Improving Older Adult Health by Operationalizing State Plans on Aging and Health Improvement

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ABSTRACT

The COVID-19 pandemic, a growing aging population, and inconsistent equity in aging have prompted more public health departments and agencies that focus on older adult services to establish partnerships to improve older adult health. To develop a model for strengthening and better aligning public health-aging partnerships, the Association of State and Territorial Health Officials (ASTHO) and Trust for America's Health engaged the Georgia Division of Aging Services (DAS) and Georgia Department of Public Health (DPH) to participate in a pilot project. ASTHO conducted an intensive qualitative analysis of Georgia's State Health Improvement Plan and State Plan on Aging to systematically assess shared priorities and differences. Through facilitated discussions about the results, prioritization, and planning, DAS and DPH developed an action plan with 2 priority areas to collaborate on and further their partnership. This process can be replicated by other jurisdictions seeking to enhance public health-aging collaboration.

KEY WORDS: healthy aging, partnerships, planning

Ensuring that all people can live with optimal health is the fundamental role of state health departments (SHDs). This mission implicitly includes older adults, a population that SHDs can make explicit in their initiatives by prioritizing healthy aging.[1-3] Historically, some SHDs have collaboratively supported healthy aging with sibling agencies that focus on aging or "state units on aging" (SUAs). The COVID-19 pandemic was a natural impetus for more intentional intergovernmental partnerships between SHDs and SUAs to prioritize the health of older adults. Older adults' increased risk for severe illness from COVID-19, social isolation through observing social distancing, and limitations in accessing regular care and services due to restrictions to prevent spread of COVID-19 spurred these partnerships.[4,5] In addition, as the population of adults aged 65 years and older is projected to increase from 54 million in 2021 to 85.7 million by 2050,[6] it is essential to build such partnerships as well as systems that promote healthy aging across the life span.

SUAs promote healthy aging by tracking and serving the needs of older adults, guided by the Older American's Act.[7] SHDs may have limited capacity to focus on healthy aging, either due to lack of funding or due to departmental priorities, with some integrating the topic into existing work. However, applying a life course approach to public health work that includes the needs of older adults helps SHDs to achieve health improvement goals. Healthy aging also aligns with efforts to increase equitable health outcomes, as the ability to age with a high quality of life across population groups can be a key indicator of optimal health for all.

The essential services of SHDs can support healthy aging across the life course by creating systems, changing environments, and informing policies that advance population health outcomes and transform social determinants of health (SDOH) and equity.[8] For example, this could include supporting maternal and infant health and preventing adverse childhood experiences to promote health early in life, while also championing policies that improve the built environment and access to health care services to support the health of communities, including older adults. While

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SHDs may have limited expertise in aging, they can partner with SUAs, which have valuable networks and an understanding of issues that impact the health of older adults. Both SHDs and SUAs develop and implement agency-wide plans to guide their work, which are valuable tools to identify shared priorities and forge partnerships.[9,10] SHDs' role to promote health early in life aims to help people reach older adulthood healthily, a goal that overlaps with SUAs' focus on older adults' ability to age well while living in the community. This article describes a pilot project to systematically crosswalk existing plans in one state to develop a model for strengthening public health-aging partnerships. In this context, "crosswalk" means to analyze intersections and differences in priorities.

Methods

In 2021, Trust for America's Health (TFAH), with funding from The John A. Hartford Foundation (JAHF), partnered with the Association for State and Territorial Health Officials (ASTHO) to facilitate a pilot project to crosswalk the objectives and strategies of a State Health Improvement Plan (SHIP) with a State Plan on Aging (SPoA). The crosswalk led to action planning to identify shared priorities and chart a strategic path forward.

ASTHO and TFAH engaged the Georgia Department of Public Health (DPH) and Division of Aging Services (DAS) in the pilot. These agencies have a history of collaboration, with stronger connections born out of COVID-19 pandemic response and funding awarded to the state through the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act.[11] Both agencies were interested in exploring additional opportunities to partner on mutual goals and agreed to participate in the pilot project. DAS and DPH each designated a lead and team members, including staff who work on dementia, injury prevention, performance improvement, and livable communities. A total of 3 DAS and 4 DPH staff members participated in the process. ASTHO and TFAH brought their experience with capacity building and SHD-SUA collaboration to the process.

