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Case Studies of Health Promotion in the Aging Network: Council on Aging of Southwestern Ohio

Final Report

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CASE STUDIES OF HEALTH PROMOTION IN THE AGING NETWORK: COUNCIL ON AGING OF SOUTHWESTERN OHIO

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Study of the Health Promotion and Disease Prevention Services Program of the Older Americans Act

Older adult health promotion and disease prevention is one of the top priorities for the Administration on Aging. The Administration on Aging plays an important role in the larger Federal effort to promote healthy lifestyles, particularly among older populations. Although illness and disability rates increase with age, a large body of research demonstrates that health promotion and disease prevention activities can help ensure healthy and independent lives for older Americans. For example, exercise and other health-promoting behaviors have been shown to improve aerobic power, strength, balance, and flexibility, while decreasing acute medical problems such as fractures, myocardial infarctions, and cerebral vascular accidents in older persons. Screenings, such as mammograms and evaluations of stool specimens, have been shown to decrease morbidity and extend life in this group as well (Rabiner et al., 2004).[1] The Administration on Aging, along with its other Federal partners, has worked to use this evidence-based knowledge to improve the health and independence of the nation's seniors.

As part of these efforts, the Administration on Aging administers Title III-D of the Older Americans Act to support health promotion and disease prevention services. This portion of the Older Americans Act requires that disease prevention and health promotion services and information be provided at senior centers, meal sites, and other appropriate locations, giving priority to areas of the state which are medically underserved and in which there are a large number of older individuals who have the greatest economic need for these services. Designated funding for these activities is intended to provide seed money for developing health promotion and disease prevention programs with other community partners, and to serve as a catalyst in promoting health promotion and disease prevention initiatives. In 2003, Congress appropriated a total of $21.9 million for Title III-D preventive health services as part of a Title III budget of $1.25 billion. In addition, the Administration on Aging has supported other health promotion activities by hosting a national summit on health promotion, funding the National Resource Center on Nutrition and Physical Activity and the National Resource Center for Evidence Based Programs, and working with the Centers for Disease Control and Prevention, the National Institute on Aging, the Agency for Health Care Research and Quality, and the Centers for Medicare & Medicaid Services to develop coordinated health promotion strategies.

This report is part of a larger set of studies conducted for the Administration on Aging by RTI International to provide information on the implementation of the Title III-D programs of the Older Americans Act. The goal of this study is to assess how the Aging Network has used the limited Title III-D funds as a catalyst to develop health promotion and disease prevention programs for older Americans. This information will be important for assisting states and communities wishing to replicate these types of efforts and for assisting state and Federal decision makers in planning the future of the Title III-D program.

[1] Rabiner et al. (2004) summarized the current research on evidence-based health promotion/disease prevention activities for older people and their outcomes.

This project has seven principal research questions:

- How do health promotion and disease prevention activities fit into the overall activities of the Aging Network?
- Has the Aging Network leveraged its Title III-D dollars to develop larger health promotion and disease prevention programs?
- Have the Area Agencies on Aging developed partnerships with other organizations to create more extensive health promotion programs for older people?
- Have Area Agencies on Aging developed and chosen model programs that are evidence-based?
- How comprehensive are the health promotion and disease prevention activities of the Area Agencies on Aging?
- Have programs been implemented on a widespread basis, involving large numbers of older people?
- Is broad data about program participants and the effectiveness of the programs available and used by program managers and administrators?

These questions are addressed through three major study components:

Literature Review. The study questions were refined and potential case study sites were identified through an extensive literature review on the state of the art in evidence-based Health Promotion and Disease Prevention efforts for the elderly (Rabiner et al., 2004). This was used to refine our conceptual framework for the study and to identify areas where these programs have been effective with senior populations.

Expert Interviews. Experts in the field were interviewed to collect input on current efforts underway in the private sector, the extent to which these health promotion and disease prevention efforts are being evaluated, and the types of health promotion activities that were considered most effective with the senior population. The experts also assisted in selecting a set of eight case study sites, recommending different features that were important for inclusion. In addition, these interviews were useful for coordinating our efforts with other related efforts in the field. The experts represented national associations, such as the National Association of State Units on Aging and the National Council on the Aging staff, as well as national and local program managers and researchers. Valuable input was also provided by regional and national Administration on Aging staff.

Case Studies. Case studies of eight selected Area Agencies on Aging were conducted to gain a better understanding of the Aging Network's involvement in health promotion activities. The case studies build on the other sections of this study and represent the largest component of the assessment.

This report is one of the eight case studies that were conducted. Area Agencies on Aging are the key organizations for implementing the provisions of the Older Americans Act. They provide access, management, and direct health and social services, including health promotion and disease prevention services to older Americans. The agencies were selected based on their reputations for innovative approaches to health promotion activities, including participation in national disease prevention and health promotion programs. Additional selection criteria included variations in the type of health promotion and disease prevention activity offered, diversity in geographic location, leveraging of multiple funding sources, the type of Aging Network member that leads the initiative, and types of collaborating entities. The Area Agencies on Aging selected for study were Atlanta, Georgia; Los Angeles, California; Seattle, Washington; Phoenix, Arizona; Cincinnati, Ohio; Orlando, Florida; Portland, Maine; and the state agency which also functions as an Area Agency on Aging for the state of Delaware.

The case studies focus on those determinants of health most amenable to impact through programmatic interventions. A person's health status is determined by a variety of factors, including individual factors such as an individual's biology, socioeconomic background, attitudes and beliefs, and

his/her motivations and health behaviors (Rabiner et al., 2004). It is also determined by community factors, including the role of the social and physical environment, access to quality care, public interventions and policies, and their results. In the case studies, we concentrated on those programs and policies which intervened at those levels where change can be made on the individual level, by modifying attitudes, beliefs, motivations, and health behaviors of older persons.

Data for these case studies were collected through telephone and on-site interviews and a review of secondary sources, including program reports, evaluations, and web sites. Interviews were conducted with staff members from the selected AAAs, the State Unit on Aging, and partner health promotion providers. Area Agencies on Aging staff were interviewed to understand their approach to health promotion, funding, and other program characteristics. State program officials were interviewed to understand the relationship of the local health promotion efforts to the statewide efforts. Local providers, advocates, consumers, the education community, and other members of the Aging Network were interviewed to understand the details of the programs and the factors affecting the development of these programs. At some sites, people were interviewed solely by telephone; at other sites, in-person interviews were conducted. Data for these case studies were collected from June 2004 through February 2005.

