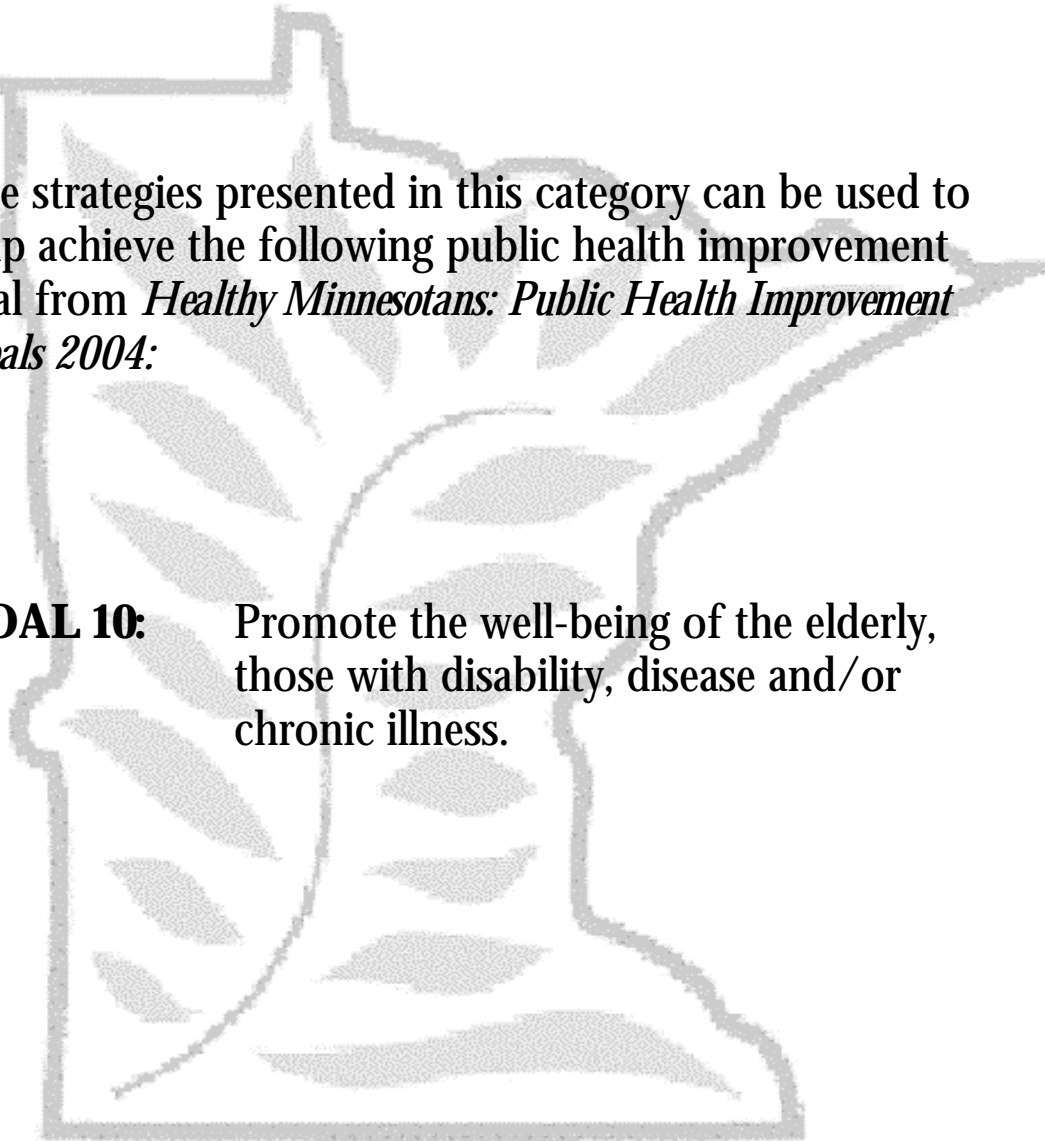


Category:

DISABILITY/DECREASED INDEPENDENCE

The strategies presented in this category can be used to help achieve the following public health improvement goal from *Healthy Minnesotans: Public Health Improvement Goals 2004*:

GOAL 10: Promote the well-being of the elderly, those with disability, disease and/or chronic illness.



CATEGORY: DISABILITY/DECREASED INDEPENDENCE

Introduction	1
Promote Healthful Aging and Support the Well-Being of the Elderly	3

Promoting healthful aging and supporting the well-being of the elderly has emerged as an important public health issue in this century. The issue will become more important in coming years as the relative proportion of the elderly increases. Minnesota's population of people aged 65 and older will almost double in size between the years 2000 and 2030. By the year 2030, when the first of the baby boomers turn 85 years old, older people will constitute 23 percent of the total state population, up from 12.7 percent of the population in 2000 (Department of Human Services, 1998).

It is fair to assume Minnesota's continuum of long term care services and social and housing systems will be significantly affected although the exact dimensions are hard to predict. We know that older populations have relatively greater needs for support services and that the availability and affordability of services determine an older person's ability to live independently in the community. We also know that Minnesota, as a society, is continually growing older. According to the state demographer's office, by the year 2020, most counties in Minnesota will have decreasing populations where deaths exceed births.

The sheer size of this cohort makes this an important issue for the state. The need that accompanies reduction in functioning, increased disability, and chronic conditions is likely to be enormous and overwhelm the traditional response of family, the private sector, and government. Matching appropriate services to the needs of older people will require careful planning by federal and state government, the private sector and individuals.

Some of the things that can be done now to promote healthful aging and to support the well being of the elderly in Minnesota include:

- ▶ Fostering healthful behaviors such as good nutrition, physical exercise, medications management, obtaining flu shots, efforts to reduce isolation, and promote mental health.
- ▶ Assisting the elderly in obtaining full benefits entitlement to combat the effects of low income that many elderly face, such as malnutrition, poor housing, and social isolation.
- ▶ Designing a continuum of long-term care options that are conducive to preserving independence and dignity.
- ▶ Preventing falls that are major contributors to injury and death among the elderly.
- ▶ Supporting active participation in one's community through meaningful activity.
- ▶ Providing a full continuum of care to an aging population by increasing community capacity to support people as they age. This can be accomplished through devising service strategies that focus on the whole person, expanding the availability of the informal and quasi-formal support networks, and promoting meaningful integration of the aging population into all aspects of community life.

While a recent study shows that disability among older Americans is declining rapidly and at an accelerating pace¹, the sheer number of those aged 65 and older living with disabilities is significant.¹ Between 1982 and 1994, the number of Americans with chronic disabilities increased by about

¹ Mauton, KG, Gu, XL. (2001). Proceedings of the National Academy of Sciences; May 8.

