Issue Brief

How State Health Agencies Can Support Healthy Aging

Key Findings

Assessment of the aging population will drive efforts in supporting healthy aging

Constructing an environment conducive to healthy aging will only escalate among state priorities and it's crucial for state health officials to build awareness, develop strategic plans, and employ the most effective tactics

Leveraging The Healthy Brain Initiative Public Health Road Map in identifying and employing strategies will provide a successful foundation for state effort

Introduction

The Centers for Disease Control and Prevention (CDC) Healthy Aging Research Network defines "healthy aging" as the development and maintenance of optimal physical, mental, and social well-being and function in older adults.[1] Healthy aging is most likely to be achieved in physical environments and communities that are safe and support adopting and maintaining attitudes and behaviors known to promote health and well-being, as well as through the effective use of health services and community programs to prevent or minimize the impacts of acute and chronic disease.[2] AARP reports that four out of five baby boomers intend to age in place.[3] Aging in place is defined as the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level.[4] Creating an environment conducive to aging in place not only helps decrease the total cost of care, but also allows older adults to maintain a higher quality of life.[5]

ASTHO Recommendations

Educate Primary Care Providers

Strengthen Legislative Action and Awareness to Enhance Quality of Services and Resources

Identify Older Adults and Caregivers to Determine Needs and State Capacity to Serve Older Adults

Utilize Evidence-Based Practices and Apply in Priority Areas

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In the year 2012, individuals 65 years or older represented 28 percent of the U.S. population,[6] and the 65 and older population increased from 35 million in 2000 to 41.4 million in 2011[7]. The HHS Administration on Aging projects that the older adult population will increase to 79.7 million by 2040.[8] Furthermore, racial and ethnic minority populations represented 21 percent of the older adult population in 2011 and are projected to increase to 20.2 million in 2030 (28 percent of older adult population).[9] As the U.S. demographics continue to change, implementing successful and culturally-appropriate approaches to healthy aging will depend on the ability of community, local, and state leaders across agencies and sectors to collaborate.

More than a quarter of all Americans, and two-thirds of older Americans, have multiple chronic conditions, and treatment for these populations accounts for 66 percent of the country's healthcare costs.[10] Furthermore, dementia has been classified as the most costly disease in the United States at $109 billion in 2010, surpassing heart disease at $102 billion and cancer at $77 billion.[11] When including the estimated value of informal home care, it increases this estimated annual cost to a range of $159-$215 billion.[12]

In response to the demographic shift and the projected economic impact, a federal call to action to address Alzheimer's disease and other dementias has emerged. The National Alzheimer's Project Act was enacted in 2011 and created an important opportunity to build upon and leverage HHS and other federal efforts to help alter the trajectory of Alzheimer's disease and related dementias (ADRD). The law called for a National Plan for ADRD with input from the public-private Advisory Council on Alzheimer's Research, Care, and Services.[13]

Congress appropriated funding to CDC in 2006 to "address brain health with a focus on lifestyle issues."[14] As part of its Healthy Brain Initiative, CDC's Healthy Aging Program and the Alzheimer's Association collaborated with other partners to create *The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013–2018.* This Road Map outlines how state and local public health agencies and their partners can promote cognitive functioning, address cognitive impairment for individuals living in their communities, and help meet care partners' needs. The Road Map was informed by input from more than 280 stakeholders. Its final 35 actions focus on a five-year period and align with the core functions of public health. The action items are included under four domains: (1) M: monitor and evaluate, (2) E: educate and empower the nation, (3) P: develop policy and mobilize partnerships, and (4) W: assure a competent workforce.[15] Throughout the Road Map, examples and case studies document how states are applying select action items in their work.

State health officials serve a vital role in helping public health systems identify and coordinate the public health role in healthy aging by building and maintaining coalitions, developing a competent workforce, providing high-level support of financial partnerships, and mobilizing policy and partnerships to best support an evolving population.

