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examining local health department resources and systems for seniors

Partnering to Preserve Senior Health in California's Public Health System

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SUMMARY: California's population is growing and aging, but the public health and aging infrastructure is not keeping up. While demand increased, two-thirds of California's Local Health Departments (LHDs) and Area Agencies on Aging (AAAs) experienced budget cuts in the 2010-2011 fiscal year, while nearly 40% faced staffing reductions. Budgetary and personnel reductions compromised the ability of local health departments to serve seniors in a number of critical areas, including the investigation of health and environmental hazards, the enforcement of public health laws, the implementation of health promotion programs and quality improvement activities. With no end in sight to California's budget crisis, the authors recommend that local public health system stakeholders reexamine the distribution of responsibilities, eliminate redundancy in overlapping areas and pinpoint gaps in services. LHDs may also benefit from streamlining and coordinating service delivery with system partners through written formal agreements with AAAs, and cross-agency sharing of provider and consumer electronic information systems. This policy note is based on a survey of senior managers within LHDs and AAAs.

Background

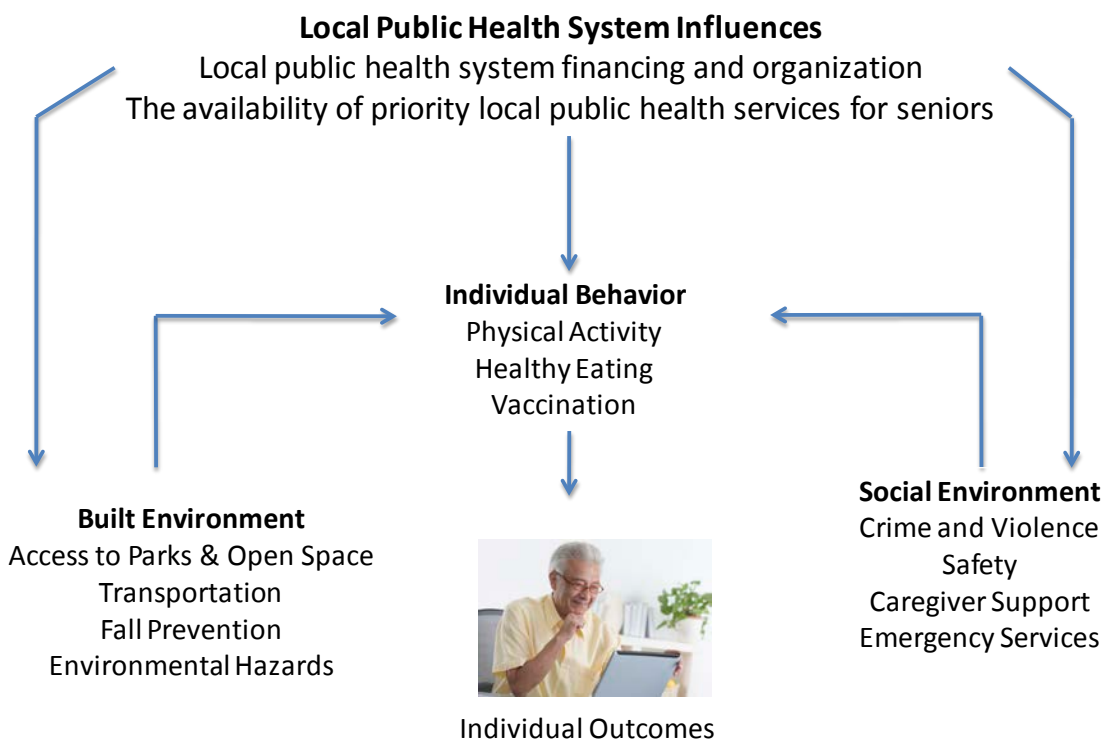
By 2020, adults age 65 and older will account for 20% of the U.S. population.¹ Accompanied by this growth are costly, often disabling chronic health conditions, many of which are preventable through concerted public health efforts.² For example, today over half of older adults age 60 and older are overweight or obese³ and a substantial proportion do not engage in regular physical activity.