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SECTION 1
INTRODUCTION

Increasing attention is being given to health promotion and disease prevention strategies for the population, in general, and for the older population. As part of that initiative, Title III-D of the Older Americans Act funds activities to keep seniors healthy. Compared with other titles under the Older Americans Act, the funding for Title III-D is very small, $21.9 million nationally in 2003, out of combined funding for meals and services that support frail elders under Title III of $1.25 billion. This disparity in the investment for these programs reflects the intent of the Act not to fund health promotion programs for all elders across the U.S., or even all clients served through other Older Americans Act programs. Rather, it reflects the intent of the Act to provide some level of support that would result in the leveraging of resources from other sources to expand health promotion and disease prevention programs for older people. This case study is part of a larger effort to understand what the Aging Network has done with the modest investment the OAA provides, how they have expanded their health promotion and disease prevention efforts, what the characteristics of these programs are, and what needs to be done to better assess these programs and improve them over time.

The Council on Aging of Southwestern Ohio is the Area Agency on Aging (AAA) serving the five counties around Cincinnati. Its mission is to prevent premature institutionalization and provide services, funding, and support for community-based programs that enable older persons to live independently at home. The Council on Aging was selected as one of the sites for this study of health promotion and disease prevention programs of the Aging Network because of its strength in several key areas.

- The Council actively supports health promotion and disease prevention activities as a key to helping frail elders maintain their independence. It has made this a central element in its program development efforts, and has used its Older Americans Act funding to develop a significant investment in health promotion and disease prevention programming. The Council's decision to do this was based both on demand from the current and potential participants and the growing body of research indicating that health promotion and disease prevention programs for older persons help them maintain health and independence.
- The Council has a strong collaborative working relationship in health promotion and disease prevention programming with many community partners, including the local health department, the Ohio Department of Aging, a large hospital provider, and a strong university-based research center.
- The Council is a site of the Robert Wood Johnson Foundation's Active for Life Program, which helps sedentary persons aged 50 and older develop more active lifestyles. There are 9 such sites across the U.S.
- It operates an innovative medication management program that could be replicated in other AAAs throughout the United States.
- It is working to evaluate its health promotion and disease prevention efforts for older persons

- The Ohio Department of Aging, also values health promotion and disease prevention and has made it a priority area.

During June and July 2004, 14 telephone interviews were conducted with Council on Aging staff, state officials, senior center administrators, special project coordinators, public health providers, health care administrators and researchers who were knowledgeable about the various health promotion and disease prevention activities for older persons being supported by the aging network and the larger community of Southwestern Ohio. In this case study, we provide an overview of the Council on Aging site, a general description of the health promotion and disease prevention programs being supported by the aging network, and a detailed description of key health promotion/disease prevention activities.

This case study examines:

- How health promotion and disease prevention activities fit into the overall activities of the Council on Aging of Southwest Ohio.
- The leveraging efforts of the Council using the small amount of Title III-D dollars to develop larger health promotion and disease prevention programs.
- Partnerships which the Council has developed with other organizations to develop health promotion programs for older people.
- How the Council developed and chose the programs it supports.
- The degree to which the Council has developed a comprehensive set of health promotion and disease prevention activities.
- How comprehensively these Council programs have been implemented in its service area.
- What data are available on program participants and the effectiveness of Council programs, and how these data are used by program managers and administrators.

SECTION 2
OVERVIEW OF COUNCIL ON AGING OF SOUTHWESTERN OHIO

The Council on Aging is responsible for planning, coordinating, and administering programs for older adults in Butler, Clermont, Clinton, Hamilton, and Warren Counties. Its vision is for every older adult in its region to have choices among a range of services that will assist him/her to remain independent in his/her chosen environment.

Organization and Sources of Funding

The Council on Aging, which was incorporated in 1971, provides a wide range of services to its older population. In addition to its Older Americans Act programs, it provides: (a) case management and in-home services through the Preadmission Screening System Providing Options and Resources Today (PASSPORT) program, the state's Medicaid home and community-based services waiver program, and (b) home and community-based services through the Elderly Services Program (ESP).

Medicaid's PASSPORT program provides home care services to Medicaid-eligible persons aged 60 who live in the community and who need nursing home level care. Categorically eligible Medicaid beneficiaries may receive up to thirteen different services, including assessment and screening, case management, homemaker, adult day health care, in-home or congregate meals, chore services, in-home medical equipment, and transportation services (http://www.help4seniors.org). Approximately 1,900 Council on Aging participants were served by the Medicaid waiver program during 2003.

The ESP, the other large home care program administered by the Council on Aging, is available to residents aged 65 and over (in Clinton and Hamilton Counties) or aged 60 and over (in Butler and Warren Counties) who reside in these counties, are unable to receive services from other resources, and have at least two impairments in activities of daily living or instrumental activities of daily living. Funding for this program is provided through special county property tax levies that are earmarked for services for older people. Those individuals who are determined to be eligible for ESP services may receive the following services: adult day services, companion services, home-delivered meals, home medical equipment, home care, personal care, respite care, home repairs, electronic monitoring systems, and/or medical transportation (http://www.help4seniors.org). Council on Aging staff reported that roughly 12,000 clients who were ineligible for Medicaid waiver services were case managed by the AAA in this program.

The Council on Aging's 2003 operating budget was $60,806,390 (***Exhibit 1***). Approximately 12 percent of Council on Aging revenue came from Older American Act funding. Federal dollars are leveraged by a number of other sources, including state and local funds, contributions from participants, the Medicaid PASSPORT program, and local foundations. State funds accounted for roughly 3 percent of Council on Aging revenue. Approximately 47 percent of Council on Aging revenue came from local senior service levies (which are county property taxes that have been earmarked and set aside for the Elderly Services Program in the four counties served). Most of the remainder of the AAA budget (35 percent) came from Medicaid's PASSPORT program. Two percent of program revenues came from participant contributions, and about 1 percent of funds came from local foundations and other sources.