In March 2021, the DAS and DPH teams met with ASTHO and TFAH to review the proposed approach, provide input on the process, and discuss desired outcomes. ASTHO then used its existing qualitative analysis tool for conducting an annual environmental scan of public health priorities to crosswalk the Georgia SHIP (2016-2021) and SPoA (2020-2023).[12] DAS and DPH created these plans independently of one another. Participants in the pilot project had varying levels of involvement with their agency's plan development and implementation. ASTHO scanned both plans using a coding framework and definitions based on common public health data sources. The coding covered public health infrastructure and public health areas (Table 1). Two ASTHO staff independently reviewed and coded the objectives and strategies within the SHIP and SPoA to identify common themes and emergent topics. ASTHO analyzed the findings and compiled a crosswalk report summarizing relevant SHIP and SPoA objectives and strategies for each code.

Table 1 outlines the codes and subcodes for each domain within ASTHO's environmental scan codebook that was used to conduct the crosswalk of the SHIP and SPoA. The domains are the main thematic areas for analysis. Public health infrastructure refers to organizational structure or process, whereas public health areas refer to program areas identified as a priority. Although specific to public health, the domains and codes were also relevant for the SPoA because of the SUA's mission to promote and protect the well-being of a population, a similar goal of the SHD. ASTHO reviewers used these codes and subcodes to categorize objectives and strategies within both plans according to these topic areas. Items in bold indicate additions made on the basis of input from the DAS and DPH teams.

Table 2 summarizes the number of times each code and its subcodes with high frequency of use was applied during the scan of the SHIP and SPoA.

Once the crosswalk was completed, the DAS and DPH teams independently reviewed the resulting report analyzing the areas of overlap and distinction between the SHIP and SPoA. ASTHO then facilitated 4 meetings to review the findings, prioritize focus areas, and create a vision and action plan for further collaboration. Meetings took place on Zoom and used Technology of Participation (ToP) facilitation methods, a prioritization matrix exercise, MURAL virtual collaboration platform, an action plan template, and mindfulness exercises to support engagement and resilience during each session.

The series of meetings included the following:

1. *Consultation meeting*: ASTHO overviewed the crosswalk analysis and facilitated a ToP Focused Conversation about opportunities, gaps, and next steps. The DAS and DPH teams reflected on areas of interest and overlap between the 2 plans that informed future sessions.[13]
2. *Initial action planning*: ASTHO facilitated a wrap-up to the ToP Focused Conversation and a prioritization exercise to narrow the action area topics that would be most relevant and feasible for DAS and DPH. The group built on this consensus to create a vision for their partnership and develop the first action plan priority.

TABLE 1
Coding Framework for the Crosswalk[a]

Domain 1: Public Health Infrastructure	Domain 2: Public Health Areas

• Accountability/performance management
• Assessment/surveillance
• Collaboration and partnership development
• Communications
• Community partnership development
• Emergency preparedness and response
• Funding
• Informatics
• Organizational administrative competencies
  o Leadership and governance
  o IT
  o Human resources
  o Financial management
• Policy development and support
• Workforce development
	• Access to and linkage with clinical care
	  o Affordable care
	  o Integrated care
	  o Quality of care
	• Behavioral health and substance misuse
	  o Alcohol
	  o Marijuana
	  o Mental health
	  o Opioids
	  o Suicide
	  o Tobacco
	• Chronic disease prevention
	  o Cancer
	  o Cardiovascular disease
	  o Dementia
	  o Diabetes
	  o Obesity
	  o Oral health
	  o Respiratory diseases
	  o **Nutrition**
	  o **Alzheimer's and related dementias**
	• Injury prevention
	  o Violence prevention
	  o Occupational health
	  o Unintentional injury
	• Communicable disease control
	  o Antibiotic resistance
	  o Foodborne illness
	  o Health care–associated infections
	  o Hepatitis
	  o HIV/STDs
	  o Immunizations
	  o Influenza/flu
	  o Tuberculosis
	  o Vaccine-preventable diseases
	• Environmental public health
	  o Air quality
	  o Climate change
	  o Vector-borne disease
	  o Water quality
	• Maternal, child, and family health
	  o Adverse childhood experiences
	  o Breastfeeding
	  o Children/youth with special health care needs
	  o Early childhood development
	  o Family planning
	  o Infant mortality
	  o Maternal mortality
	  o Maternal/prenatal care
	• General health and wellness
	• Health equity

Abbreviations: DAS, Georgia Division of Aging Services; DPH, Georgia Department of Public Health; IT, information technology; STD, sexually transmitted disease.
[a] Items in bold indicate additions made on the basis of input from the DAS and DPH teams.