600,000 to 7 million.² However, chronic problems, such as arthritis, osteoporosis, incontinence, visual and hearing impairments, and dementia are of concern because of their significant impact on day-to-day living. Chronic conditions are most frequently cited as the main cause of need for assistance with activities of daily living (ADL) skills. Therefore, primary prevention of diseases and chronic conditions triggering assistance with ADL will be critical to reducing the number of those dependent on help with ADLs. To accommodate the changing needs of an increasingly older society, we must prevent the ill from being disabled and help people with disabilities preserve function and prevent further disability. The strategies presented here support local efforts to do just that.

For related strategies see, “Arthritis”, “Health Disease, Heart Attack and Stroke”, “Nutrition”, “Osteoporosis”, and “Physical Activity/Inactivity” in the *Chronic/Noninfectious Disease* category; “Mental Health” in the *Mental Health* category; “Promote Access to Health Care” in the *Service Delivery System* category; and “Fires, Falls and Other Home Hazards” in the *Unintentional Injury* category.

² Federal Interagency Forum on Age-Related Statistics. (August 2000). *Older Americans 2000: Key indicators of well-being*. Available at: <http://agingstats.gov>.

CATEGORY: Disability/Decreased Independence

TOPIC: PROMOTE HEALTHFUL AGING AND SUPPORT THE WELL-BEING OF THE ELDERLY

The strategies below can be used to work on this topic.
Organizations that may play a role in implementing each strategy are indicated.

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Create a community consortium for the development of services for seniors.	Local Government	✓	✓		Social Services, RSVP	✓	Pharmacies, Extension Services
Promote service coordination.	✓	✓	✓		✓		
Implement eldercare assessment and health promotion clinics.	✓	✓	✓		✓		
Support family caregivers.	✓	✓	✓	✓	✓	✓	Parish Nurses
Establish a health promotion program for older adults.	✓	✓	✓	✓	✓	✓	
Conduct peer counseling for the elderly.	✓	✓	✓		✓		Parish Nurses
Promote the prevention of falls in the home.	✓	✓	✓		✓		
Promote medication management.	✓	✓	✓			✓	Pharmacies
Promote the use of residential smoke alarms.	✓	✓	✓		✓	✓	Extension Services

Strategy: Create a community consortium for the development of services for seniors.

	Systems	Community	Individual
Primary			
Secondary		✓	
Tertiary	✓		

Background:

Minnesotans aged 65 and older comprise 12 percent of the population. Between 1990 and 2000, the 65 plus population grew 9 percent, lower than the rate for the younger population. This overall number reflects very low growth among younger elderly, ages 65 to 74, combined with more rapid growth for those over age 75. There was a 24 percent increase in the extremely old population – 85 and older. The low growth for the younger elderly is attributable in large part to low birth rates during the Great Depression of the 1930s.

The related predictable aging-associated decline in health and function demands a realistic balancing of seniors’ levels of medical need, functional status, individual health preferences, and cost in order for them to remain living independently. To provide for and coordinate these needed compensatory services, communities require two factors:

- ▶ A mechanism to assure the availability of a community-based, long-term-care continuum of needed services.
- ▶ A mechanism to access those services, assuring the right services are available at the right time at a right price (see the promotion of service coordination strategy for additional information).

This strategy creates within communities a consortium of service providers, consumers, advocates for seniors, and payers of services to assess and plan for a network of needed services, ensure consumers link with those services, and evaluate for effectiveness and efficiency on an ongoing basis. It could also build on efforts already existing, such as programs through the Area Agencies on Aging and/or seniors’ advocacy groups.

In 2001, all Minnesota counties’ social service agencies completed a “gaps analysis” regarding needs of their elderly population. The results are to be used to support a variety of strategies including service development through the Community Service and Services Development Grant Program. The purpose of the grants is to “help communities rebalance the services for persons age 65 years and older by reducing facility care and increasing the supply of home- and community services including housing and service options.” Grant development is to occur biennially in accordance with the CSSA planning process. Gaps analysis results may be retrieved from: <http://www.dhs.state.mn.us/agingint/lctaskforce/gapsdefault.htm>.

Additional resources:

Bibliographic resources:

- ▶ Aday, L. 1997. Vulnerable populations: A community-oriented perspective. *Family and Community Health* 19(4): 1-18.
- ▶ Bailey, D., and Koney, KM. 1992. *Developing Community-based Consortia: An Integrative Framework*. Cleveland, OH: Case Western Reserve Univ., Mandel School of Applied Social Sciences.

- ▶ Krothe, J. 1997. Giving voice to elderly people: Community-based long-term care. *Public Health Nursing* 14(4): 217-226.

Organizational resources:

- ▶ Minnesota Board on Aging and its various Area Agencies on Aging, at (651) 296-2770 or (800) 333-2433 for general information and/or the Senior LINKAGE LINE.
- ▶ Minnesota Department of Health, Division of Facility and Provider Compliance, at (651) 215-8700.
- ▶ Minnesota Department of Human Services. Two relevant resources are: Seniors Agenda for Independent Living (SAIL), at (651) 251-1946; and Project 2030, at (651) 296-2062, www.dhs.state.mn.us/aging/aboutaging/default.htm.
- ▶ U.S. Department of Health and Human Services Agency on Aging, www.aoa.gov.

Evidence for strategy:

In order for such a consortium to succeed, each member has to identify and value a positive return on their “investment” in the consortium. If the intent of the consortium is to assess for gaps in the current long-term-care continuum, develop and implement the needed services, and assure a “seamless” referral and access system, each consortium member must see a personal or organizational gain in the work of the consortium. Differing perspectives among consortium members must, therefore, be addressed early in the consortium’s development, so the organization can focus on the mutual benefit of all its members (Aday, 1997).

Several consortia-development phases need to occur for members to develop “buy in” to the process (Bailey and Koney, 1992). These phases include:

- ▶ A convening person or local organization must step up and take leadership in convincing potential consortium members that participation is to their benefit for reasons that closely fit their individual missions (e.g. economic, political, or social action). This *assembling* phase is characterized by high levels of intense face-to-face communication among stakeholders and focuses largely on selling the consortium’s purpose.
- ▶ After the members are in place, the leader must begin to provide guidance in establishing a consortium *culture* that encourages and rewards free exchange of facts and opinions with the identification of mutual gain and community betterment.
- ▶ The dialog then moves into the *ordering* phase, in which operational issues of role differentiation, systems integration, and structure are addressed. This phase is characterized by conflict and a high degree of intensity. A turnover in membership may occur at this point, as the reality becomes clearer, and some determine it is no longer in keeping with their missions. Alternatively, new members may seek to join. The leader must demonstrate skills in active listening, empathy, negotiation, and feedback in recognizing and appreciating the many differences that will arise within the group.
- ▶ Having grappled with the issues of differentiating and integrating the many systems, roles, and structures, the consortium makes the transition from

ordering into *performing*. At this point, members must understand the costs and benefits of their involvement, their own roles, and the ways they fit into the larger context, and they must move to placing higher value on the “good of the consortium” than on the “benefit” to their own organizations. Compromise, collaboration, and creativity are required. Each member participates in subgroups developed to operationalize the various systems, which have been established to accomplish the consortium’s goals. The leader’s role is to continue communicating a sense of how things will be better when the purpose is met and to provide informal collective evaluation of the completed tasks to the whole group.