While the Council provides the full range of Older Americans Act-funded activities, available data do not indicate just how much of the Council's budget is directed to health promotion activities. These dollars are very likely a small percentage of the Area Agency on Aging's funding, presented in Exhibit 1. Much of the funding for health promotion and disease prevention activities is provided by the senior centers, through the provision of facilities and cooperation in the development, management and monitoring of classes and other activities, and no central report of these expenditures is made to the Council. Moreover, available data do not allow the Area Agency on Aging to determine how many of the AAA's clients actually participate in HPDP activities either overall or by individual activity. While activity attendance numbers are sometimes collected by the senior centers, there is no computerized data collection system so that available data is mostly in hardcopy and not consistently or easily accessible.

Exhibit 1. Council on Aging Operating Budget in 2003

Source of Revenue	Amount (in $)	Percent of Operating Budget
Older Americans Act	$6,980,990	12%
State	2,065,940	3
Local	28,791,610	47
Medicaid PASSPORT	20,992,640	35
Participant Contributions	1,348,170	2
Other Sources	627,040	1
Total	$60,806,390	100%

SOURCE: www.help4seniors.org

Demographics

Statewide, 17.4 percent of the population was 60 years of age or older in 2000; this proportion has grown 3.1 percent since 1990 (U.S. Census Bureau, 2000). The total aged 60 or older population of the Council on Aging's planning area in 2000 was 243,164, with most individuals residing in Hamilton County. Between 1990 and 2000, the four rural counties of the Council on Aging's service area experienced growth among the age 60 and older population ranging from about 7 percent in Clinton County to 40 percent in Warren County. In contrast, urban Hamilton County experienced a decline of about 6 percent in this population between 1900 and 2000 (U.S. Census Bureau, 1990, 2000). Council on Aging staff report that the median age for all AAA program participants is 79 years.

The Council on Aging serves a population that is about 90 percent Caucasian, with most of the minority population located in Hamilton County, where Cincinnati is located. Almost all of the minority older population of Hamilton County (roughly 25 percent of the county's older population) is African American.

Role of the Senior Centers

A significant element in the success which the Council on Aging has had in implementing its programs is the cooperation and support of a network of 65 senior centers and community centers that provide a range of social, recreational, and health promotion/disease prevention activities for older adults. The Council and most of the centers agree on the importance of health promotion and disease prevention activities both for the health of older Americans and for the future vibrancy of the centers, and are working together to develop these activities. The Council on Aging provides leadership and funding, helps the aging network to develop new health promotion/disease programs, and works with others to evaluate health promotion/disease prevention activities, while the senior centers provide facilities, administration and monitoring functions, recruitment, and fundraising support. Council staff report that the larger senior centers have been enthusiastically supportive, while some smaller centers, limited by lesser resources, have been willing to participate in developing health promotion programming to the extent they are able. Because the senior centers are administratively independent of the Council, the actual services offered at the centers depend on the decisions of the local center boards and management. Many of the centers also have close ties to local governments through local property tax levies earmarked for services for older people, giving these centers a further measure of autonomy from the Council on Aging.

The senior centers are organized and operated by a number of different organizations, including independent nonprofit organizations under the direction of self-perpetrating boards, long-term care service providers, and agencies of county and township governments. Historically, planning for the city of Cincinnati has been at the neighborhood level with separate senior centers being established in each neighborhood setting. As a result, Cincinnati has a large number of senior centers, with facilities located as close together as a mile or two apart. Because of the close proximity of many senior centers, some centers have begun to compete for older participants.

The senior centers are authorized to serve a population that is age 50 or 55 and older, as determined by the sponsoring government body or non-profit, although the Council on Aging reports that the largest proportion of participants is over age 70. While the Council on Aging staff members indicate that most participants are mobile and independent, the centers make accommodations for those with a variety of functional limitations. As a group, the centers serve an ethnically and economically diverse population roughly equivalent to the overall population of the particular area. The average daily census has been reported to vary widely by center, ranging from a low of approximately 15 attendees at the small centers to over 1,000 participants at the larger and better equipped centers.

SECTION 3
HEALTH PROMOTION/DISEASE PREVENTION ACTIVITIES

The Council on Aging offers a full range of programs under Title III of the Older Americans Act and promotes a number of innovative health promotion and disease prevention initiatives to make senior centers more relevant to and better prepared to meet the demands of the aging Baby Boom generation. Several planning activities were launched in recent years in response to an Ohio Department on Aging study surveying seniors which found that Baby Boom generation seniors would be increasingly seeking innovative programming, including health promotion activities, from senior centers (Ohio Department on Aging, 2002). The report found that, in general, Ohio senior centers had an image of catering to a more sedentary and older population. Travel opportunities, exercise equipment, hobby and game activities and education were services for which the younger respondents demonstrated interest at a significantly higher rate than older respondents. Council on Aging staff had also observed that a decreasing number of older persons were participating in traditional activities at the senior centers. While no specific study of this trend was conducted, Council staff concluded that innovative programming, particularly health promotion and disease prevention, was a missing element which could reverse this development.

The Council on Aging's health promotion and disease prevention activities include:

- The Senior Center Re-Engineering Initiative, which was a planning effort designed to increase the availability of health promotion and disease prevention activities in senior centers.
- The Active Living Every Day program, which is a Robert Wood Johnson Foundation-funded initiative intended to change the lifestyles of sedentary seniors.
- The Council on Aging Learning Advantages Medication Management program, which provides health education on prescription drugs to disabled older people in their homes.
- The Hamilton County Falls Prevention Task Force, which seeks to reduce falls that result in serious injury and death.
- The ongoing health promotion/disease prevention programming at senior centers, which includes a variety of health screening and exercise activities.