As a result, demand for senior services is growing, placing a strain on local health departments, which are charged with protecting the health and welfare of older adults (age 60 and older), a vulnerable population that often encounters large social and environmental barriers to engaging in physical activity, adopting a healthy diet, and receiving recommended health screenings.⁴ LHDs, as well as other local public health system partners, including AAAs, are further challenged by California's ongoing budget crisis.

To understand the challenges, the UCLA Center for Health Policy Research and the UCLA Fielding School of Public Health established ELHDRS (**Examining Local Health Department Resources and Systems for Seniors**) to study the capacity of California's public health system to serve older adults. As part of that project, California LHD and AAA department directors and designees were surveyed to understand how local public health systems are organized to address senior health, and how system partners are adapting to budgetary cuts.

We adapted the evolving Healthy People 2020 logic model of the determinants of health to conceptualize local public health system influences on the health of older adults (Exhibit 1).⁵ Public health assurance, assessment and policy development activities can affect the health and well-being of older adults by influencing the social environment and the built (or physical) environment. LHDs directly intervene by providing services to support the improvement in health behaviors for older adults in community-based settings. For example, some LHDs offer immunization and physical activity programs, and some sponsor large-scale campaigns to promote cancer screening. The specific methodology for this study can be found on page 12 of this policy note.

Exhibit 1: The Influence of Local Public Health Systems on Senior Health Behaviors and Outcomes

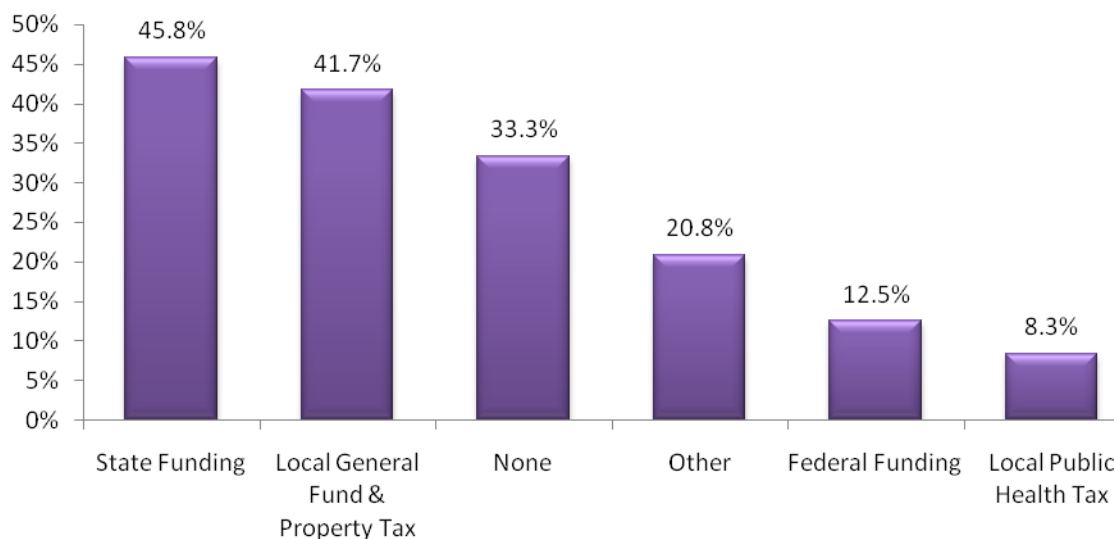


Source: Adapted from the Healthy People 2020's Conceptual Logic Model.

Financing and Staffing

The most common LHD funding source for public health programs and systems for seniors was state funding (45.8%), followed by local general fund and property tax revenues (41.7%; Exhibit 2). Both state and property tax revenues have been shrinking in California.