- ▶ In the final phase, *ending*, consortium members come together to measure the extent to which its purpose has been met. The members may determine the work is of continuing value and design a permanent structure. They may also change the original purpose and return to the ordering phase, or they may splinter, with some choosing a radically different course and returning to assembling.

Has this strategy been implemented in Minnesota?

Yes, in counties participating in DHS’s Seniors Agenda for Independent Living (SAIL) program. In addition, several consortia focusing on needs of the elderly are hosted by regional Area Agencies on Aging around the state.

Indicators for this strategy:

- ▶ Existence of a continuum of services reflective of the elderly population’s needs.

- ▶ Percentage of home- and community-based services expenditure as part of long-term-care total expenditures.
- ▶ Minutes from meetings or other documentation of the coalition’s proceedings.
- ▶ Reduction in number of “case mix A” clients occupying nursing home beds.

For more information contact:

- ▶ Candy Hanson, Adult Services Supervisor, Chisago County Elderly Services Committee, at (651) 213-0301, cjhanson@co.chisago.mn.us.
- ▶ Dawn Simonson, Aging Initiative, Minnesota Department of Human Services, at (651) 215-1824, dawn.c.simonson@state.mn.us.
- ▶ Minnesota Association of Area Agencies on Aging, at: (507) 288-6944, FAX: (507) 288-4823, 421 First Avenue SW, Suite 201, Rochester, MN 55902.

Strategy: Promote service coordination.

	Systems	Community	Individual
Primary	✓		
Secondary			
Tertiary			✓

Background:

A full continuum of services in the community is required to maintain frail elderly within the least restrictive residential environment for as long as possible. Mechanisms also need to be in place within communities to assure that those in need of services can access them. Elders and their families may be assisted through the services of a service coordinator (i.e. a professional individual who is not employed by a health

care provider, but who is knowledgeable about the area's community-based resources for the elderly). Basic service coordination consists of:

- ▶ Provision of outreach to those potentially in need of the services.
- ▶ Screening, intake, and eligibility determination.
- ▶ Assessment.
- ▶ Service arrangement.
- ▶ Monitoring and follow-up.
- ▶ Reassessment.
- ▶ Care planning.
- ▶ Assistance of client's negotiations with a complex, fragmented health care system.
- ▶ Assurance of continuity of care.
- ▶ Provision of comprehensive coordination along a continuum of care.

Although it is not required, a professional providing service coordination is often certified as a certified case manager (CCM). He or she may provide services as an independent operator, or may be employed by a payer or service provider, or perhaps by an elderly consortium.

A critical component of the effectiveness of service coordination is the availability of data from a thorough assessment of the senior's physical, functional, mental, and social capacities. A plan of care tailored to meet the senior's specific needs will depend on this (see the strategy on implementation of eldercare assessment and health promotion clinics for additional information).

Additional resources:

Bibliographic resources:

- ▶ Jamieson, MK. 1989. Nursing our neighbors. *Am J Nurses* 89(10): 1290-01.

- ▶ Krothe, J. 1997. Giving voice to elderly people: Community-based long-term care, *Public Health Nursing* 14(14): 217-226.
- ▶ Kersbergen, A. 1996. Case management: A rich history of coordinating care to control costs. *Nursing Outlook* 44: 169-72.
- ▶ Lyon, JC. 1993. Models of nursing delivery and case management: Clarification of terms. *Nursing Economics* 11(3): 163-169.

Organizational resource:

- ▶ Area Agency on Aging. Commission on Case Manager Certification. Minnesota Board on Aging, at (651) 296-2770.

Evidence for strategy:

For an elderly individual with even minimally diminished capacity, accessing services can be problematic. Being an informed consumer may be impossible, even with supportive family, friends, or both to assist. Such external factors as complex referral systems, eligibility mazes, forms, transportation to appointments, and automated phone answering requiring the caller to select from a menu can become barriers to access. Equally significant, however, can be personal barriers, such as, diminished hearing and vision, fear of loss of independence, grief over loss of function, or depression. Even for the able and the competent, access is compromised by lack of knowledge of options; most elderly believe nursing home placement is their only available alternative. Information about other options is most frequently discovered by word-of-mouth from peers (Krothe, 1997).

Has this strategy been implemented in Minnesota?

Yes, long-term care consultation (formally called “preadmission screening”) is available through most local public health departments in Minnesota and is required for individuals interested in support services through county programs. In addition, some private case management firms operate in the metro area. One example is Living at Home/Block Nurse, Inc., which also has branches in Greater Minnesota.

Indicators for this strategy:

- ▶ Number of persons with “case mix level A” currently in nursing homes.
- ▶ Service coordinator client satisfaction.
- ▶ Level of client functional measures over time.

For more information contact:

- ▶ County public health departments’ long-term care consultant.
- ▶ Malcolm Mitchell, Living at Home/Block Nurse Program, at (651) 649-0315.

disease is preferred, this strategy is not realistic in the old and very old sub-populations. Tertiary interventions aimed at preventing adverse outcomes of disease emerge as reasonable goals, especially when linked with primary interventions to prevent impairments or functional declines associated with the aging process itself (Guralnik, Fried, and Salive, 1996). A service to provide the mix of screening and assessment resources associated with these interventions can also provide the functional and physical assessment necessary for selection of appropriate in-home services described in the service coordination strategy.

While the most familiar setting in which this can occur is that of a clinic, such screening and assessment services can also be offered via mobile van or in the home. Similarly, while the most familiar provider of such services is a physician, most screening and assessment procedures are well within the license of advanced practice nurses or mid-level medical practitioners. A physician can be involved if diagnosis and treatment are also part of the services provided.

Strategy: Implement eldercare assessment and health promotion clinics.

	Systems	Community	Individual
Primary	✓		
Secondary	✓		✓
Tertiary			✓

Background:

With rapid growth of the older population expected in the next century, the prevention or postponement of disabilities is a major public health concern. Although preventing disability from a disease by preventing the

Assessment and health promotion services can be operated as a freestanding enterprise, associated with a medical or health system practice, a nursing home, or a public health nursing clinic, or under the auspices of a consortium (see the strategy on creating a community consortium for the development of services for seniors for more information). The measure of its success is appropriate and effective referral and follow-up within the community served (not including internal referrals).

