ways to get engaged and work together on healthy aging initiatives at the national level |

Table C2: Support health promotion/ disease prevention programs for older adults

| **Aging States Project Recommendation** | **Concept Map Cluster** | **Concept Map Statements** | **Action Steps** |
|---|---|---|---|
| Exploring legislative changes that would ensure the inclusion of older adults as a priority target population in relevant health promotion/ disease prevention programs. | Strategic Partnerships, Planning & Policy Dev't, Program Dev't & Evaluation, | 8, 53, 71, 74 | (1) Build a political constituency to provide strategic partners who embrace (and advocate for) our issues and mission |
| Identifying new opportunities to gain support for resources that enhance healthy aging. | Capacity Building & Infrastructure | 15 | (1) Build a political constituency to identify funding sources |

## Appendix V: List of Statements by Cluster

**Professional Development**

6 Seek gerontology and geriatric training for state public health staff and public health professionals.
67 Ensure that DPH staff has knowledge and experience in health promotion & aging.
1 Develop or expand cultural competence training for health care professionals.
23 Train the public health staff at both the state and local levels about aging and HPDP for older populations.
41 Disseminate and translate best practices; technical assistance in application.

22 Develop training to reduce barriers and bridge the gap between public health and aging cultures.
47 Facilitate mutual interest HPDP training for staff of health and aging departments.
16 Author articles and publications to share with others in the aging network related to their challenges and accomplishment.

**Capacity Building & Infrastructure**

37 Develop/build the network of (existing) specialists in public health and aging issues.
15 Develop capacity to write grants or do other funding raising to gain more funds for healthy aging.
36 Encourage use of evidence-based program models at state and local levels.
78 Identify one state health department person whose primary responsibility is aging.
17 Sponsor mini grants to local collaborative (public health & aging services) to conduct health promotion projects.
19 Fund a position in department of health in aging, and fund a position in aging unit to relate to DOH.
28 Coordinate state level technical assistance and consultation for local program development and evaluation.
33 Provide technical assistance on program design, implementation and evaluation.
66 Provide centralized support to state & local project staff in the design & eval. of health promotion programs in aging.
4 Identify and utilize content experts on various health issues of interest to older adults.
68 Hold a state healthy aging conference.
88 Support creation of an Office of Elder Health.

**Strategic Partnerships**

8 Facilitate policy development at the state and local level to support healthy aging.
5 Establish collaborative relationships and research programs with SUA and CDC's Prevention Research Centers.
42 Partner with other groups within the community with resources such as churches, colleges and Universities.
59 Collaborate with AARP chapters, union retiree groups, veterans groups, etc. on health promotion initiatives.
50 Integrate healthy aging into existing categorical grants for a focus on this specific age group.

44 Contribute to coordination of initiatives across SHD/SUA/AAAs and LHDs.
77 Establish mutually logical and beneficial linkages between the SHD and SUA (III-D).
29 Collaborate with communities to assess/improve environment and community design for older citizens.
73 Have SUA and SHD collaborate on information for the national 211 system.
55 Develop state plans in collaboration with other state agencies to address the HP/DP needs of older persons.
86 Develop & execute strategic plans in collaboration with SUAs to address HP/DP among older persons.
93 Encourage coordinated long range strategic planning for HPDP at local level.
52 Provide funds to contract w/ academic institutions to develop collaborative health promotion programs in aging.

**Planning & Policy Development**

56 Coordinate a public health response to mental health issues in elderly with other stakeholders.
74 Make policy recommendations based on the best available science.
13 Support systems change to improve effectiveness of community health promotion efforts.
9 Conduct a needs assessment and develop a strategic plan.
53 Analyze state and community policies that affect the health and quality of life of older adults.
2 Set up a process through which local aging & public health staff review incidence rates & concerns of the aging.
63 Involve of older adults to assess & address the public health needs of their age group.
72 Support a consumer advisory group to provide direction/advocacy for health promotion strategies for older persons.