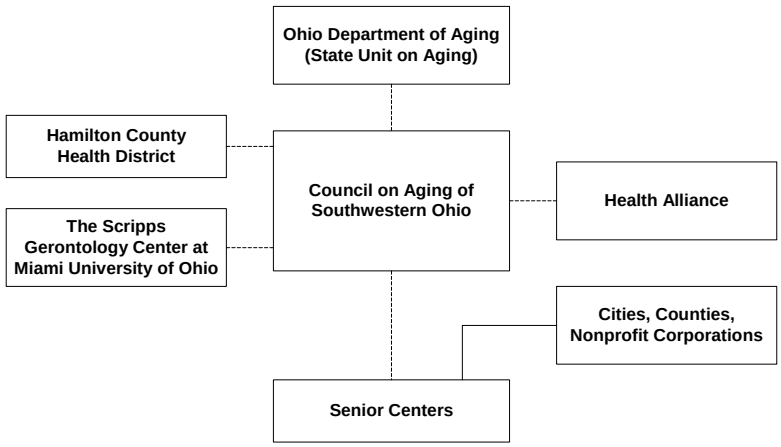
The Council on Aging leverages its resources by working with many partners in health promotion/disease prevention planning and activities. The Council on Aging consults with state agencies, community organizations and an academic research center in developing and evaluating its health promotion activities (see ***Exhibit 2***). These partners include:

- The Ohio Department on Aging, which is the State Unit on Aging, which provides guidance and funding. The state encouraged AAAs to adopt health promotion as a top priority during 2004. The Department on Aging also assisted in the development of the Re-Engineering initiative and the proposal for the Active Living Every Day project.
- The senior centers are the main locus of the health promotion/disease prevention activities and actively implement many of the initiatives of the Council on Aging. In addition, the

centers develop their own contacts with local health departments and other health care providers to arrange for hypertension screening, influenza immunizations, and other services, and to publicize their services.

- The Hamilton County Health District, which provides blood pressure screening and influenza immunizations at some senior centers. In addition, the Health District is a close collaborator on the Active Living Every Day project, hiring and contracting with class facilitators, screening potential participants, and inputting data from class evaluations.
- The Health Alliance, a major nonprofit healthcare provider in the area which provides hospital, clinic and long-term care, is a partner on the Active Living Every Day program. Its physicians are a major source of referrals for the program and it distributes educational materials about the program and encourages people to adopt a more active lifestyle.
- The Scripps Gerontology Center of Miami University in Oxford, Ohio, provides extensive evaluation services for the Council on Aging and many of its programs.

Exhibit 2. Interaction of the Council on Aging of Southwestern Ohio with Other Organizations on Health Promotion/Disease Prevention Initiatives



Planning for Health Promotion: Senior Center Re-Engineering Initiative

In 2002, the Senior Center Re-Engineering Initiative was developed to encourage the senior centers to implement new health and wellness programs. The Council on Aging was motivated to launch the program after results of a Department of Aging's survey of baby boomers (aged 55-60) and older participants (aged 65-70) indicated that many baby boomers and older participants wanted a greater number and variety of programs offered by the senior centers. After a number of subsequent discussions with the State Department of Aging, the Council on Aging convened a Re-Engineering Task Force—comprised of Council on Aging staff members and local area providers--charged with developing a strategy to ensure the relevance and usefulness of senior centers in the years to come. This Task Force met monthly over a two-year period to develop an overall strategic plan.

The plan that the Re-Engineering Task Force developed to address the challenge of reinvigorating senior centers was to create a number of health promotion and disease prevention programs that would appeal to baby boomers. The Task Force, which disbanded in July 2004 when its planning objectives were fully accomplished, recommended that the Council on Aging hire a staff member devoted exclusively to the Re-Engineering effort. The Council on Aging hired an administrator in June 2003 with Title III-B funding who is devoted solely to coordinating Re-Engineering activities for all 65 of the senior centers.

The administrator has concentrated efforts to introduce health promotion programs in the areas of physical activity. Several studies, as discussed in the literature review, have shown that even light exercise among older and/or sedentary individuals can have measurable health effects, and such activities as walking and aerobic exercise are being encouraged (Talbot et al, 2003; Castro et al 2002; Binder et al, 2002; King et al, 2002).

While the Council on Aging acknowledges that there is a limit to the activities that it can stimulate through funding and persuasion, it remains convinced that promoting healthy aging will be an essential strategy to sustain senior centers in the years to come. In June 2004, to encourage some senior centers to modernize and expand their wellness programming using Title III funds, the Council on Aging issued a request for proposals to the senior centers, offering up to $20,000 to support new wellness activities at senior center facilities. The Council on Aging hopes to fund a number of such small projects annually, such as the development of walking trails and the purchase of exercise equipment. Although the Council on Aging could only support $70,000 worth of new activities during the 2004 fiscal year, it expects to support a second round of proposals using funds made available in fiscal year 2005.

The Re-Engineering initiative has faced several challenges, including the fact that there is substantial variation in the leadership, infrastructure, and fiscal solvency of the senior centers—some have impressive facilities, dynamic leaders, and new program offerings while others are small or have limited attendance and funding. Smaller centers with older clients are less inclined to make changes, citing a concern with changing the programs that serve existing clients or expressing a desire to reach more of the current population of older adults rather than reaching out to younger persons. Although the Re-Engineering initiative is being monitored by the Council on Aging, no formal evaluation of its impact or effectiveness has been conducted. Support for this planning effort has been provided primarily through funding from appropriate parts of Title III (approximately $100,000/year), which has been used to cover the full-time salary of the Re-Engineering program administrator and to transport participants to and from senior center sites to attend programs.

Since the Re-Engineering administrator has been functioning for less than six months, the program has just begun to take shape. The administrator has been primarily engaged in establishing personal lines of communication with the senior centers. The administrator has also been working with one of the smaller senior centers as a demonstration case in developing health promotion and other programming on a small budget.

The administrator has also been involved in developing a 'Wellness Coalition' of senior center directors, led by Council staff. Still in an early stage of development, this 'Wellness Coalition' began as meetings of Council staff and administrators of senior centers offering the Active Living Every Day program (described below), to discuss program issues. The meetings are now being expanded to invite administrators of any senior center interested in offering health promotion and disease prevention programming to a forum for discussing and sharing information related to any health promotion and disease prevention activity. Attendance by senior center representatives is voluntary, with only a few attending so far, and the group meets monthly at one of the senior centers. Council staff lead the meetings, which include an informational presentation from a senior center representative followed by a discussion. While the overall intention of the group is to promote health promotion and disease prevention programming at the senior centers, this is at present a discussion group with no budget, no specific goals, and no plan for an evaluation of its activity

No evaluation criteria were given for the Re-Engineering administrator's performance. It would be useful to measure the penetration of health promotion and disease prevention programming in senior centers across the Council service area, as well as the amount of programming and attendance at those programs for comparison to the current situation.