Exhibit 2: Sources of Funding Available to Support Local Health Department Interventions for Seniors, California 2011



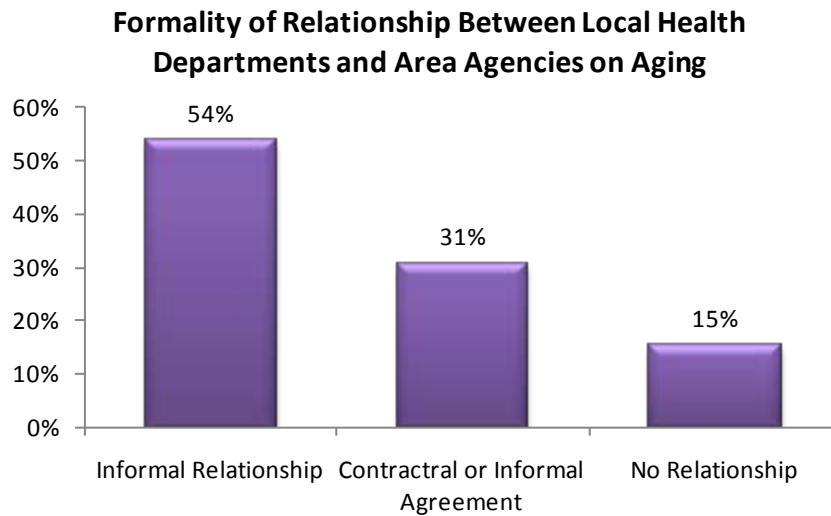
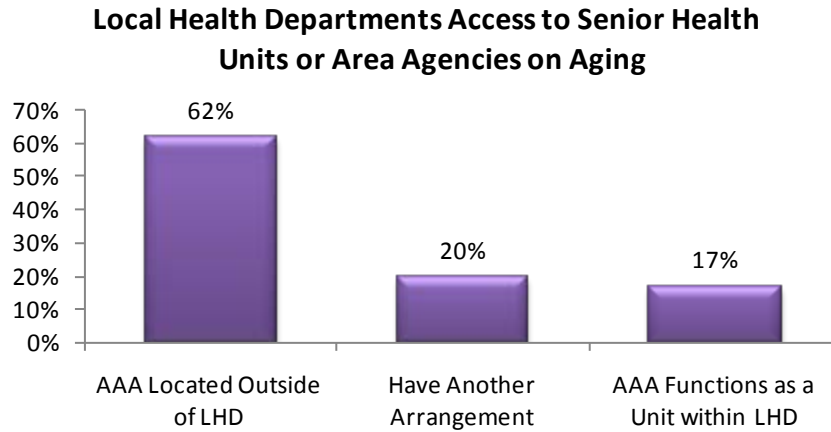
Note: Titles of bars indicate any funding from that source reported by a LHD, and none indicates that no funding was present.
Source: ELHDRS Survey

Forty-three percent of LHD informants experienced an increased demand for key services for older adults. In spite of the growing demand for these services, 79.3% of LHDs and 61.9% of AAAs experienced budget cuts for the 2010-2011 fiscal year. A sizeable portion of LHDs (38%) had a reduction in staff resulting from furloughs, layoffs, early retirement or attrition during the same period.

The Power of Partnerships

LHDs coordinate and deliver public health interventions for seniors in several ways that do not always involve their local AAA. This relationship may be facilitated through organizational arrangements, such as a less formal partnership for a specific influenza vaccine campaign to a more formal sharing of resources and programs or formal contractual relationships. The majority of AAAs (64%) are independent entities, and over half of LHD informants (54%) had not established a formal relationship with their AAA. These arrangements are displayed in Exhibit 3.