Within such a service, elders and their families can expect, at a minimum, the following (Public Health Foundation, 1993; Institute of Medicine, 1990):

- ▶ Assessment of functional capacity, applying standardized instruments (see special notes).
- ▶ Review of health history and current management regimen (including medications).
- ▶ Assessment of cognitive capacity, applying standardized instruments.
- ▶ Nutrition screening.
- ▶ Provision of age-appropriate screening procedures as recommended by the United States Task Force on Preventive Services (e.g., smoking, blood pressure, breast cancer up to age 75, hearing, and vision).
- ▶ Provision of immunizations.
- ▶ Referral to other providers, when necessary.
- ▶ Tenacious follow-up.

Additional resources:

Regarding functional assessment for the elderly, the literature is large. Most sources include some version of the activities of daily living (using the Activities of Daily Living [ADL] scale or the Instrumental Activities of Daily Living [IADL] scale).

However, recent innovations to be considered include:

- ▶ Breslow, L., Beck, JC., et al. 1997. Development of a health risk appraisal for the elderly (HRAE). *American Journal of Health Promotion* 11(5): 337-343.
- ▶ Padula, C. 1997. Development of the health promotion activities of older adults measure. *Public Health Nursing* 14(2): 123-8.
- ▶ Song, M., and Lee, EO. 1996.

Development of a functional capacity model for the elderly. *Research in Nursing and Health* 19: 173-181.

Regarding health promotion for the elderly:

- ▶ Association of State and Territorial Health Officers (ASTHO). 1993. *Wearing Well: Public Health Eldercare Challenges and Resources*, Pub. #131, Washington, DC: Public Health Foundation.
- ▶ Dychtwald, K. 1985. *Wellness and Health Promotion for the Elderly*. Aspen.
- ▶ Hawranki, P. 1991. Preventing health problems after the age of 65. *Journal of Gerontological Nursing* 17(11): 20-25.
- ▶ Institute of Medicine. 1990. *The Second Fifty Years: Promoting Health and Preventing Disability*. RL. Berg and JS. Cassells, Eds. Washington, DC: National Academy Press.

Other:

- ▶ Collins, CE., Butler, RT., et al. 1997. Models for community-based long-term care for the elderly in a changing health system. *Nursing Outlook* 45(2): 59-63.
- ▶ Guralnik, JM., Fried, LP., and Salive, ME. 1996. Disability as a public health outcome in the aging population. *Annual Review of Public Health* 17: 25-46.

Evidence for strategy:

Recent studies have suggested that falls, confusion, and depression are leading contributors to disability among the elderly, in addition to the changes related to the natural course of their chronic diseases (Guralnik et al., 1996; Hawranik, 1991; Arnold, Kane, and Kane in Dychtwald, 1985). In many instances, falls and confusion are, in turn, related to mismanagement of prescribed medications,

oftentimes compounded by self-medication with over-the-counter drugs. For this reason, they should be emphasized as part of the clinical encounter. (See also strategy, “Promote Medication Management” in this section.). Conducting timely health assessments and offering health promotional opportunities can help to prevent and decrease disability from falls and chronic diseases among the elderly. For additional related strategies see the strategies on “Mental Health” in the *Mental Health* category and the strategies on “Fires, Falls and Other Home Hazards” in the *Unintentional Injury* category.

Has this strategy been implemented in Minnesota?

Yes, to a limited extent. Geriatric outpatient clinics and specialists, mostly concentrated in urban areas, offer comprehensive clinical assessment. Public health nursing clinics, including elderly health promotion activities, are sponsored by some local public health agencies. See the related strategy, “Establish a health promotion program for older adults” in this section.)

Indicators for this strategy:

- ▶ Number of assessments completed.
- ▶ Number and results of timely and appropriate follow-ups.
- ▶ Number of clinics in the community or region.
- ▶ Emergency Room (ER) and hospital admissions for fall-related injuries.
- ▶ ER and hospital admissions for medication toxicity.
- ▶ Number of seniors successfully completing smoking cessation programs.
- ▶ Clinic referral and follow-up rates.

For more information contact:

- ▶ Contact your local public health or social services agency.

Special notes:

*Elderly assessment instrumentation is a large literature, too large to summarize adequately in this compendium. Interested readers may wish to check out *Assessing the Elderly: A Practical Guide to Measurement* by Rosalie Kane and Robert Kane (Lexington, Mass: Lexington Books, 1981). It provides a review of four widely used tools: the *Sickness Impact Profile (SIP)*, the *OARS instrument* (from Duke’s Older Americans Resources and Services Group), *CARE (Comprehensive Assessment and Referral Evaluation)*, and *PACE (Patient Appraisal and Care Evaluation)*.*

Strategy: Support family caregivers.

	Systems	Community	Individual
Primary			
Secondary			
Tertiary			✓

Background:

Older adults first turn to their families and friends when they need help. An estimated 7,000,000 households now contain an individual who is helping an older adult with personal care, household management, or both. The most important coping resources are the combination of family helpers who join forces and the co-residence of an elderly person with a helper (Boaz and Hu, 1997). Interventions and other kinds of support that help families to build needed internal or external resources (i.e., developing their capacity for problem solving, sense of

mastery, and perception that changes can be managed, as well as stabilizing their own support network) are critical to families' capacities to fulfill their roles as elder caregivers. Community efforts to develop and maintain a continuum of services for community-based eldercare cannot ignore the development and maintenance of family caregivers. Examples include:

- ▶ Support groups for caregivers, a frequently employed strategy at the local level.
- ▶ Specific training for caregivers in aspects of care provision for which few are ordinarily prepared. A curriculum recently developed for this purpose focused on monitoring vital signs, managing elimination problems, managing confusion, using medications wisely, lifting and moving individuals, maintaining hygiene, and exploring nutritional issues (Mahoney and Shippee-Rice, 1994).

Additional resources:

Bibliographic resources:

- ▶ Barer, B., and Johnson, C. 1990. A critique of the care giving literature. *The Gerontologist*: 20: 26-29.
- ▶ Boaz, RF., and Hu, J. 1997. Determining the amount of help used by disabled elderly persons at home: The role of coping resources. *Journal of Gerontology: Social Sciences* 52B(6): S317-S324.
- ▶ Fink, S. 1995. The influence of family resources and family demands on the strains and well-being of care giving families. *Nursing Research* 44(3): 139-146.
- ▶ Mahoney, DF., and Shippee-Rice, R. 1994. Training family caregivers of older adults: A program model for community

nurses. *Journal of Community Health Nursing* 11(2):71-78.