**Data for Action**

75 Add questions to BRFSS to routinely collect information about issues specific to older adults.
81 Prepare a report on the "State of Health for Older Adults in ____" which makes use of BRFSS and other data sources on disease and injury.
57 Collect, interpret and disseminate data about health of older adults.
79 Create a health profile of the aging population by each county in the state and by state as a whole.
85 Track racial/ethnic, socio-economic, and geographic disparities in older adult health.
91 Make available and use common data sources for program planning, implementation and evaluation.
97 Surveillance of risk factors such as social connectedness, depression, multiple co-morbidities.
83 On-going surveillance and monitoring that gives information that can drive effective program development.
95 Gather local-level data on the health and utilization of health services of older adults.
12 Develop and make available accurate projections of the impact of the growth of the aging population.

**Program Development &Evaluation**

58 Develop practical evaluation tools for use in the field.
90 Include impact measures, such as quality of life and disability, in surveillance data.
71 Model policies that promote healthy behavior for older adults--health care, communities, institutional settings.

76 Enable the development of a user-friendly and current information database containing resources available to older adults in the state.

**Specific Program Opportunities**

98 Develop a program to increase physical activity among older persons (implement National Blueprint).
26 Improved access to services with transportation.
51 Identify effective community interventions able to prevent or forestall chronic health problems common to aging.
64 Facilitate broader use of covered preventive health services by older adult, incl immunizations.
87 Address the health of caregivers--spouses and adult children, who themselves may be older.
45 increase awareness and capacity for screening for depression and substance abuse.
80 identify and disseminate best practices for improving the health of older adults
32 Improve injury and falls prevention program in older population.
10 Develop self-management programs, empowering elderly to take charge of their own health needs.
89 Keep in mind rural area elderly as well as those in urban areas and support programs and initiatives accordingly.
34 Support pilot demonstration programs & promote their replication where need & capacity exist.
24 Integrate messages for seniors into existing DOH programs.
49 Encourage development of community based programs that integrate many of the available programs.
84 Develop ideas and techniques to promote better physician and patient relationships (i.e. explain diagnoses and procedures).
65 Emphasize minority health issues.
60 Develop programs to educate older adults and their families about the importance of health screenings.
27 Enhance disease management and self-management initiatives by incorporating geronotological principles.
70 Support programs on end of life issues, e.g. advanced care planning and end of life choices.
48 Use techniques to reach out to diverse populations (i.e. minorities, gay and lesbian community, rural populations).
43 Increase number of health screenings that are specific to cultural/ethnic groups.
46 Target the specific and different aging issues of young old populations (65-75) and old old (75+).
96 Reach out to employers to include HP/DP activities for retirees and those who are close to retirement.
20 Programs to enhance patient provider communication.
11 Develop a program with "leaders," older adults who will communicate/promote chronic disease prevention programs.
39 Create community-based safety programs for older pedestrians that include education, environmental adaptation and enforcement.
94 Provide program materials for specific interventions in quantities adequate to meet community demand.
38 Place emphasis on sex and aging issues including HIV/AIDS education, prevention, counseling; men's/women's health.
69 Find creative ways to provide multigenerational programs.
3 Support the development of health resource manual(s) for men which would influence older men's wellness & change behavior regarding their health.

**Public Information & Education**

7 Run statewide media campaigns on health topics to reach seniors through a variety of channels.
82 Provide information and training on medication management.
18 Provide resources to address needs of the various racial/ethnic and/or immigrant populations.
30 Develop large print, low literacy and culturally appropriate education materials.
61 Support creation of information that would reach the homebound client.
54 Support an effort to train seniors to train their peers on health topics so more seniors could be reached.
25 Fund train-the trainer model for health promotion activities in community, health care & institutional settings.
31 Provide public health expertise to informal elder caregivers.
14 Develop social marketing campaign for older adults.
40 Facilitate development of integrated health communications campaigns across disease and injury programs.
62 Disseminate healthy aging how-to materials and other resource materials to local agencies and communities.
21 Develop a State Wide Website to link older adults to health information.
35 Support public education to debunk stereotypes/myths about aging.
92 Help older adults become more technology (i.e computer) savvy especially in regard to internet health information.