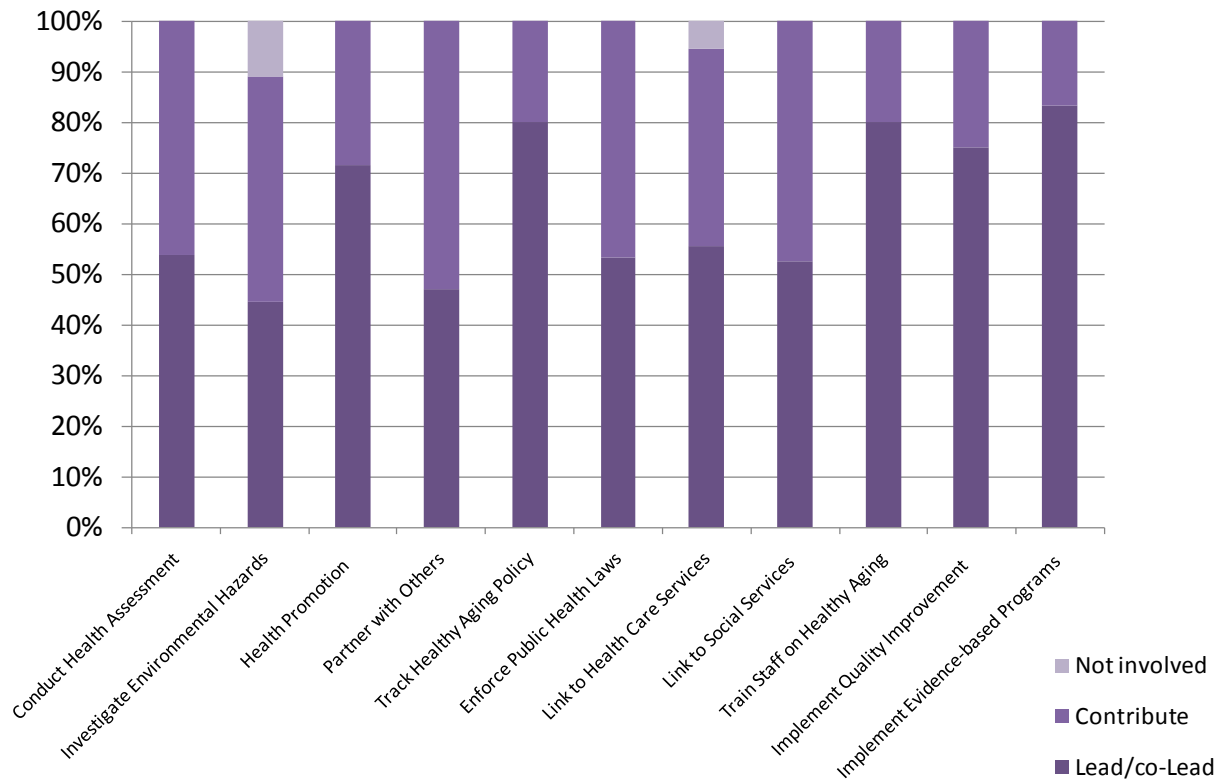
Exhibit 3: Local Health Departments' Access to Senior Health Units or Area Agencies on Aging and Relationship with Area Agencies on Aging



Source: ELHDRS Survey

AAAs reported being heavily involved in most dimensions of protecting and promoting the health of older adults. For example, AAAs lead or co-lead activities targeting seniors in 9 of 11 public health accreditation standards, ranging from 53% in performing community health assessments to 83% in applying evidence-based practices and programs into their activities. This was similar to the number reported in a previous California state survey of AAAs⁶ where 80% reported being involved in evidence-based health promotion.⁷ When AAAs were not leading or co-leading these activities, they were contributing to the work (Exhibit 4).