- ▶ Miller, LL., Hornbrook, PG., et al. 1996. Development of use and cost measures in a nursing intervention for family caregivers and frail elderly patients. *Research in Nursing and Health* 19: 273-285.
 - ▶ Penrod, JD. et al 1995. Who cares: The size, scope and composition of the caregiver support system. *The Gerontologist* 35(4):489-497.
- Organizational resource:
- ▶ Vocational-Technical Colleges and other providers of Home Health Aide training.

Evidence for strategy:

A recent study supported by the federal Agency for Health Care Policy and Review (AHCPR), found that, after controlling for disabilities in physical and cognitive functioning, the most important coping resources are the combination of family helpers who join forces and the co-residence of an elderly person with a helper (Boaz and Hu, 1997). Other research has shown that a family's capacity to provide needed services to a frail elder member is dependent on a balance between the family's ability to maintain its well-being (i.e. members' satisfaction with the functioning of the family unit, their perception of their own health and emotional well-being, and their perception of the family's health) and the strain and demands on the family related to caring for the senior. Family well-being, in turn, was found to be related to the family's own internal resources (in terms of problem solving, sense of mastery, and perception that changes can be managed) and the extent to which their own family support network functioned. Other research has demonstrated that when family caregivers felt better about

their situation, had more confidence in their ability to care for the care receiver, and felt reassured that they were doing the right things, making the right decisions, and giving the right care, overall costs to the long-term-care system were reduced, with improved outcomes (Miller et al., 1996).

Has this strategy been implemented in Minnesota?

Yes, many organizations provide support groups for caregivers. Often this is a collaborative effort among community groups providing resources for those with decreased independence and disability. Typically this would include such organizations as hospitals, local public health departments, voluntary health associations (e.g., local chapters of the American Cancer Society) hospices, faith communities, etc.

Indicators for this strategy:

- ▶ Well-being of families providing care for elders.
- ▶ Percentage of total long-term-care expenditures represented by home- and community-based-services expenditures.
- ▶ Number of support and respite groups for caregivers.
- ▶ Number of organizations, providers, etc., that offer support and services for caregivers.

For more information contact:

Local community and information referral services.

Strategy: Establish a health promotion program for older adults.

	Systems	Community	Individual
Primary		✓	✓
Secondary			
Tertiary			

Background:

This strategy describes the Anoka County Health Promotion Program for Older Adults. However, any health promotion program for older adults can be modeled after this one. The Anoka County Health Promotion Program for Older Adults encourages and supports older citizens to assume responsibility for their health, experience healthy aging, and live well. The program emphasizes three types of change: awareness, lifestyle, and supportive environment. It is available to all senior residents and it involves extensive collaboration with organizations and programs already reaching out to older adults, including churches, community education, city recreation, public health nursing, community agencies, and senior centers.

Potential areas of content of any health promotion program for older adults include:

- ▶ Nutrition.
- ▶ Lifestyle changes.
- ▶ Health problems and appropriate care.
- ▶ Access to care.
- ▶ Clinical services.

Group classes, each lasting two hours in length, are held once a week for six weeks.

Topics covered in the series include:

Week 1: Eating Healthy for Your Heart
Hypertension

- Week 2: Fitness
Foot Care
- Week 3: Fiber and Water in Your Diet
Food Guide Pyramid
Shopping on a Budget
- Week 4: Safety for Seniors
Hearing Through Older Ears
- Week 5: Using Medications Wisely
Brown Bag Medication Check
- Week 6: Loss, Grief, and Depression
Know Your Community
Resources

Classes are presented by a variety of representatives from the community, including public health nurses, nutrition staff, pharmacists, law enforcement officers, a hearing loss educator, a hospital EMS coordinator, etc. Class participation can be enhanced through special incentives, such as water bottles, safety lights, food, therabands, etc., provided to support lifestyle-change activities. Incentives for the program can be sought through donations from businesses in the local geographic areas where the classes are held.

Additional resources:

Bibliographic resources:

- ▶ Hawaranik, P. 1991. Preventing health problems after the age of 65. *Journal of Gerontological Nursing* 17(11).
- ▶ Resnick, B. 2001. Geriatric health promotion. *Medscape Nursing* 1(1).
- ▶ Wallace, S. and Levin, J. 2000. Patterns of health promotion programs for older adults in local health departments. *American Journal of Health Promotion* 15(2):130-133.
- ▶ Williams, SJ. et al 1998. Health promotion workshops for seniors: Predictors of attendance and behavioral

outcomes. *Journal of Health Education* 29(3):166-173.

Organizational resource:

- ▶ National Eldercare Institute on Health Promotion. American Association of Retired Persons, 601 E. St. NW, 5th Floor-B, Washington, DC 20049. [Extensive publications and curricula.]

Evidence for strategy:

Many of the illnesses or problems experienced by seniors have the potential to be prevented, postponed, or reversed - even after the age of 65. This fact has tremendous implications, given rising health care costs and the growing senior population (Hawranik, 1991).

In evaluating the Anoka Health Promotion Program for Older Adults via pre- and post-test (at three and six months) surveys, the behavior of the participants showed statistically significant change in eight of the ten indicators the project was tracking. Indicators that changed at the .01 level of significance include the following: reading nutritional labels; increasing exercise; never opening the door to anyone without knowing that person's identity; increasing awareness of drug side effects; observing foot conditions; wearing seat belts; drinking water; and choosing foods with lower caloric content. In addition, four of these areas (those relating to exercise, drug side effects, nutritional labels, and status of feet) were statistically significant at the .001 level.

Focus groups with participants indicated satisfaction with the classes. Participants described the program as a thorough, complete, interesting, positive, and fun experience. The classes stimulated curiosity,

increased awareness and knowledge, and challenged older adults to modify some behaviors.

Has this strategy been implemented in Minnesota?

Yes, the Anoka County Community Health and Environmental Services Department implemented a Health Promotion Program for Older Adults through a grant they received from the Medtronic Foundation.

Indicators for this strategy:

- ▶ Reduction of salt intake.
- ▶ Frequency of reading nutritional labels when choosing foods to purchase.
- ▶ Choice of foods with fewer calories.
- ▶ Reduction of fat intake.
- ▶ Increase in aerobic exercise.
- ▶ Maintenance of water intake (i.e., drinking eight-ounce glasses of water four to seven times per day).
- ▶ Failure to open the door to anyone without knowing that person’s identity.
- ▶ Awareness of purpose, action, and potential side effects of medications.
- ▶ Number of people who observe the status of their feet for common foot conditions.
- ▶ Frequency of car safety belt use.
- ▶ Participation rates.
- ▶ Participant satisfaction.

For more information contact:

- ▶ Anoka County Community Health and Environmental Services Department, at (763) 422-7048.
-

Strategy: Conduct peer counseling for the elderly.

