Health Promotion and Disease Prevention for Older Adults

Intervention Themes and Strategies Used in Québec Local Community Health Centres and Seniors' Day Centres

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ABSTRACT

Objective: Despite the considerable potential of disease prevention and health promotion (DPHP) among older adults, extant data suggest that this field of intervention is still underdeveloped. To shed further light on this issue, this paper presents the results of an inventory of DPHP interventions for older adults conducted in local community health centres (CLSCs) and seniors' day centres in the province of Québec.

Methods: All CLSCs (N=147) and day centres (N=124) were invited to participate (response rates: 74% and 79%). Data were collected through telephone interviews. Interventions were coded according to type of intervention strategies and target themes.

Results: Awareness-raising and health education strategies emerged as the most frequently-cited type of intervention strategies, reported by 77% of CLSCs and 95% of day centres, respectively. The two themes reported by a majority of CLSCs were physical health (87%) and community issues (58%). Lifestyle habits (92%) and social issues (92%) were the two most frequently-cited themes in day centres.

Discussion: DPHP for older adults is substantially well developed in terms of intervention offerings in the two types of organizations under study. However, the range of available interventions requires expansion to increase the potential of DPHP programs to tackle the numerous challenges posed by the aging of the population.

MeSH terms: Health promotion; prevention & control; aged; community health centres

La traduction du résumé se trouve à la fin de l'article.

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Population aging is of considerable concern to public health authorities because aging is associated with increased prevalence, incidence, and severity of chronic conditions.[1-3] A pivotal role for public health consists of ensuring that population aging does not result in more widespread disabilities and reduced quality of life in the latter years of life. Disease prevention and health promotion (DPHP) offer a potentially powerful response to this new challenge.[4-7] Yet several authors have suggested that despite the considerable potential of DPHP for older adults, this field remains underdeveloped. For example, it appears that older adults are less frequently targeted by DPHP efforts than are other age groups.[4,8,9] Moreover, it seems that there exist disparities in access to information and support services for some population subgroups such as older adults with low income or low health literacy.[10] Finally, the programs and strategies directed towards the elderly appear to still often emphasize a traditional approach which involves an exclusive targeting of individual determinants of health (e.g., knowledge, attitudes, etc.) to the detriment of an innovative, ecological approach that would also consider a variety of environmental determinants (such as the interpersonal, organizational, community, and policy environments).[5,11-13] Regarding the ecological approach, such a picture is far from being consistent with major recommendations and policy frameworks in public health where this approach has been proposed as the preferred means of improving the health of populations.[14-17] Indeed, in line with these orientations, recent studies and reflections have concluded that efforts directed at multiple levels, from individuals to policies, are essential to successfully address issues particularly relevant to older adults,[18] such as the promotion of physical activity[13,19] or the prevention of abuse.[20]

The few evaluations of DPHP program availability for older adults used data that were almost 10 years old and were exclusively focussed on the US context.[21,22] The analyses also lacked detail regarding program descriptions. As a result, the current state of DPHP programming for elderly populations is largely unknown. To fill this gap, this paper presents the results of an extensive inventory of DPHP interven-

tions for older adults conducted in two types of local health organizations in the province of Québec.

METHODS

Design and context

This study is based on an inventory of existing DPHP interventions for older adults offered in Local Community Health Centres (CLSCs) and seniors' day centres.

CLSCs are public sector organizations whose mission it is to offer the population of their geographical catchment area routine preventive and curative health and social services (including rehabilitation and social reintegration programs). Seniors' day centres are also public sector organizations attached to long-term care facilities or CLSCs. They offer varied preventive and curative programming for a clientele with cognitive impairments or other physical/functional disabilities within their mandates of rehabilitation and secondary/tertiary prevention.

Population

All CLSCs (N=147) and seniors' day centres (N=124) were invited to participate in the study. The response rates for these two types of organizations were 74% and 79%, respectively. Data were collected through telephone interviews between November 2002 and September 2003. The selection of respondents was left up to the management of each organization; they were instructed to select the person the most knowledgeable about DPHP programs for older adults in their organization. Many factors drove the choice of this procedure, including experience gained over the course of pilot studies, the large variability found across organizations in term of organizational structure, and consultations with key informants.

Eligible interventions were those dealing with health promotion and primary/secondary/tertiary prevention specifically aimed at older adults and in place currently or during the previous year. Program development work and research activities were excluded. In keeping with the methodology proposed by the Task Force on Community Preventive Services,[23] the inventory did not include care provided by a health professional during a clinical intervention with a patient or client.

Measures

The aim of the first interview was to draw up a list of DPHP initiatives meeting the eligibility criteria in the organizations. We used a semi-structured interview protocol. After being read the criteria, respondents were asked to come up with initiatives on their own. A series of probes helped ensure that interventions targeting the health of older adults through actions taken on their environments were not omitted. For each of the initiatives listed, respondents were then asked to provide a brief description of the activities, the nature of the targeted clientele, and the name of a resource person.