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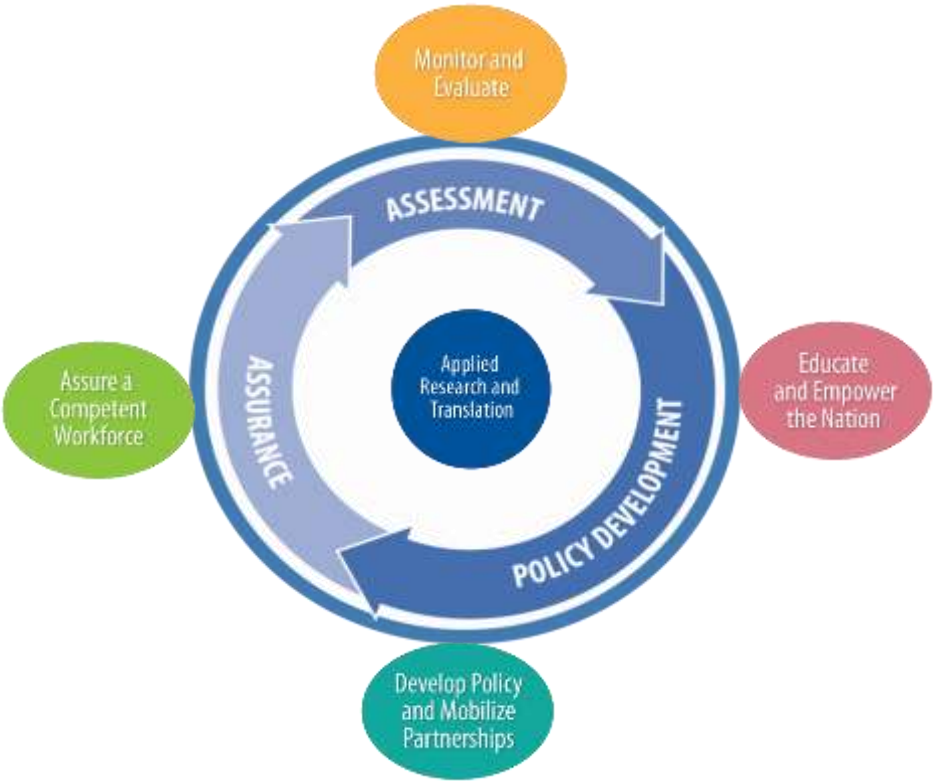

Healthy Aging Collaboration Opportunities

Given the complexities surrounding the aging of our society, it is crucial for public health to take an active role in promoting cognitive health and related influential lifestyle factors. CDC's Road Map provides leaders at all levels with a framework for constructing public health strategies that best support the growing older adult population. This multifaceted approach considers the various components that influence the role of public health and health policymakers at the state level. Healthy aging is affected by a variety of stakeholder partnerships that include: transportation, preparedness planning, financial security, food insecurity, multiple chronic conditions, social isolation risk (mental/behavioral health), and naturally occurring retirement communities (NORC).

The infrastructure supporting older adults varies within each state. The common conceptual healthy aging framework requires the input of a diverse set of stakeholders and brings together diverse components such as, state ADRD plans, state aging plans, evidence-based caregiving interventions, coalition or advisory committees, silver hair legislatures, legislative aging subcommittees, area agencies on aging (AAAs), state agencies, nonprofit organizations, patient and family caregiver advocates, and academic or research-based institutions.

Integrating Public Health and Healthy Aging

Public health's three core functions of assessment, policy development, and assurance are instrumental to successfully approaching healthy aging. Due to the variety of healthy aging efforts at the state level, it is important to apply public health fundamentals to strategically address all components impacting

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healthy aging. Collaboration between social services, public health, primary care, aging services, and public administration is vital for collective action. In light of national efforts to improve health systems and focus on older adults, it is important for state health officials to recognize and promote integrated opportunities for population capacity building and sustainability around efforts impacting the health and well-being of older adults. .

> "The coordination of contributions by private, nonprofit, and governmental partners may provide leverage for synergistic opportunities and more comprehensively address and promote cognitive functioning and the needs of care partners." – **Jewel Mullen, MD, MPH, Connecticut Commissioner of**

From February-April 2014, ASTHO conducted eight hour-long interviews with state agencies and community-based organizations to identify ways in which public health can support healthy aging overall. The interviews covered best practices, lessons learned, and strategies to be considered when approaching healthy aging among various populations. A few of the recommendations from these interviews are highlighted below.

Recommendation #1: Educate Primary Care Providers

Physicians can help identify specific ways in which older adults can maintain quality of life and continue to age in place, and they serve as resources for those affected with Alzheimer's and other dementias and their caregivers. They are one of the primary ways in which individuals engage with the healthcare system, regardless of where they are along the healthy aging spectrum.