Active Living Every Day

Physical exercise has been shown to have a number of health benefits. (Talbot et al, 2003; Castro et al 2002; Binder et al, 2002; King et al, 2002). In order to encourage physical activity in persons age 50 and older, the Robert Wood Johnson Foundation developed the *National Blueprint: Increasing Physical Activity Among Adults Age 50 and Olde*r which outlines a program to translate the scientific evidence supporting exercise into national practice by helping older Americans become physically active. Pilot projects based on this program are being implemented nationwide through the Foundation-supported Active for Life program. The Council is one of nine sites receiving grants from the Robert Wood Johnson Foundation to demonstrate the effectiveness of this approach in increasing physical activity among older people (Robert Wood Johnson, 2001).

The Council on Aging's Active Living Every Day program is a 20-session, classroom-based health promotion program designed for sedentary older persons living in the community. It is not an exercise class, but rather a lifestyle training program. Active Living Every Day is one of the two health promotion approaches being offered through the Robert Wood Johnson Foundation's (RWJF) Active for Life program.[2] The four-year grant began in January 2003, and was received after a highly competitive selection process with almost 500 organizations applying. Nine locations across the country received these grants, which were awarded to organizations demonstrating the potential to launch a research-based physical activity program for midlife and older adults and to potentially sustain such a program through existing community institutions.

The course-based program, which is uniform at all Active Living Every Day sites, is comprised of weekly, one-hour group sessions that are designed to help older persons learn how to take better care of themselves. The curriculum is presented from the guidebook one chapter at a time by an experienced and trained leader. Class members learn behavioral skills for self-reflection, self-monitoring, goal setting for spending time in physical activity, stress management, how to appropriately reward one's self, and how to make lifestyle changes. The Council on Aging anticipates that the Active Living Every Day program will help increase participation in the senior centers, thereby supporting and enhancing the goals of the Re-Engineering initiative.

The program is specifically targeted to sedentary elders who have been inactive for some time. The goal of the program is to increase physical activity to the Surgeon General's recommended level of 30 minutes of moderately intense activity most days of the week, but individuals are told that it is acceptable for them to be working toward that goal at the end of the course.

The class is taught using a theoretical model of behavioral change developed for the national RWJF Active for Life Program with the intent that, at the end of 20 weeks, participants will have the tools they need to make lifestyle changes and can overcome relapses and continue to develop an active way of life. The classes enroll no more than 18 participants in order to encourage social support among class members. The overall Active for Life evidence-based curriculum was developed by the Cooper Institute in Austin, Texas, and is marketed by Human Kinetics, a physical activity training and information company.

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2 There are two different models of the Active for Life program—classroom-based Active Living Every Day (offered at the Council on Aging), and telephone-based Active Choices. Both courses focus on accomplishing small, but meaningful, changes to help older persons increase physical activity levels and adopt healthier lifestyles.

It has been challenging to recruit sedentary people who by definition are not motivated to be active. Council on Aging recruiters have found that is it necessary to approach the same people in many different ways to get them to respond, a process that is costly. The most successful approaches have included endorsements of the Health Alliance, a major nonprofit healthcare provider, and provider referrals from Health Alliance physicians. Health Alliance management has supported the program as a community service. One Health Alliance employee suggested that changing lifestyles to become more active is an excellent prevention technique that the organization wants to support and encourage among its community partners.

Prior to enrolling in an Active Living Every Day course, potential participants are required to undergo an initial screening/intake process including the administration of a physical functioning test and the measurement of blood pressure, weight, body mass index, and self-rated health, all of which are overseen by the Hamilton County Health District. Those with an elevated blood pressure are discouraged from participating in the more strenuous screening tests and are counseled on the management of hypertension, but they are not disqualified from the course itself. The liability risk that the Council on Aging assumes for participants is limited because the usual class activity is sitting rather than exercising.

One important program goal is to enroll 1,000 participants by the end of the fourth year of the grant. During the initial start-up year (2003), the program enrolled 100 participants in eight classes, and during the current (second) year of the program, the Council on Aging is on track to meet its goal of 300 participants, with eight Active Living Every Day classes and 130 participants during the first half of 2004.

The Council on Aging is seeking to implement the Active Living Every Day program in all five counties and to make it available to all demographic groups in its area. Council on Aging staff report that the course tends to appeal more to women than men, perhaps due to its style of "sharing" feelings about lifestyle issues. It has been implemented in communities of different racial and economic makeup and in rural as well as urban areas. Nearly all the classes have been ethnically homogenous because they were drawn from individual neighborhoods. During the first year, Council on Aging staff reported that most participants were age 70 and older. During the second year, however, the Council on Aging and its partners have targeted participants in the 50- to-60 year age range with some initial success. During the first year of the program, eight classes were held in different senior centers, and the Council is seeking to increase the number of classes and centers during the second year, with the goal of offering the program in all five counties before the end of the grant.

Classes are led by one full-time and two three-fourths-time facilitators who travel among multiple senior center sites. All the facilitators are contract employees of the Hamilton County Health District, one of the Council on Aging's key project partners. Initially, the plan to sustain the Active Living Every Day program after demonstration funding ends was to train existing center personnel to act as facilitators of Active Living Every Day courses. However, because it will be too expensive to underwrite the intensive training required for each instructor to become and remain certified by the program, the Council on Aging has been consulting with other Active for Life Program grantees and the RWJF to assess the costs and benefits of alternative approaches to continue the program after the grant ends. As of November 2004, the plan to sustain the program beyond 2007 is to hire a full-time staff member whose salary will be shared between the Council on Aging and the Hamilton County Health District. This individual will be a certified Active for Life facilitator who will offer the Active Living Every Day program to senior centers throughout the five-county AAA service area.

Active Living Every Day participants have had positive experiences with the program. Participant's comments have included "I've lost 15 pounds," "My doctor has taken me off my diabetes medication," and "I'm more active and positive about life!"

One Active Living Every Day participant wrote, "I had been walking to help control diabetes. My husband was diagnosed with atrial fibrillation. Until the medications were adjusted, he got short of breath if we walked uphill. It was scary; I think more for me than him. Instead of trying to find other ways to continue being active, we gave up walking and filled our time with other things. Active for Life opened our eyes about how little moderate activity we were getting. At first, we had a hard time . . . It took several weeks until we began to look forward to our walks. We agree that we feel stronger and healthier. We know we will face other health issues in the future. We plan to remember that giving in is the worst plan we could have."

The program is funded by a four-year $972,460 grant from the RWJF, along with $309,700 of support from the Council on Aging (using Title III funds, state block grant monies and support from local property tax levies), and $81,150 from the Hamilton County Health District. In addition, a small amount of Title III-B dollars are used to transport participants to and from participating senior center sites. Participants also pay a one-time fee of $15 to attend the course.