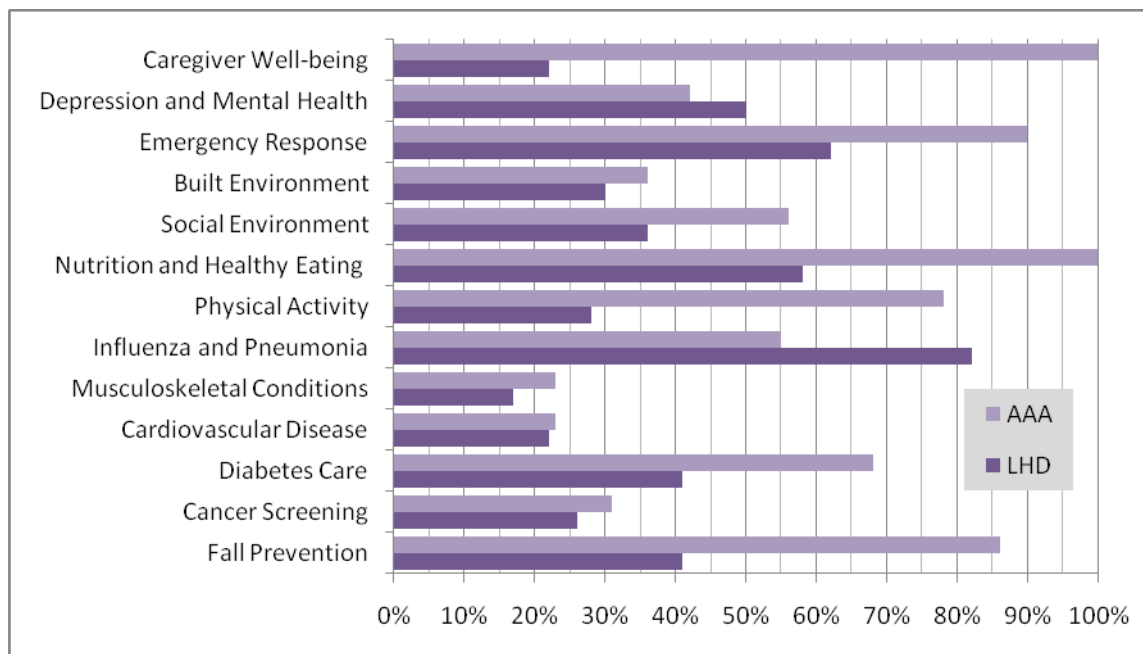
Exhibit 4: Contribution of Area Agencies on Aging toward Local Health Department Activities Targeting Seniors



Source: ELHDRS Survey

Nearly 7 in 10 of LHDs (69%) specifically target seniors in their program activities, whereas 100% of AAAs conduct health promotion activities that inform and educate the public about senior health issues and healthy aging. Among those LHDs and AAAs engaged in senior health activities, there is distinct variation in their focus areas. Virtually all AAAs provide caregiver support services and activities in nutrition and healthy eating. Both AAA and LHD informants reported substantial involvement in diabetes care, fall prevention, social environment and emergency response activities targeting seniors, with AAAs having more emphasis on these activities. LHDs were more focused on delivering influenza and pneumonia vaccines for seniors than were AAAs (Exhibit 5).

Exhibit 5: Percentage of Local Health Departments and Area Agencies on Aging Engaging in Health Promotion Activities for Seniors across Program Areas



Source: ELHDRS Survey

To meet the demands of seniors, LHDs most commonly formed collaborative relationships with AAAs, social service agencies and mental health departments as shown in Exhibit 6. AAAs were the most common LHD partner in delivering health promotion activities for seniors, establishing partnerships, and linking seniors to health and social services. Social service agencies tend to be partners in the investigation of environmental health hazards, enforcing public health laws pertaining to seniors, and linking seniors to social services. LHD collaboration with the local mental health services agencies was most common for investigating environmental health hazards, which includes responding to extreme heat events, abuse and neglect, and illness outbreaks in senior settings, as well as with facilitating referrals to health and social services. Other organizations, such as hospitals and long-term care facilities, community health centers and non-profit organizations were also frequently reported as key partners in meeting seniors’ needs.

Exhibit 6: Local Health Departments’ Reported Engagement of Partners in Meeting Seniors’ Needs along 11 Public Health Standards

	AAA	Social Service	Mental Health	Hospital and LTC	Community Health Center	Non-profit	Physician Practices
Health Assessment	54	29	33	13	13	8	8
Investigate Environmental Hazards	67	75	71	50	25	21	25
Conduct Health Promotion Activities	88	54	42	50	38	38	25
Partner with Others	71	50	42	25	25	38	4
Track Healthy Aging Policy	63	38	29	8	0	13	0
Enforce Public Health Laws	63	67	42	13	8	8	13
Link to Personal Health Care Services	71	58	50	38	33	21	42
Link to Social Services	79	67	58	38	29	33	38
Train Staff on Aging Issues	21	13	17	4	4	8	0
Implement Quality Improvement Activities	17	13	8	0	0	0	4
Apply Evidence-based Program	25	8	4	8	4	13	4