	Systems	Community	Individual
Primary			
Secondary			
Tertiary	✓		✓

Background:

Keeping seniors socially connected to their community is key to promoting mental health and quality of life of the frail elderly. One strategy to support this connection is peer counseling. Activities supporting this strategy include:

- ▶ Develop a network of healthy seniors and volunteers with disabilities from the community who can provide peer counseling and support.
- ▶ Recruit and select a representative sample of individuals who can effectively relate to their peers in the home and community setting. Consider ongoing recruitment to maintain an adequate number of volunteers.
- ▶ Work with other provider organizations in the community to develop and deliver an orientation and in-depth training program which covers a range of topics from senior growth and development, communication and interpersonal relations, community resources and ways to make referrals, and cultural diversity, to some cognitive behavioral therapy skills.
- ▶ Identify incentives to keep volunteers engaged over time. These incentives might include in-services, coffee meetings, reimbursement for some expenses, recognition events, etc.
- ▶ Arrange for regular individual or group supervision and consultation. Be

available by phone (on a scheduled basis) to provide help and consultation as needed.

- ▶ Provide regular in-service trainings, which include skill-building presentations. Use other local provider groups and senior organizations as resources for in-service training.
- ▶ Identify vulnerable or at-risk seniors.
- ▶ Promote the program in the local community through bulletin inserts for worship services, presentations to service clubs and other organizations, gatherings at high rises and assisted living facilities, and meetings with other health and human service providers.
- ▶ Engage referring organizations and individuals by providing summary feedback about the referrals they are making, keeping in mind data privacy, overall objectives of the program, and the training and skills of the peer volunteers.
- ▶ Select from referrals those individuals who could benefit from a peer counselor. Examples include those who are healthy, live alone, and have limited transportation readily available; formerly active individuals who are suddenly absent from community activities; new retirees who are at a loss about what to do next; individuals who have recently relocated from a familiar community or neighborhood and from a private home to a group-living setting (e.g. condo or apartment) or from a rural to a more urban setting; those who have recovered from illness episodes and are reluctant to re-engage in the community; and caregivers who need outside support and encouragement.
- ▶ Assess referred individuals and match them with volunteer counselors. The

peer counselor and the professional can then discuss appropriate steps to take based on individual need.

- ▶ Monitor the necessity of professional involvement, especially if peer counselors become extensions of professional services. A volunteer activity can become quite labor intensive.

Additional resources:

- ▶ Beck, AT. *Cognitive Therapy*. This is an audiotape of lecture presented at Western Psychiatric Institute and Clinic, Pittsburgh, P.A, on April 24, 1987.
- ▶ Gallagher, EM. 1985. Capitalize on elder strengths. *Journal of Gerontological Nursing* 11(6): 13-17.
- ▶ Hargrave, T., and Hanna, S. (Eds). 1997. *The Aging Family: New Visions in Theory, Practice, and Reality*. New York: Brunner/Mazel.
- ▶ Penning et al. 1992. Homebound learning opportunities: Reaching out to older shut-ins and their caregivers. *Gerontologist* 32(5):704-707.
- ▶ Seniors helping seniors through trying times. (1994, October/November). *Secure Retirement*, 72-75.

Evidence for strategy:

The Elder Network in Southeastern Minnesota provides peer counseling for seniors. Satisfaction surveys of clients indicate a 90 percent rate of satisfaction with the service. Clients indicate that their needs were clarified and met, not through others doing for them, but through the peer counselor's asking the kinds of questions that helped them to do for themselves.

Has this strategy been implemented in Minnesota?

Yes, many residents of Southeast Minnesota have access to elder peer counselors through volunteer programs in their communities. These programs are expanding into other areas of the state.

Indicators for this strategy:

- ▶ Engagement or re-engagement of participants in the community.
- ▶ Appropriate use of community resources.
- ▶ Numbers of volunteers in the community.
- ▶ Reports of change in affect and social behavior by significant others.
- ▶ Active interaction with others.
- ▶ Successful management of living alone, living in a new living environment, or both.
- ▶ Reduced hospitalizations.
- ▶ Decreased suicide attempts and completions.
- ▶ Increased volunteer life satisfaction and personal growth.
- ▶ Customer satisfaction, e.g., individuals' needs are being met.
- ▶ Number of peer counselors.
- ▶ Number of organizations involved in peer counseling programs.

For more information contact:

- ▶ Central Minnesota Elder Network (serving Douglas County), at (302) 763-9084, www.rea-alp.com/~cmen.
 - ▶ The Elder Network, at (507) 285-5272, www.elder-network.org.
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Strategy: Promote the prevention of falls in the home.

	Systems	Community	Individual
Primary			✓
Secondary			✓
Tertiary			

Background:

Each year, one-fourth of all persons aged 65-74 years and one third or more of those aged 75 or older, report a fall. While falls occur at every age, the greater severity of injuries experienced in old age, combined with the longer recovery periods they require, make falls particularly serious threats to the health and functioning of older persons. In fact, falls are the leading cause of death from injury for people aged 65 and older and are particularly common among those who are over age 85. While most falls do not result in serious physical injuries or death, falls are often associated with loss of confidence in the ability to function independently, restriction of physical and social activities, increased dependence, and increased need for long-term care. Among persons aged 65 and older, less than 50 percent of those hospitalized after a fall return home.

Characteristics of those seniors at highest risk for falls include physical inactivity, alcohol or prescription drug misuse, home safety hazards, sensory impairments (e.g., uncorrected hearing or visual impairment), and medication mismanagement.

For more specific information about falls in the home, see the section on “Fires, Falls and Other Home Hazards” in the *Unintentional Injury* category.

For other related strategies, see the sections on “Nutrition” and “Physical Activity/ Inactivity” in the *Chronic/Noninfectious Disease* category; the section on “Alcohol and Other Drugs” in the *Alcohol, Tobacco, and Other Drugs* category. Strategies to modify these risk factors include:

- ▶ Physical inactivity:
 - ▶ Exercise programs to improve gait, balance, and muscle mass.
 - ▶ Instruction in and encouragement of exercise programs (i.e. walking, physical balance, Tai Chi). factors include:
- ▶ Alcohol misuse:
 - ▶ Screening for alcohol and prescription drug misuse.
 - ▶ Education on pharmacologic effects of alcohol in older adults and behavioral strategies for limiting use.
 - ▶ Referral to alcohol or drug treatment programs for those abusing alcohol or prescription drugs.
- ▶ Home safety hazards (with attention to floor surfaces, lighting, bathrooms, stairs, traffic patterns, and accessibility):
 - ▶ Home safety assessments and reduction, elimination, or both of hazards, so, for example, homes have clear and well-lit pathways and stairs (i.e., pathways clear of throw rugs, cords, etc.), seniors wear appropriate footwear, and bathrooms are equipped with grab bars, non-skid mats.
- ▶ Sensory impairments:
 - ▶ Screening for unknown or untreated hearing and vision impairments.
 - ▶ Appropriate referral for formal audiological and hearing aid evaluation.
 - ▶ Referral to resources in the community designed to assist those

with uncorrectable vision impairments in maintaining activity and function.