All nine Active for Life grantees, including the Council on Aging, routinely collect uniform data on program participation, satisfaction with the program and a variety of health outcomes. They submit all information to the University of South Carolina (USC), the RWJF-funded contractor conducting a formal evaluation of both the Active Living Every Day and Active Choices programs. The main outcomes to be assessed include physical functioning, weight, body mass index, blood pressure and four items related to chronic disease, pain, and use of medications for high blood pressure. Classroom facilitators take

attendance at each class and record information from each class in a data base prepared for them by the USC. Because no comparison group is studied, USC will focus on monitoring the relative progress of participants of the two different Active for Life models (i.e., Active Living Every Day, which the Council on Aging along with four other sites participates in, versus Active Choices, which is being administered at four other grantee locations). Due to the rigorous nature of the USC evaluation being conducted with RWJF support, the Council on Aging has not implemented its own evaluation of this program. Council on Aging staff has reported that preliminary first year outcome and process data, will be made available to the public in February 2005.

Council on Aging Learning Advantages Medication Management Program

Older persons are at particular risk for health problems due to inappropriate medication. Being more vulnerable to chronic diseases, they typically use more medications than younger people. About 5 percent of Medicare patients are made ill by their medications annually, leading to as many as 1.9 million drug related injuries, and an estimated 125,000 Americans die each year from prescription drug misuse. More than half these adverse drug events could be prevented if patients adhered to medication instructions (Haber, 2003; Lazarou et al, 1998; Gurwitz et al, 2003).

The Council on Aging Learning Advantages (COALA) Medication Management program, which recognizes the importance of the problem being faced by large numbers frail older persons who are required to take multiple prescription drugs, is designed to address prescription drug challenges through intensive, short-term medication management training and assistance to enable older participants to remain living in the community for as long as possible. Unlike most rigorously controlled, evidence-based medication management programs described in the literature (Rabiner et al., 2004), the COALA program approach is based on the particular needs of a given participant/caregiver unit. More specifically, two nurse-trained health educators meet with caregivers and their family members in the home of participants to help them understand and administer their unique medication regimens. During in-home visits, health educators rely on a specially developed COALA training manual, and tailored medication management information obtained from a Council on Aging-purchased web-based data base that provides easy-to-read information on prescription drugs, herbal remedies, over-the-counter medications, and drug interactions. In a departure from most health promotion activities which focus on a relatively healthy population, participants are often very severely disabled and chronically ill.

The COALA medication management program obtains referrals in a number of ways. Council on Aging case managers who assess clients for other programs (such as PASSPORT) are the primary source of referrals. Referrals also come from family caregiver support groups and home health agencies. The

program is advertised through posters in stores. In addition, outreach efforts are underway to churches and to fire and police departments, which typically receive calls from people in distress.

After obtaining a referral for medication management services, a health educator contacts each participant to determine the names and dosages of medications being taken. This information helps to determine the additional data needed from the informational website regarding the recommended dosage(s), potential drug interactions, and other medication issues. The health educator then makes an initial visit, typically three hours in duration, to assess the participant, provide information on caregiving and use of medications, identify medications that may be used but may not have been mentioned (such as aspirin), and to answer any questions that the participant or caregiver may have. The health educator also reviews the relevant sections of the COALA care manual with the participant and caregiver, and provides the participant with a personal copy.[3]

Generally three to four sessions are provided to a given family unit, with health educators initiating these follow-up visits. After follow-up sessions, the informal caregiver or the participant is expected to be responsible for the participant's medications. Caregivers are free to contact the health educators if they feel the need for additional training to help them to manage new medication regimens at home.

Obtaining referrals has been difficult, despite the fact that the service is free. Council on Aging staff believe that home health agencies may be reluctant to provide referrals to their program because they fear that the program will take home health patients from their agencies. From January through May of 2004, the program received 158 referrals and made 165 visits, but COALA nurses report that they still have some capacity to increase their case loads since together they are able to visit 24-26 people per week.

While the current program is small, the nurse health educators believe that provider resistance is being overcome. They also believe that their case load will begin to grow, because they have observed growth in every area where they have been able to identify clients and provide the service. The cost per visit is just over $100 based on the January-May, 2004 period, but the nurse health educators also

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[3] The COALA care training manual, which includes information on both the management of medications and other types of in-home assistance, initially was developed as part of the COALA home health aide program that was launched in 2000. The COALA home health aide program is a formal training program designed to increase the number of qualified home health aides available to help older persons remain independent and living at home. The COALA program has since expanded to include the management of medications for community-dwelling older adults and their caregivers.

engaged in marketing activities for the program during that time, so that the cost per visit would likely be reduced in a larger program where administrative expenses could be spread over a larger population base.

The program is supported by Older Americans Act funds including Title III-E ($23,000/year) for caregiver support and Title III-D ($23,530/year) for medication management, as well as a small amount of Administration on Aging demonstration grant funds for caregiver support and program evaluation activities. The Title III funding primarily has been used to hire the two COALA health educators.

> Excerpts from typical letters received from medication management clients: "We truly appreciate your concern for us . . . We do thank you, also, for all the good help and information offered on your visit to our house . . ." "The services of [your nurse were] very helpful and enlightening to me, also the manuals and leaflets."

As with the other promising programs being operated by the Council, the COALA program has not been operating for very long. While the initial program to train aides began in 2000, the medication management element was not initiated until 2002 and has so far served only a small number of persons, only now beginning to overcome the resistance from Medicaid providers mentioned earlier. The program is being evaluated by the Scripps Gerontology Center at Miami University, which is examining the impact of medication management services on the health and well-being of family caregivers. Under an AoA caregiver evaluation grant provided to the Council on Aging in 2001, data are being collected to study how this program is impacting family caregivers. Data are being collected before the nurse case managers meet with the families to record physical and mental health status, caregiver burden using the Zarit scale, and caregiver knowledge; a second knowledge assessment is conducted after the caregiver meets with the nurse case manager. A final set of data are also obtained three months after the meeting, covering the same areas as the initial data collection as well as a self-report of the impact of the training on injuries and hospitalizations for the care recipient. These grant activities have received a no-cost extension due to the slow pace of program enrollment, but the Scripps researchers now expect to produce a report by June, 2005. Preliminary data indicate that as a result of the training program caregiver burden is decreasing as the caregivers become more competent and knowledgeable.