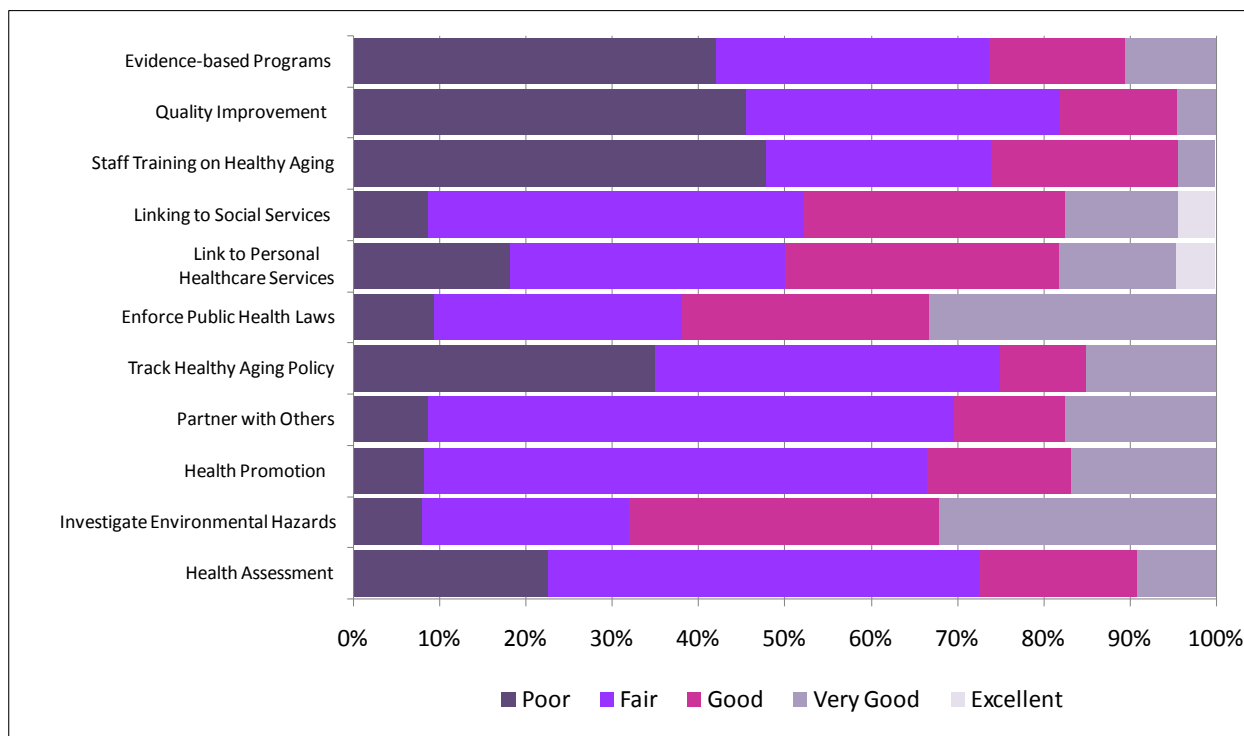
Note: Numbers represent the percentage of LHDs partnering with the agency type to meet the corresponding public health standard in the row on the left-hand column.

Source: ELHDRS Survey

Perceived Effectiveness of the Capacity of Local Health Departments to Meet the Needs of Seniors in Their Jurisdiction

LHD respondents were asked to rate their own overall performance in meeting the needs of seniors in their jurisdiction on a 5-point scale, ranging from 'Poor' to 'Excellent'. Slightly more than one-third (35%) reported being ‘Very Good’ at enforcing public health laws; about one-third reported ‘Very Good’ (32%) at investigating potential environmental health hazards (Exhibit 7). The greatest problem areas were in establishing partnerships with other organizations and delivering health promotion activities for seniors. Other challenges faced by LHDs were in training their staff on healthy aging issues, reporting their performance as either ‘Poor’ (48%) or ‘Fair’ (28%). Almost half (45%) noted they were only ‘Fair’ at developing or implementing a quality improvement strategy to improve services for seniors.