Following compilation of responses to interviews, respondents were asked to validate the information. The first step in this procedure consisted of creating a general list of all interventions by type of organization. This list was then returned to the respondents along with their own organization's data, with a request that they verify the accuracy of the information and make any changes deemed necessary. Upon receipt of validation material, all organizations were contacted once again to verify all new information added. The results from organizations that completed this validation (89% of the CLSCs and 92% of the seniors' day centres that participated in the initial interview) provided confirmation and extension of information obtained during the initial interviews. The mean number of additional interventions identified was 0.96 (SD=2.0) for CLSCs and 0.54 (SD=1.5) for the day centres, suggesting that the first set of interviews were quite encompassing.

Analysis

Interventions (n=768 for CLSCs and n=1255 for day centres) were coded according to two dimensions, namely, type of *intervention strategies* (e.g., awareness-raising/information/education, community development, political action) and *target themes* (e.g., lifestyle, social problems) (the coding grid is available from the corresponding author upon request). The proportion of interventions for which information was insufficient for coding was very low across CLSCs and seniors' day centres: 6.4% and 2.2%, respectively, for the intervention strategies dimension, and 2.8% and 1.6% for the target themes dimension. An inter-rater validation conducted on a subgroup of 106 randomly selected interventions established agreement rates at 83% and 86% for intervention strategies and target themes, respectively. This validation exercise involved the principal investigator (LR) and the research assistant who coded all the material (JPS).

The Health Sciences Research Ethics Committee of the Université de Montréal approved the project.

RESULTS

Table I presents information on the types of intervention strategies most frequently identified. Awareness-raising and health education strategies emerged as the most frequently-cited type in both CLSCs and seniors' day centres. More detailed analysis revealed conferences and workshops to be the most common intervention activities falling within these types. It should be noted that among the types of intervention strategies widely used in CLSCs (i.e., by at least 50% of them), only one type included activities targeting the environment (Round Table/Coalition); all other types involved strategies aimed directly at clients (awareness-raising/education, immunizations) or their immediate caregivers. The profile of the day centres revealed the existence of a variety of intervention strategies. Similarly to CLSCs, though, almost all the types listed involved actions aimed directly at clients or their immediate caregivers. Three types of intervention strategies were reported by almost all day centres: awareness-raising/education, physical activity, and social activities.

Table II shows the themes addressed most frequently. For CLSCs, the two intervention themes reported by a majority of establishments were physical health and community issues. More detailed analysis revealed extensive variability among the physical health themes mentioned: influenza/pneumococcal infections, falls/injuries, and cancer were the three most frequently identified themes related to physical health. Housing, transportation, and food security were the three most common themes associated with community issues. The profile for day centres revealed that lifestyle habits (the great majority linked to physical activity) and social issues/problems (the majority

TABLE I

Intervention Strategies Most Frequently Identified in CLSCs* (n=109) and Seniors' Day Centres (n=98)

a) CLSCs	Proportion Offering This Type of Intervention %	b) Day Centres	Proportion Offering This Type of Intervention %
Awareness/Education†	77.1	Awareness/Education¶	94.9
Immunization	66.1	Physical Activity**	90.8
Participation in Round Table/Coalition	59.6	Social Activities	88.8
Caregivers Support‡	52.3	Cognitive/Sensory Activities	78.6
Organizational Support§	40.4	Manual Activities††	58.2
Coordination of Services	37.6	Caregivers Support	45.9
Training of Volunteers/Professionals	32.1	Multi-activity Initiatives‡‡	30.6
Screening	30.3	Personal Support Interventions§§	23.5
Specific Programs||	21.1	Immunization	21.4

* Initiatives targeted at older adults exclusively.
† Most frequently-cited strategies were conferences/workshops (reported by 63% of CLSCs) and leaflets and other written material (8%).
‡ Most frequent strategies were self-help groups (28%), respite care (17%), and training (9%).
§ Included administrative and financial support.
|| Included the "VIACTIVE" program (a province-wide program aimed at increasing physical activity among seniors, reported by 15% of CLSCs).
¶ Most frequent strategies were conference/workshops (94%) and newsletters (6%).
** Most frequent strategies were exercise classes (79%), games (33%), and relaxation (30%).
†† Craft, carpentry, etc.
‡‡ Initiatives involving three or more distinct intervention strategies.
§§ The most frequent strategy was self-help group (22%).