California: Guidelines for Alzheimer's Disease Management

The California Department of Public Health (CDPH), working in partnership with the Alzheimer's Association, developed evidence-based quality improvement guidelines for primary care providers focused on delivering high-quality care to those diagnosed with dementia. Funding from the Administration on Aging's Alzheimer's Disease Support Services Program was used to help develop, disseminate, and implement the guidelines.

> **Healthy Brain Initiative Road Map W-02:** Develop introductory, basic materials for public health professionals on cognitive health and impairment to help them understand their role

The initial development brought together stakeholders to form the California Workgroup, a coalition representing a wide array of experts, practitioners, consumers, and researchers to review evidence about quality care. Throughout the development, dissemination, and implementation phases, the CDPH engaged stakeholders who would be applying the guidelines. The CDPH recognized that collaborating with physicians would produce the most effective guidelines. The Guideline for Alzheimer's Disease Management was published in 2008. The guidelines fall within one of three categories of assessment, treatment, and patient and family education and support. The Guideline for Alzheimer's Disease Management is updated every five years as indicated in the California's State Plan for Alzheimer's Disease: An Action Plan for 2011–2021.

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To improve dissemination to every physician, the guidelines were summarized in a one-page reference sheet that could be easily distributed and reviewed. CDPH also required that every California Alzheimer's Disease Center use the guidelines for one year and evaluate utilization. A randomized controlled study concluded that implementation of the dementia-based guidelines lead to better health outcomes for people with dementia.[16] The study indicated a 30.1 percent difference in adherence of dementia care guidelines (between 238 patient-caregiver pairs at nine intervention clinics for more than 12 months), as well as receiving higher care quality on 21 of 23 guidelines-based recommendations when comparing the intervention group to those with the usual delivery of care. Furthermore, patient health-related quality of life, overall quality of patient care, caregiving quality, social support, and level of unmet caregiving assistance needs were better for participants in the intervention group than those in the usual care group.

Healthy Brain Initiative Road Map W-03: Support continuing education efforts the improve healthcare provider's ability to recognize early signs of dementia, including Alzheimer's disease, and to offer counseling to individuals and their care partners

Recommendation #2: Strengthen Legislative Action and Awareness to Enhance Quality of Services and Resources

It is important to identify the best ways for state health policymakers to develop policies and mobilize partnerships that target older adult populations' needs. Recommendations executed at the state level can have far-reaching results when paired with engagement at the community and local levels.

Texas: The Texas Council on Alzheimer's Disease and Related Disorders

The Texas Council on Alzheimer's Disease and Related Disorders (the Council) is a legislatively mandated council formed in 1987 that is actively functioning today with legislatively appointed volunteers. A key factor to the Council's successful development and sustainability is the coordinating support the Council receives from the Texas Department of State Health Services (DSHS) Alzheimer's Disease Program (ADP). The ADP Coordinator manages Council communication and contributes DSHS strategic input to Council activities. The ADP Coordinator also organizes the activities of the Texas Alzheimer's Disease Partnership (the Partnership), which includes volunteers from across the state who form work groups to implement activities from the Texas State Plan on Alzheimer's Disease. Additionally, the Council and the Partnership provide collaborative environments where individuals and groups can share their different missions and goals while identifying opportunities for collaboration.

Healthy Brain Initiative Road Map P-05: Engage national and state organizations and agencies to examine policies that may differentially impact persons with dementia, including Alzheimer's disease

Louisiana: The Community Choices Waiver Program

In fall 2011, Louisiana introduced a new and improved Medicaid waiver called the Community Choices Waiver (CCW). The previous Elderly and Disabled (EDA) Waiver included support coordination (case

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management), transition intensive support coordination, transition services, personal assistance services, adult day health care service, and environmental accessibility adaptations. The original EDA waiver had a limited scope and was not meeting the needs of the growing older adult population in Louisiana. The CCW includes all of the services within the EDA Waiver but adds assistive devices and medical supplies, skilled maintenance therapy services (physical, occupational, and speech), nursing services, home-delivered meal services, caregiver temporary support services (respite care for family caregivers), housing stabilization services, and housing transition/crisis intervention services. Eligibility for the Community Choices Waiver includes those who meet Medicaid eligibility, are 21 years of age or older, and meet nursing facility level of care. Developing and implementing this waiver redesign brought together a group of stakeholders representing consumer groups and advocates providing input on service designations and budget limits. Louisiana's waiver redesign serves as a model for change in helping older adult populations age in place and maintain a higher quality of life.