3. *Follow-up action planning*: ASTHO facilitated the group through its second priority within the action plan.
4. *Wrap-up*: ASTHO facilitated refinement of the final action plan, reflection on the process, and celebration of accomplishments.

TABLE 2
Coding Frequency for SPoA and SHIP

Code/Subcode	SPoA Frequency	SHIP Frequency
Domain 1: Public health infrastructure		
General infrastructure-related areas	67	56
Accountability and performance management	19	1
Assessment and surveillance	6	4
Collaboration and partnership development	11	15
Communications	12	15
Emergency preparedness and response	1	0
Funding	2	3
Informatics	5	5
Organizational administrative competencies	6	6
Financial management	4	0
Human resources	0	1
IT	1	5
Leadership and governance	1	0
Policy development and support	2	7
Workforce development	23	13
Domain 2: Public health areas		
Access to and linkages with care	17	44
Affordable care	1	3
Integrated care	0	4
Quality of care	2	16
Behavioral health and substance misuse	2	20
Mental health	1	1
Tobacco	0	19
Chronic disease prevention	6	50
Alzheimer's and related dementias	3	2
Cardiovascular disease	0	9
Dementia	3	2
Diabetes	0	11
Nutrition	2	9
Physical activity	0	6
Communicable disease control	0	11
Environmental public health	0	4
General health and wellness	11	4
Health equity	8	13
Injury prevention	3	2
Maternal, child, and family health	0	12
Obesity	0	12

Abbreviations: SHIP, State Health Improvement Plan; SPoA, State Plan on Aging.

DAS and DPH participants reviewed and learned about each other's plans primarily through the crosswalk analysis report and overview during the consultation meeting. Participants were encouraged to reference the full SHIP and SPoA as needed during their review of the findings. DAS and DPH team members reviewed materials, such as the crosswalk analysis report, and provided feedback on action plan drafts between sessions. ASTHO and TFAH used an iterative process to design each meeting to suit the needs of the group toward the final goal of an actionable, coordinated plan.

Results

The crosswalk findings were a launching point for understanding each other's agency-wide plans and uncovering mutual priorities between DAS and DPH. The frequency of each code during the crosswalk scan is summarized in Table 2.

The most frequent codes across the SHIP and SPoA were General Infrastructure-Related Areas, Collaboration and Partnerships, Communication, Workforce Development, Access and Linkage to Care, and Health Equity. Both plans named strategic partners to collaborate with on several activities, with overlap in health care partners and community-based organizations. They both prioritized telehealth and had a variety of strategies to increase access, utilization, and funding. Both plans included objectives to address needs in health professional shortage areas (HPSAs) and increase health care coverage and financing. For example, the SPoA aimed to identify areas with a low number of providers and the SHIP aimed to decrease the number of people living in an HPSA. Both plans included equity-centered approaches such as engaging priority populations, tailoring information to specific groups, and eliminating health disparities, while also working to address upstream determinants of health and well-being such as access to services and improving diagnosis and treatment. The SHIP had a higher volume of codes in Chronic Disease Prevention, whereas the SPoA had a higher volume of codes in Accountability and Performance Management. The SHIP focused on traditional chronic disease prevention with emphasis on hypertension and diabetes, while the SPoA focused on dementia and nutrition. Many of the strategies in these areas overlapped with shared priorities in access to care, collaborating with partners, and communicating with the public.