Hamilton County Falls Prevention Task Force

Falls are the leading cause of injury-related visits to the emergency room in the United States, and the primary cause of accidental deaths in persons over the age of 65 (Fuller, 2000). The mortality rate for falls increases with age for both genders and all ethnic and racial groups. One-third of community-dwelling older persons and 60 percent of nursing home residents fall each year. Interventions to prevent

falls, including education, strength and coordination training, and environmental changes, have been shown to be effective in reducing falls (Yates & Dunnagan, 2001; Tinetti & Williams, 1997; Gill et al, 2002; Gill et al, 2003; Messier et al, 2000; Van Norman, 1996).

The Council on Aging is a member of the Falls Prevention Task Force, which is chaired by the Hamilton County General Health District. Formed in 1999, the goal of the task force is to reduce injury and death of older people related to falls. The Task Force is not a programmatic intervention, but rather a forum for providing and sharing information among agencies with an interest in addressing the issue.

The Task Force was established shortly after the Hamilton County General Health District initiated the Hamilton County Injury Surveillance System (HCISS), which was designed to provide population-based statistics for Hamilton County residents on the burden of injury. The Hamilton County Injury Surveillance System HCISS data for the 1998-2002 period indicated that falls were the leading cause of injury-related deaths, hospitalizations, and emergency room visits among older persons in Hamilton County (http://www.hamiltoncountyhealth.org/pdfs/reports/injurysurveillance02.pdf). Specifically, falls were the top cause of injury-related deaths for persons aged 65 and over between 1998 and 2002 (73/100,000), the primary reason for non-fatal hospitalizations for persons aged 65 and over (1,359/100,000), and the leading cause of non-fatal emergency room visits for persons aged 65 and over (4,829/100,000).

The Task Force is comprised of volunteer representatives from hospitals, non-profit organizations (including senior centers), local government, public health departments, emergency medical systems, and fire departments. While the Ohio Department of Health provides some financial support for this initiative, community health care professionals who participate on a pro bono basis have served as the critical backbone of the Task Force.

The Task Force has worked to: (a) reduce the prevalence of falls in the community; (b) track data on emergency room visits, hospitalizations, and deaths due to falls; and (c) offer a series of community education programs through its speaker's bureau.

Recent initiatives launched by the Falls Prevention Task Force include:

- A medication management group working with pharmacists to promote and develop consumer education materials and make medical referrals for persons at high risk;
- An activities work group surveying the number and types of wellness programs to develop new strength training approaches at the senior centers; and

- A Loews Foundation grant awarded to Hamilton County government to support environmental modifications for high-risk seniors' homes—hundreds of grab bars, bath chairs, and high toilet seats have been installed since 2002.

Another positive outcome of this collaborative joint venture has been enhanced communication between the emergency medical system and the fire department in serving fall victims.

As opposed to the other initiatives discussed in this report, the task force was not initiated by the Council, and its work is limited to Hamilton County. The Hamilton County Health District, the local health department, collects data through the Hamilton County Injury Surveillance System, a joint collaboration with the county coroner and local hospitals which tracks the most common types of injuries in the county, which are either fatal, require hospitalization, or can be treated in the Emergency Department. Although the evaluation of this program is the responsibility of the Health District, data reflecting the trends in the number of falls allow an assessment of the impact of the initiative.

Health Promotion/Disease Prevention Programming at Senior Centers

Research has demonstrated that exercise has measurable physical and psychological benefits, and physical activity is an integral part of many health promotion programs (Geffken et al, 2001; Mazzeo et al, 1998; U.S. Department of Health and Human Services, 2000). The senior centers offer a range of such Title III-D funded physical activities as walking clubs, chair volleyball, aerobics, jazzercise, Tai Chi, yoga, and tap dancing. These activities have both a social and a physical health component. In fact, one center director reported, "We've had several people who met at the Wednesday dance and got married." Regarding low impact aerobics, "We have three people in their 80s and one can kick her leg higher than any of us."

Chair volleyball, with organized leagues, and walking clubs have been among the most popular health promotion activities provided by the senior centers. An organized senior center sport with formal rules and tournaments, chair volleyball is a variation of regular volleyball but the participants remain seated at all times. The chair volleyball tournaments are highly competitive and very popular among the senior center participants.

Other wellness programs offered by the senior centers include blood pressure checks, weight checks, health counseling, and influenza immunization clinics provided with support from the local health departments. Private health organizations have offered vascular screening, and, for a small fee, bone density tests. One center that is located near a bowling alley made arrangements for its clients to have regular bowling sessions there. Some facilities have pools and hold water resistance activity classes. The centers sponsor other programs that they consider health promotion, such as, in one center, a chaplain

offers grief support. Others host meetings of support organizations for people with Alzheimer's disease and the sight-impaired.

The senior centers are an eclectic group of operations, organizationally independent of the Council and operated by an assortment of private organizations and city and county governments. While the Council contracts with them for Older Americans Act services, it has not maintained any systematic record of basic participation, productivity, financing or program evaluation for the senior centers in the five counties served by the Area Agency on Aging. Systematic data collection, particularly of attendance records and costs for the various activities, would help the Council assess levels of participation, productivity, and financing and help guide the allocation of Council funding. Such records would also allow the Council to identify other senior center activities which would be supportive of its efforts. Improved data for health promotion activities is under discussion with the Hamilton County Health District, which is charged with helping the Council on Aging assess the impact of the health promotion/disease prevention programs it supports at senior centers (including, but not limited to chair volleyball and health screenings). It is currently in the process of developing research projects to measure the impact of its health programs by documenting the pre- versus post-intervention status of the health and well-being of older persons being served.

SECTION 4
CONCLUSION

The key questions for these case studies focus on the role of Title III-D of the Older Americans Act and the Area Agencies on Aging in developing health promotion and disease prevention initiatives for older people. Developing these initiatives is a major challenge because direct funding through Title III-D is, by any measure, extremely small.

The Council on Aging of Southwest Ohio has used its Title III D funding to make health promotion and disease prevention a central component of their programming, responding to demand from the current and potential participants and the growing body of research indicating that health promotion and disease prevention programs for older persons help them maintain health and independence. The Council has worked to leverage these resources to develop new health promotion/disease prevention activities because it believes that doing so is vital both to the survival of senior centers and to its success in meeting the demands of the Baby Boom generation.