Recommendation #3: Identify Older Adults and Caregivers to Determine Needs and State Capacity to Serve Older Adults

To best serve the older adult population, it is essential to identify older adults' and caregivers' needs, as well as evaluate the state's or community's capacity to serve older adults. Older adult needs are complex and fall within a large range of areas, so an analysis of the population is necessary to construct the most effective healthy aging plan, implement services, and promote policies.

Texas: Statewide Caregiver Assessment Questionnaires

Legislation enacted in Texas in 2009 (SB 271) mandated the Texas Department of Aging and Disability Services (DADS) to work with AAAs to develop and implement standard tools to be used to evaluate caregivers' needs. Two forms were developed: the Caregiver Status Questionnaire (CSQ) and the Caregiver Assessment Questionnaire (CAQ). After review and pretesting, the forms were incorporated into DADS automated systems so that data from the forms could be collected for analysis and preparation of a biennial report to the governor and the state Legislative Budget Board.

Healthy Brain Initiative Road Map M-08: Define the needs of caregivers and persons with dementia, including Alzheimer's disease and younger onset, as they relate to employment and employers

AAA staff implements the CAQ face-to-face or over the telephone; the CSQ is used to identify caregivers at the Medicaid point of entry. These instruments gathered data on more than 21,000 caregivers during the first 17 months of use (October 2010-February 2012). The CAQ and CSQ are both designed to gather data on the needs of informal caregivers to identify specific services to meet those needs, as well as measure the effectiveness of existing caregiver support programs, improve existing programs, and develop new services.

Some lessons learned include the importance of engaging all stakeholders throughout the development, implementation, and evaluation processes; disseminating information about the project early and frequently to gain buy in; and structuring the assessment tools to complement existing infrastructure.

North Carolina: State Aging Readiness Assessment via Executive Order

The North Carolina Aging Services Plan 2011-2015 focuses on five main elements: supporting caregivers for persons with Alzheimer's and other dementias, supporting those dealing with early onset dementia, improving community awareness and education around the disease, supporting workforce policies to empower caregivers, and educating and supporting public officials.

Healthy Brain Initiative Road Map
M-06: Support state and local needs assessments to identify racial/ethnic; lesbian, gay, bisexual, and transgender; socioeconomic; and geographic disparities related to cognitive health and impairment and help ensure materials are culturally appropriate.

In 2012, to help focus efforts on the Aging Services Plan drafted by the Division of Aging and Adult Services and North Carolina Department of Health and Human Services, an Alzheimer's stakeholder group was convened which lead to the development of a Dementia Coalition that focuses on the state plan's five elements. Stakeholder group participation included individuals from public health, health services, social services, mental health, aging agencies, and community-based partners. Following the creation of this coalition, then-Gov. Beverly Eaves Perdue issued an executive order to disseminate a state aging readiness assessment; the intention of this survey was to gather information from state agencies regarding how well they were prepared for meeting the rapidly evolving program and service needs related to the aging of the state's population and workforce. This assessment was accompanied by the complementary development of a corps of aging liaisons within state agencies. The development of the assessment and aging liaisons corps helped centralize and link North Carolina's aging efforts while integrating existing previous efforts as well. North Carolina's 2011 Aging Readiness Assessment Report outlines their next steps moving forward. Some next steps for the Division of Aging and Adult Services and the University of North Carolina Institute on Aging include: continue to support communications and collaboration among the corps of aging liaisons; enlist the support of the aging liaisons to share information with the Governor's Advisory Council on Aging, and conduct an inventory of state programs and services targeted specifically for older adults and/or their family caregivers; pilot a local assessment, mirroring state assessment; and maintain a web-hub of information relevant to this initiative.

Recommendation #4: Utilize Evidence-Based Practices and Apply in Priority Areas

There are a variety of evidence-based practices available. Identifying and adopting such programs or initiatives can help sustain positive population health impact.