During the consultation meeting, the DAS and DPH teams reflected on these findings and the areas of intersection between the 2 plans. Through facilitated discussion and a prioritization exercise, the

group identified opportunities to collaboratively develop partnerships, address SDOH, and strategically communicate data to key audiences. Through this iterative process, DPH and DAS came to consensus on 2 priorities for the final action plan: (1) engaging existing and emerging partners in rural areas to address SDOH; and (2) leveraging each agency's existing data about older adults to guide future activities and inform their current and new partners. The team prioritized these areas to leverage shared risk and protective factors and intentionally coordinate upstream efforts for improving older adult health. For priority 1, DAS and DPH planned to work together to build an invitation for open dialogue with new and existing partners in rural areas, convene partners, and facilitate conversations about addressing SDOH through innovation at the local level. For priority 2, DAS and DPH agreed to add healthy aging indicators to a DPH data profile, develop state and local data profiles on healthy aging, and disseminate the completed profiles to the public and partners, including potential new partners. DAS and DPH team members, as well as other relevant staff members from their agency, took immediate actions outlined in the plan following the final meeting. TFAH provided funding via JAHF to DPH as the fiduciary agent to sustain implementation of the action plan with DAS.

ASTHO and TFAH surveyed participants partway through the process to get feedback on the virtual sessions and their effect on the DAS-DPH partnership. Of the small sample (n = 3), 100% strongly agreed that the virtual sessions effectively fostered partnerships between the public health and aging agencies. One respondent commented, "While there is an existing, and strong, partnership between our agencies, this opportunity allowed us to take a deeper dive into potential areas for specific and strategic partnership." When asked about the effectiveness of the methods to establish a collaborative virtual environment, a respondent shared that they "helped to format a clear stage for planning and identifying key focus areas and priorities." Another indicated that the prioritization matrix exercise was an effective way to narrow down the work that could be done together. Reflecting on the successes of virtual sessions, one respondent wrote, "I have a better understanding of the state plan for public health [and] of programs/initiatives we can promote/work on together."

ASTHO and TFAH also gathered feedback through a facilitated discussion during the final call. When asked what was most helpful, DAS and DPH team members named defining goals and objectives that were manageable, having dedicated time and structure for discussions, and team collaboration to draw out priorities. Participants were surprised by the depth of the state plans, the number of opportunities for collaboration, the usefulness of the crosswalk's key word search, and the timeliness of the project given BOLD funding and the COVID-19 response that had spurred partnership between DAS and DPH. They suggested improvements such as discussion about how to communicate the success of the process and its outcomes, as well as inviting the commissioners of each agency to join for a final report or providing them with a summary.

Discussion and Conclusion

The crosswalk supported the DAS and DPH teams in "operationalizing [their] plans in a collaborative way," as one participant reflected during the closing meeting. This aptly describes the goal of the pilot project—a model that other SHDs and SUAs can replicate to strategically collaborate at any jurisdiction level. Georgia's crosswalk helped formalize collaboration to advance equitable outcomes among older adults.

DAS and DPH already had a strong foundation to build upon, which allowed the group to dive into the content without having to invest additional time learning each other's terminology and establishing trust. In future iterations of the crosswalk model, it

Implications for Policy & Practice

- Establishing partnerships between governmental public health departments and units on aging is critical to advancing healthy aging now and in the future.
- Conducting a crosswalk to compare and analyze the plans of public health departments and units on aging, such as the SHIP and SPoA, can help to strategically identify shared priorities and opportunities for collaboration. This process can be replicated and adapted by other jurisdictions at the state and local levels.
- Having a structured process and dedicated time for understanding the results of the crosswalk of public health and aging plans supports strategic thinking and planning for furthering collaboration and operationalizing shared priorities between departments.
- It would be beneficial for public health departments and units on aging to participate in one another's future plan development processes to proactively increase alignment between their priorities. For agencies that are not actively developing a new plan, retrospective review of existing plans is feasible and strengthens partnerships so that future plans are developed prospectively with shared goals, resources, and engagement that facilitates shared impact on populations.

may be necessary to plan time for relationship building. For jurisdictions looking to initiate SHD-SUA partnerships, they can begin with learning about one another's priorities through regular meetings, reviewing each other's agency plans, or participating in a formal collaboration opportunity like the crosswalk model ASTHO and TFAH facilitated with Georgia.

The value of strengthening and growing the systems and structures that support healthy aging at this time in our nation's history cannot be overstated. SHD-SUA partnerships are necessary to make that happen. To close, we offer advice that DAS and DPH participants shared during the final call: given the importance of healthy aging to the future of our society, prioritize this work and take "no" off the table to envision what is possible.

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