- ▶ Medication mismanagement:
 - ▶ Careful assessment and monitoring of older people’s medication use (particularly drug-drug interactions, including drug-alcohol interactions).
 - ▶ Health teaching pertaining to adequate nutritional and fluid intake to avoid electrolyte imbalances and dehydration (certain medications, such as, antihypertensives, antidepressants, diuretics, and anti-anxiety agents can directly or indirectly be causative factors in falls).
 - ▶ Medication management to assure proper use of medication (see medication management strategy).

Additional resources:

- ▶ American Geriatrics Society, et al. 2001. Guideline for prevention of falls in older persons. *Journal of the American Geriatric Society* 49:664-672.
- ▶ Rawsby, E. 1998. Review of the literature on falls in the elderly. *Image: Journal of Nursing Scholarship* 30(1): 47-52.
- ▶ Wagner, E., LaCroix, A., Grothaus, L., Leveille, S., Hecht, J., Artz, K., Odle, K. and Buchner, D. 1994. Preventing disability and falls in older adults: A population-based randomized trial. *American Journal of Public Health* 84(11):1800-1806.

Evidence for strategy:

Monitoring medication among elderly patients and promoting exercise for agility and strength among seniors are known to reduce the incidence or severity of falls. A modest, one-time prevention program

appeared to confer short-term health benefits on HMO senior enrollees, although benefits diminished by the second year of follow-up (Wagner et al., 1994).

Has this strategy been implemented in Minnesota?

Yes, various parts of this strategy (i.e., home inspection and hazard correction, as well as medication management) are integral components of almost all public health nursing programs that serve frail and elderly persons.

Indicators for this strategy:

- ▶ Percentage of persons aged over 65 who engage in light-to-moderate activity at least 30 minutes per day.
- ▶ Percentage of elderly persons compliant with their medication regimens.
- ▶ Number of home hazards identified that were eliminated or corrected.
- ▶ Number of persons with unknown or untreated sensory impairments whose visual or hearing impairments are corrected to the degree possible.
- ▶ Number of hospitalizations for hip fractures related to falls.
- ▶ Number of emergency room visits for falls that occurred in the home.
- ▶ Number of persons aged 65 and older who return home after being hospitalized for fall-related injuries.
- ▶ Number of fall-related deaths.

For more information contact:

- ▶ Mark Kinde, (651) 281-9832, mark.kinde@health.state.mn.us; MDH Injury and Violence Prevention Unit.
- ▶ Pam York, (651) 281-9831, pam.york@health.state.mn.us, MDH Nutrition and Physical Activity Unit.

Special notes:

To be effective, fall-prevention programs must avoid negative consequences. For example, encouraging physical activity without proper supervision or attention to risk factors in the environment may actually cause injuries. In addition, programs designed to reduce injuries should measure a broad range of outcomes. For example, effects on older persons' quality of life (e.g. their autonomy and independence) are important outcomes.

Strategy: Promote medication management.

	Systems	Community	Individual
Primary		✓	✓
Secondary		✓	✓
Tertiary			

Background:

With increasing age, elderly persons tend to take more prescription medications. In the U.S., 75 percent of noninstitutionalized persons over age 65 had at least one medication prescribed, with a mean number of prescribed medications of 10.7 (Kaspar, 1982). In addition to prescribed medications, it is estimated that 75 percent of individuals aged 65 years and older use nonprescription drugs. One study found that seniors used over-the-counter drugs at a rate seven times greater than that of younger adults (Kofoed, 1985). While medication regimens are beneficial for treating disease processes, the problems for the patient, family, and health care provider associated with maintaining an adequate medication program are complex and varied.

Seniors have a variety of problems related to the management of their drug regimens, including forgetting to take medications, as well as their overuse, under use, and incorrect use (not taking medication as labeled). Factors that contribute to these problems include:

- ▶ Functional impairments such as decreased mobility (has difficulty getting to the pharmacy, measuring liquid doses, or breaking pills), visual impairment (cannot read labels or differentiate colors), hearing impairment (cannot hear instruction), and poor memory (cannot remember to take medications).
- ▶ Perceptual factors such as low perception of the seriousness of a condition, susceptibility to a condition, or efficacy of treatment; absence of symptoms, although medication does not relieve symptoms; and fear of addiction to medications.
- ▶ Educational factors such as lack of knowledge or understanding of a medication regimen or inability to speak English.
- ▶ Provider-client interaction factors such as ineffective communication; lack of confidence in a provider; inadequate explanations of medication regimens; absence of written materials; and infrequent monitoring and feedback.
- ▶ Treatment factors such as complexity, number, and side effects of medications; interactions between medications; number of changes required in habits, lifestyles, or both; physician error; and more than one provider or pharmacy.
- ▶ Access factors such as lack of economic resources; containers that are difficult to open; long distance to a pharmacy; labels that are difficult to read; and unclear directions.

- ▶ Social support factors such as living alone and unsupportive attitudes of family members.

The multiplicity and complexity of the factors influencing medication management demands a multifaceted intervention approach that includes:

- ▶ A community assessment of seniors' needs regarding medication to determine the reasons for noncompliance with their medical regimens.
- ▶ Home visiting programs for the elderly that include:
 - ▶ Assessments to determine a client's ability to comply with prescribed medications (e.g., the number and types of prescription medications taken and the degree to which they are taken as prescribed, the number and types of over-the-counter medications taken and the degree to which they are taken as directed, the number of physicians prescribing medications, the number of pharmacies involved in preparing prescriptions, the determination of drug interactions, and the use of alcohol).
 - ▶ Negotiation of a "medication reminder system" with the client.
 - ▶ Ongoing communication with the client's primary physician regarding medications.
 - ▶ Ongoing monitoring of the vulnerable client's health status and well-being.
 - ▶ The coordination of community organizations and groups (i.e., pharmacists, senior citizen groups, and clinics) that provide education to seniors regarding medication management.