Texas: The Aging Texas Well Clearinghouse

The Aging Texas Well Clearinghouse (ATW Clearinghouse) is a public database of national and state-level evidence-based information and research serving as a tool for researchers, practitioners, and individuals to identify areas of collaborative opportunity. The ATW Clearinghouse evolved from the ATW Initiative that began in 1997 and was formalized under Executive Order RP 42 in 2005. The database supports the Texas Healthy Lifestyle (TXHL) grant demonstration project and evidence-based programs across Texas. In addition to providing a variety of evidence-based practices, it highlights where practices are being implemented, which contributes to community capacity building efforts.

Healthy Brain Initiative Road Map E-04: Coordinate national and state efforts to disseminate evidence-based messages about risk reduction for preserving cognitive health.

North Carolina: Project C.A.R.E

The North Carolina Division of Aging and Adult Services provides family consultation and support services to family members who are caring at home for a relative with dementia through Project C.A.R.E. Strong partnerships among the AAAs, Duke Family Support Program, Alzheimer's North Carolina, and local departments of social services have made this an ongoing initiative since 2001. Project C.A.R.E. uses a family consultant model to deliver comprehensive support to dementia caregivers to increase quality, access, and choice for low-income rural and minority families. Family consultants offer expertise in Alzheimer's disease and related disorders and visit the homes of dementia caregivers in crisis with timely, individualized assessment, guidance, counseling, advocacy, and education. In surveys, approximately 94 percent of caregivers reported that Project C.A.R.E. services allowed them to provide care at home longer and 94 percent rated their satisfaction with the overall program above average or excellent.

Maine: Savvy Caregiver Program

The Maine Department of Health and Human Services Office of Aging and Disability Services collaborates with statewide interdisciplinary partners to deliver the evidence-based Savvy Caregiver Program. The program, offered as a two-part series, was expanded in 2013 to reach caregivers of individuals with intellectual and developmental disabilities and dementia. Savvy Caregiver is an evidence-based psycho-education curriculum for caregivers of those living with dementia in the community that focuses on adjustments in approach and environment. Outcomes of Savvy Caregiver indicate that more than 1,500 participating caregivers have improved self-efficacy in their ability to respond to disruptive behavior and have experienced a reduction in depressive symptoms and negative reactions to the care recipient's behavior. These outcomes were sustained at 12 months. Since August 2011, 184 caregivers have been reached through Part II, and outcomes suggest improved competency in skills as the disease moves into later and more challenging stages, reduced symptoms of depression, and improved mood.

Conclusion

States and territories have made extensive investments and completed a tremendous amount of work surrounding healthy aging and Alzheimer's and other dementia. However, given the growing population

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of older adults, integrating all efforts will help guarantee a more comprehensive approach to supporting healthy aging and Alzheimer's and other dementia across the country. Ultimately, there are a variety of entities serving older adults in their respective missions and this issue brief offers examples and evidence of collective action. State and territorial health leadership can help support healthy aging and Alzheimer's and other dementias in the health system by educating physicians, strengthening legislative action and awareness to enhance quality of services and resources, identifying older adults and caregivers to determine their needs, evaluating state capacity to serve older adults, and applying evidence-based practices and services in meeting identified priority needs and to address inequities.

Resources and Tools

The resources and tools that were discussed during interviews with states are highlighted throughout this issue brief. These references and tools are not intended to be comprehensive.

State Aging Plans: Older Americans Act, Section 307(a)

Under the Older Americans Act, each state agency is required to develop a state plan on aging. The aim is to ensure a seamless, comprehensive service system for older adults that is responsive to needs and preferences.

State Alzheimer's and Other Dementia Plans

More than 40 states are currently developing and utilizing their own state government Alzheimer's disease plan.

National Alzheimer's Project Act (NAPA)

NAPA was signed into law in January 2011 and mandates the creation of a national strategic plan to address Alzheimer's disease and coordinate federal Alzheimer's disease efforts. It calls for a National Plan to Address Alzheimer's Disease for ADRD with input from a public-private Advisory Council on Alzheimer's Research, Care, and Services.

Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013-2018

The CDC Healthy Aging Program and the Alzheimer's Association and have developed the second in a series of road maps to advance cognitive health as a vital, integral component of public health. The Road Map outlines specific action items for public health partners on how to "promote cognitive functioning, address cognitive impairment for individuals living in the community, and help meet the needs of care partners." The Road Map's action items fall within four domains: monitor and evaluate; educate and empower the nation; develop policy and mobilize partnerships; and assure a competent workforce.

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Louisiana
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