Exhibit 7: Local Health Departments' Self-Rated Performance on Public Health Activities Involving Seniors



Source: ELHDRS Survey

LHDs with more staff or full-time equivalents (FTEs) dedicated to senior health program areas were more likely to report higher effectiveness in meeting senior health needs (on a self-rated scale from 'Poor' to 'Excellent'). The four standards impacted by staffing levels included:

1. Investigating health problems and environmental hazards to protect seniors.
2. Enforcing existing public health laws and regulations related to seniors.
3. Implementing health promotion programs targeting seniors.
4. Quality improvement activities regarding the health needs of seniors.

Local health departments with more FTEs devoted to senior health program areas contribute a higher proportion of the local effort on implementation of senior health promotion activities and evaluation of evidence-based senior health programs. LHDs that reported more severe staffing reductions compared to the previous fiscal year generally reported lower effectiveness (as 'Poor' or 'Fair') in conducting routine senior health assessments, investigating environmental health hazards, linking seniors to personal health care services, training staff on healthy aging issues and enforcing public health laws affecting seniors.

Implications

LHDs are facing substantial challenges in meeting the public health needs of older adults that call for wider systems change, including streamlining the coordination of services with partners; reexamining their role and commitment to supporting senior health services; mending the shortage in the workforce with expertise in aging; and investing in preventive health and evidence-based programming. Moving forward, system stakeholders will need to test the effectiveness of partnership strategies for meeting their obligation to promote and protect the health of all residents within their jurisdictions.

Streamlining the Coordination of Public Health and Aging Services. State government stakeholders desire better linkages between public health and aging services. Our survey results indicate that collaboration with local public health system partners, including AAAs, mental health departments and social services is an essential strategy for addressing the growing needs of an aging population in the midst of challenging economic times. Senior health has a distinct network of players, emphasizing the importance of studying their functionality and efficiency as a system, rather than as independent units. LHDs and AAAs do not work alone in support of senior health in local communities.

The AAAs and the aging services network are undergoing a major redesign to streamline an overly complex system of interlocking health and social support services. The sharing of electronic information systems across agencies, for instance, has enabled some AAAs to streamline the process of intake, needs assessment, and coordination of services and providers with partner agencies.⁷ A cross-agency data system to share provider and consumer information may become an important future marker of collaboration. Furthermore, LHDs and AAAs could enhance coordination of services by establishing written formal agreements to delineate the roles and responsibilities of each agency and fill gaps in public health services targeting seniors. Currently, over half of California's LHDs (53.8%) do not have a formal relationship with their AAA.

Reexamining Local Health Department's Role in Senior Health. The newly formed Administration of Community Living, announced in April of 2012 by the U.S. Department of Health and Human Services, may be affirming the commitment to older adults and signaling a new direction and set of responsibilities for public health systems. The public health infrastructure must be restructured to promote the coordination of services and help older adults age in place. “[*Preparation for healthy aging*] will require investment in sustained, multi-level, structural, all-sector approaches to optimizing health across the life course...” The roadmap and commitment to achieving healthy aging and delineation of authority has lagged.³ Among the Public Health Accreditation Board domains, analysis of LHDs' self-reported performance on healthy aging activities showed both strengths and weaknesses in their capacity to promote and protect senior health. When addressing senior health activities, LHDs reported high performance on enforcing public health laws and investigating potential environmental health hazards; however, they faced difficulty in partnering with others, delivering health promotion activities, training their staff on healthy aging and implementing quality improvement strategies.