Health promotion and disease prevention activities have become an increasingly integral part of the overall activities of the Council on Aging of Southwest Ohio in recent years. While the Council has had a commitment to health promotion and disease prevention since the beginning of its Title III-D funding in 1992, the emergence of health promotion as a strategically central element to their activities dates to 2002. At that time, the Ohio-wide senior center study and reports of declining senior center attendance led to the Re-Engineering project, designed to increase health promotion activities and now institutionalized through a staff position. Through this program, along with the Wellness Coalition, re-engineering grants to senior centers, and other program support, the Council is seeking to work with the senior centers to provide health promotion and disease prevention services.

The Council has developed and chosen the programs it supports through a pragmatic approach focused on using available resources and partners to make the maximum amount of health promotion programming as widely available as possible. The Council has through its own initiatives provided health promotion and disease prevention activities in areas where research has been shown to be effective: medication management, through the COALA program; and physical activity, through Active Living Every Day and the exercise programs of the senior centers. Through a partnership with the Hamilton County Falls Task Force, it has helped provide activities for falls prevention. In addition, the senior centers cooperate directly with the health department to provide clinical preventive services, such as immunizations. Older Ohioans expressed a desire for these kinds of activities, as described in the 2002 Ohio Department on Aging senior survey.

The Council generally has been effective in leveraging its Older Americans Act funds to play a larger role than those funds alone would allow. Older American Act dollars are only 12 percent of the Council budget. Although specific data on Title III-D are not available, the Council appears to be using its small amount of Title III-D dollars to develop larger health promotion and disease prevention programs. However, these funds, even when leveraged, remain extremely small.

A key part of the Council's leveraging is its partnerships with other organizations to develop health promotion programs for older people. Its partnership with its senior and community centers throughout the five-county area provides the Council on Aging with facilities and marketing for its programs including medication management, health screenings, behavioral health and exercise programs, leveraging additional support from private institutions, and state and local governments. The Council has followed a policy of reaching out to join other community health promotion efforts, for instance lending its support to the Hamilton County Falls Task Force, and thereby offering support for the activities of others in promoting the health of older persons and gaining the opportunity to establish contacts for future collaboration. Aiding the Council on Aging work with its partners is that many individuals working at or with the Area Agency on Aging have worked together for 10 years or longer.

Another important element of the Council's leveraging activities is its efforts to seek grant support from evidence-based model programs. For example, the council collaborated with the Hamilton County Health District, the Health Alliance, and some of the most enthusiastic senior centers to secure grant funding for and offer the Active Living Every Day program.

In addition to leveraging its Title III D funding with community partners, and national initiatives to fund additional health promotion activities, the Council has also stretched its resources through the use of pilot projects to demonstrate new programming before making major funding commitments. The COALA program was launched as a two-year pilot effort that became permanent only after it had been tried out on a smaller scale, and Active Living Every Day is also a pilot project. Introducing new activities through pilot programs has provided the Council with the opportunity to demonstrate the utility and feasibility of programs before making major investments, and to attract stakeholders and obtain funding from new sources.

While Council on Aging health promotion and disease prevention programming is becoming more wide-ranging, it is far from comprehensively implemented in the service area. Indeed, the availability of this programming is limited and most programs involve only a small number of people. The Senior Center Re-Engineering Initiative has only been actively working with senior centers for six

months, and Active for Life is just in its second full year of operation, with only nine classes currently in place. The COALA program has so far reached 158 households, compared to the 2,429 clients which the Council serves in the PASSPORT program.

The lack of a systematic and comprehensive approach by the Council to the monitoring and evaluation of programming makes it difficult to analyze of the effectiveness of their programs. Council staff have a general awareness that larger and better funded senior centers are providing more services, and that some of the older and smaller centers are less interested and able to do so, but the lack of an effective system for tracking and assessing programming throughout the Area Agency on Aging service area places staff at a disadvantage in developing the kind of strategy and programming which could lead to a more consistent, complete and comprehensive health promotion and disease prevention program. For instance, it will be difficult for the Re-Engineering coordinator to be effective on more than a senior center by senior center basis without such an overview.

The Council is working to collect data about selected program participants,and has developed a close relationship with Scripps Gerontology Center, a university-based research organization, providing it with an increased capacity to conduct evaluations of its programs. To date, however, the data collection and analysis conducted through this partnership has produced only isolated results. In addition, the Council on Aging has been unable to routinely and systematically evaluate the benefits of its health promotion programs, This is due in part to the lack of available funding to support ongoing program evaluation research. If additional research support were provided to the Council on Aging, it is likely that the Scripps Gerontology Center would become a stronger and more effective partner in providing it with ongoing performance data both to improve the quality of its programming, and to demonstrate its programs' usefulness to other funding sources (including county governments whose local tax levies support health promotion programs, the Administration on Aging and the Robert Wood Johnson Foundation).

To summarize, the Council on Aging of Southwest Ohio is committed to providing a wide range of health promotion and disease prevention services to its older population. These health promotion and disease prevention activities are integrated into the overall activities of the Council as a core activity, along with its case management and home-based services through the state Medicaid home and community-based services waiver and state-funded home and community-based service programs. The Council developed and chose the programs it supports on a pragmatic basis, making use of available community partnerships and other resources. The Council effectively leverages its limited Title III-D funding to expand these health promotion and disease prevention programs through grant support and

community partnerships. These partnerships include both direct relationships which the Council has developed with other organizations, as in the Falls Prevention Task Force, and through the senior centers with local health departments to provide health promotion programs and services for older people. The Council works with its partners to seek grant support, and also launches pilot programs to demonstrate their effectiveness and gain community support. While the Council is committed to developing a comprehensive set of health promotion and disease prevention activities, and has initiated services in the evidence-based areas of exercise, medication management, and falls prevention, its programs are new and much work remains to be done. Additional work is needed to comprehensively implement these activities across the service area, since these new programs still exist in relatively few sites. Although the evaluation of the COALA Medication Management program is beginning to provide information that Council program managers and administrators can use to judge the effectiveness of that health promotion service, data are not yet available on the participants and/or the benefits of many Council programs, and a systematic approach to data collection for Council health promotion and disease prevention programs remains to be developed.

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