- ▶ The establishment of support group sessions with caregivers regarding medication compliance.
 - ▶ The provision of client health education including:
 - ▶ Reinforcement and increase in clients' knowledge of their risk factors and disease management.
 - ▶ Written information, combined with individual verbal counseling, about specific client medications.
 - ▶ Written materials in large print, translated into other languages, and using educational approaches that incorporate memory aids (e.g., calendars, pill boxes).
 - ▶ Slow-paced instruction.
 - ▶ Small amounts of specific information, combining a "reminder aid" with verbal reinforcement.
 - ▶ Persistent follow-up reinforcement over time.
 - ▶ The modification of the medication regimen as needed, which includes:
 - ▶ Medication instruction tailored to individual lifestyle and daily activities.
 - ▶ Simplifying the medication regimen (systematically reviewing the need for each medication and eliminating all those of questionable value).
- concordance between physicians and patients with prescribed medications. *American Journal of Public Health* 66(9):847-853.
- ▶ Janz, N., Becker, M., and Hartman, P. 1984. Contingency contracting to enhance patient compliance: A review. *Patient Education and Counseling*. 5(4): 165-178.
 - ▶ Kasl, T. 1975. Issues in patient adherence to health care regimens. *Journal of Human Stress*. 5-17:48.
 - ▶ King, N., and Peck, C. 1981. Enhancing patient compliance with medical regimens. *Australian Family Physical* 10(12):954-959.
 - ▶ Pesznecker, B., Patsdaughter, C., Moody, K., and Albert, M. 1990. Medication regimens and the home care client: A challenge for health care Providers, in *Facilitating Self-Care Practices in the Elderly* (pp. 9-65). Haworth Press Inc.
 - ▶ Richardson, J. 1986. Perspective on compliance with drug regimens among the elderly. *The Journal of Compliance in Health Care* 1(1):33-45.
 - ▶ Sands, D., and Holman, E. 1985. Does knowledge enhance compliance? *Journal of Gerontological Nursing*, 11(4), 464-468.

Additional resources:

- ▶ Haynes, R., Taylor, D., and Sackett, D. (Eds.). 1979. *Compliance in Health Care*. Baltimore, MD: Johns Hopkins University.
- ▶ Haynes, R., Taylor, D., and Sackett, D. 1980. How to detect and manage low patient compliance in chronic illness. *Geriatrics* 91-97.
- ▶ Hulka, B., Cassell, J., Kupper, L., and Burdette, J. 1976. Communication and

Evidence for strategy:

The evidence is clear that knowledge alone is not sufficient to ensure medication compliance (Haynes, Taylor, and Sackett, 1979; Richardson, 1986; Sands and Holman, 1985). Health education programs that employ a variety of methods, such as, written information, slow-paced instruction, special counseling approaches, memory aids, and periodic reinforcement of behavioral change have been found to be more effective

in promoting medication compliance than knowledge alone. Other interventions effective at modifying noncompliant behaviors include focusing on improving the communication and relationship between patient and physician (Hulka, Cassell, Kupper, and Burdette, 1976; Kasl, 1975); contingency contracting or a specifically negotiated agreement that provides for the delivery of positive consequences contingent on desirable behavior (Janz, Becker, and Hartman, 1984); tailoring or assisting seniors to integrate the taking of medications into activities of daily living (King and Peck, 1981); and modification, simplification, or both of the medication regimen by the physician (King and Peck, 1981; Haynes, Sackett, and Taylor, 1980).

Has this strategy been implemented in Minnesota?

Yes, medication management has been a key component of public health nursing services to elderly and vulnerable clients for many years.

Indicators for this strategy:

- ▶ Percentage of seniors compliant with their medication regimens.
- ▶ Number of hospitalizations for complications due to medication mismanagement.
- ▶ Number of falls related to medication mismanagement.
- ▶ Number of clinic visits due to complications resulting from medication mismanagement.
- ▶ Number of deaths due to medication mismanagement.

For more information contact:

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 Chemical Health Promotion Coordinator.

Strategy: Promote use of residential smoke alarms.

	Systems	Community	Individual
Primary		✓	✓
Secondary			
Tertiary			

Background:

Despite the widespread adoption of smoke alarms, fires and their concomitant burn injuries remain a formidable cause of death. Elderly persons are at particular risk for fire-related deaths. Although the risk of dying in homes without smoke alarms is approximately twice that of dying in homes with smoke alarms, an MDH study of Minnesota homes in 1994-1997 revealed that only 55 percent of residences had a working smoke alarm on every level of the home (MDH and CDC, 1997). (See the section on “Fires, Falls and Other Home Hazards” in the *Unintentional Injury* category for additional related strategies.)

One strategy to reduce the risk of fire-related burns among seniors is to increase the presence of functional smoke alarms to at least one on each habitable floor of all inhabited residential dwellings. This strategy includes the following activities:

- ▶ Make home visits to assess presence or absence of smoke alarms on each habitable floor of the home and to determine the working condition of smoke alarms.

- ▶ Organize businesses and community organizations to purchase and install smoke alarms for frail and elderly persons who do not have the resources, ability, or both to access smoke alarms.
- ▶ Increase the awareness of all persons in the community (i.e., clergy, “befrienders”, social workers, etc.) who work with frail and elderly populations of the importance of checking for working smoke alarms.
- ▶ Increase the number of referrals of elderly and frail persons in the community who do not have working smoke alarms in their homes to agencies, which can provide them.

Additional resources:

- ▶ Hall, JR. 1985. A decade of detectors: Measuring the effect. *Fire Journal* 79: 37-43.
- ▶ Minnesota Department of Health and CDC. 1997. *The Minnesota Collaborative Fire-related Burn Prevention Program* [Unpublished Study]. St. Paul, MN: Author.
- ▶ Shults, R., Sacks, J., Briske, L., Dicey, P., Kinde, M., Mallonee, S., and Reddish, DM. 1998. Evaluation of three smoke detector promotion programs. *American Journal of Preventive Medicine* 15(3):165-171.

Evidence for strategy:

Smoke alarms are known to be a reliable, inexpensive means of providing an early warning of house fires. Those who are less likely to possess smoke alarms (e.g., the elderly and the poor) are also at higher risk of fire death. Even though alarms are extremely reliable, most alarms are powered by batteries that must be replaced periodically. One study of alarms and fatal

fires found that dead batteries were to blame in about two-thirds of the instances of detector failure (Hall, 1985).

Has this strategy been implemented in Minnesota?

Yes, many communities throughout Minnesota have organized smoke alarm projects. Various groups and organizations (i.e., fire departments, public health, local insurance companies, Kiwanis, etc.) with an interest in preventing residential fire-related injury and death work together to install smoke alarms in homes that had been identified as not having functional smoke alarms.

Indicators that could be used to evaluate this strategy:

- ▶ Number of homes with functional smoke alarms on all habitable floors.
- ▶ Percentage of functional smoke alarms.
- ▶ Number of hospitalizations due to fire.
- ▶ Number of deaths due to fire.
- ▶ Economic costs due to fire loss in homes without smoke alarms.

For more information contact:

- ▶ Mark Kinde, at (651) 281-9832, mark.kinde@health.state.mn.us, MDH Injury and Violence Prevention Unit.
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