There was also variation in the distribution of responsibilities between agencies where activities were shared between partner organizations. Among those LHDs and AAAs engaged in senior health activities, there is distinct variation in their focus areas. Whereas most or all AAAs provided caregiver support services and activities in nutrition and healthy eating, more LHDs reported devoting time and resources to delivering influenza and pneumonia vaccines for seniors. With further exploration, apparent variations in programmatic focus could inform decisions to redistribute funds or relocate primary coordinating sites in accordance with agency capacity and strengths. Notably, even with scarce economic resources, the vast majority of aging-friendly initiatives originated from community-based interventions at the local level.³

Mending the Human Capital Crisis in Public Health and Aging. State budget cuts are severely weakening the public sector workforce, and consequently jeopardizing the public health system's ability to respond to senior health needs. A large portion of LHDs (79%) and AAAs (62%) in our study experienced budget cuts in the previous fiscal year. A sizeable portion of LHDs (38%) had a reduction in staff resulting from furloughs, layoffs, early retirement or attrition during the same period. In addition, all LHD respondents cited difficulty with training staff on healthy aging issues. The scarcity of public health personnel with expertise in older adult care is a growing problem for LHDs.^{3,9} Forming partnerships may be one enticing resolution to limited resources, but may have limited value without a coordinated strategic plan. How will programs be sustained when many public health system partners are simultaneously being stripped of resources? Similar to LHDs across California, the AAAs are enduring their own crisis in staffing shortages. Compared to other states, California's AAAs rely more on local funding and grants, and receive significantly less support from state revenue or charitable donations. California's AAAs may have a mean budget twice the national average; however, they also have twice the number of clients.⁶ Compared to the national average, California's AAAs were twice as likely to reduce staff by not replacing them and to reduce the total number of staff through layoffs. As a result, an astounding 70% of California's AAAs eliminated programs (temporarily or permanently) compared to the national average of 18.7%. Adding to the scarcity of services and staff are the widespread reductions of other state-sponsored programs that provide valuable senior resources, such as In-Home Supportive Services, Adult Day Health Centers, the Supplemental Security Income, State Supplemental Payment (SSI/SSP) and Caregiver Resource Centers.

Investing in Preventive Health and Evidence-Based Programs. Primary prevention and chronic disease management are key to supporting healthy aging, and can be optimized through the multidisciplinary teams of public health specialists and primary care providers.⁸ All LHD respondents faced difficulty with delivering senior-directed health promotion activities. At the same time, AAAs' roles are expanding in scope in the areas of person-centered approaches, evidence-based disease prevention and health promotion, and promotion of livable communities.⁷ Nationally, a large portion of AAAs (82%) were implementing evidence-based programs in 2010, up from 55.6% in 2009. These numbers point to overlapping programmatic areas where LHDs and AAAs could restructure and define a clear set of responsibilities for each agency to avoid redundancy and improve effectiveness.

Methodology

LHD and AAA informants serving all 61 California local public health jurisdictions were invited to participate in a 45-minute web-based survey from May through August of 2011 to characterize each jurisdiction's public health resources and systems for senior health. The survey aimed to advance the field of public health systems and services research (PHSSR)⁹ by describing the variation in LHD boundaries and partnerships within local public health systems, and for addressing priority public health issues for older adults. Survey questions partly corresponded with a typology of LHD characteristics developed by Mays, spanning the dimensions of diversification (availability of 20 core public health activities); concentration (percent effort contributed by LHD); integration (types of other organizations involved); and effectiveness (perceived effectiveness of each activity).¹⁰ In addition, questions reflected and were organized around 11 domains of public health systems, as drafted by the Public Health Accreditation Board (PHAB) for voluntary accreditation.¹¹ PHAB has since finalized these standards, adding an additional dimension that was not included in our survey.

The survey was pilot-tested by LHD and AAA informants using individual cognitive interviews. Feedback during pilot testing informed the survey revision. A total of 94 potential survey respondents were identified from their titles and roles as an LHD director or designee (n=61) or an AAA director or designee (n=33). All key respondents received follow-up phone calls and email reminders to encourage participation. The response rate of 40.4% was similar for LHD and AAA respondent samples. The primary reason cited for non-participation was the length of the survey, which averaged 45 minutes to complete. Nevertheless, the perspectives of LHDs and AAAs serving more than 75% of California residents are included, as well as perspectives from both urban and rural jurisdictions.

Endnotes

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