TABLE II

Health Themes Most Frequently Identified in CLSC* (n=109) and Seniors' Day Centres (n=98)

a) CLSCs	Proportion Addressing This Theme %	b) Day Centres	Proportion Addressing This Theme %
Physical Health†	87.2	Health Habits**	91.8
Community Issues‡	57.8	Social Issues††	91.8
Caregivers and Natural Caregiving	46.8	Multi-theme Initiatives	86.7
Social Issues§	45.9	Mental Health‡‡	80.6
Multi-theme Initiatives||	42.2	Physical Health§§	71.4
Elderly Clientele in General	36.7	Caregivers and Natural Help	39.8
Health Habits¶	30.3		
Resources and Services	22.9		
Medication	21.1		

* Initiatives targeted at older adults exclusively.
† Most frequent sub-themes were influenza/pneumococcal infections (in 67% of CLSCs), falls/injuries (34%), and cancer (20%).
‡ Most frequent sub-themes were housing (35%), transportation (26%), and food security (12%).
§ Most frequent sub-themes were abuse/violence/neglect (25%), social isolation/integration (17%), and bereavement (6%).
|| Targeting three or more sub-themes.
¶ Identified as not referring to a particular health theme. Most frequent sub-themes were physical activity (23%) and nutrition (10%).
** Identified as not referring to a particular health theme. Most frequent sub-themes were physical activity (90%) and nutrition (8%).
†† Most frequent sub-themes were social isolation/integration (88%), adaptation to new technologies (8%), and abuse/violence/neglect (6%).
‡‡ Most frequent sub-themes were cognitive deficit (77%), multi-issue (7%), and self-esteem (6%).
§§ Most frequent sub-themes were falls/injuries (36%), Parkinson's disease (27%), and influenza/pneumococcal infections (24%).

having to do with a reduction of isolation and an increase in social integration) were the two most frequently-cited themes. Multi-theme interventions were observed frequently as were those dealing with mental health (the majority related to the issue of cognitive deficits). Similarly to CLSCs, a majority of day centres addressed physical health themes, the most frequently addressed being falls/injuries, Parkinson's disease, and influenza/pneumococcal infections.

DISCUSSION

The results of this inventory show that DPHP for older adults is substantially well developed in terms of intervention offerings in the two types of organizations under study. This finding runs counter to perceptions that this type of public health intervention seldom reaches this age group.[4,9] It is also in marked contrast with results obtained earlier in the few studies available on this topic. In 1996, Wallace et al.[21] found that only about 60% of US local health departments reported health promotion or disease prevention programs that specifically targeted older adults. Primary prevention was also identified in this study as the most frequent unmet need for older persons. In a similar vein, specific health programs for the elderly were reported in only half of participating agencies in a survey of state health agencies conducted in 1994 by Balsam et al.[22] While the distinct context of these two studies precludes the establishment of direct comparisons with ours, such results nevertheless show the interest of monitoring the offer of DPHP services for older adults, especially in areas and countries where the population is aging rapidly.

Of additional interest in our results is the more frequent use of intervention strategies targeting personal rather than environmental determinants of health (i.e., personal awareness-raising and education activities), a finding that is most consistent with existing views about dominant approaches to DPHP with older adults.[5,11-13] Such results also corroborate those reported by Wallace et al. in their study of local health departments' programs where they found that the most common older adult priorities, and among the most common services, were clinical services, such as immunizations and cancer programs. Noting that the only common program for older adults was flu/pneumonia immunizations, they concluded there was "a broad but often superficial coverage of older persons" (p. 133). More than six years later and in a different country, we found a relatively similar picture with regard to the intervention strategies. The range of available interventions urgently requires expansion if the goal of increasing "the health-promotive capacity of human environments" is to be achieved.[24]

As for intervention themes, the profile drawn appears to reflect an appropriate response to the current physical health status of older Quebecers. However, more inroads will have to be made regarding highly prevalent diseases such as hypertension, heart disease, and arthritis.[25]

Furthermore, other problems related to mental health and to the social and community aspects of aging, although sometimes addressed, appear to be the object of significantly less time and energy, particularly in CLSCs. While physical health problems still definitely characterize the health and well-being profiles of older populations, other issues such as depression and sleep problems, polypharmacy, or challenging physical and social environments are important problems to be tackled by DPHP planners and practitioners.[4]

This study is limited by its single-country context and by its focus on only two types of health organizations. Pursuing this kind of inquiry would seem to be indicated in other countries and types of organizations: regional health departments, non-governmental organizations, and private health care delivery settings. Furthermore, this study did not examine other important intervention dimensions such as intervention settings, intervention models, the clientele reached, etc. Future research and intervention efforts will require a more detailed analysis. Finally, it would be useful to cross-validate data obtained through the present short interview procedure against detailed information obtained through in-depth interviews and program-related documentation. Despite its limitations, this study is important for its contribution to an intervention sector that is likely to assume an increased importance as the population continues to age.

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RÉSUMÉ

Objectif : En dépit des possibilités considérables que présentent la prévention et la promotion de la santé (PPS) pour les clientèles aînées, les données existantes portent à croire que ce champ d'intervention est encore relativement peu exploité. Afin d'éclairer la réflexion sur cette question, cet article présente les résultats d'un inventaire des interventions de PPS destinées aux aînés et offertes par les CLSC et centres de jour du Québec.

Méthode : Tous les CLSC (n=147) et les centres de jour (n=124) ont été invités à participer (taux de réponse : 74 % et 79 %, respectivement). Les données ont été recueillies au moyen d'entrevues téléphoniques. Les interventions recensées ont été codées selon deux dimensions : leurs thématiques et leurs stratégies.

Résultats : Les stratégies d'éducation à la santé et de sensibilisation ressortent comme étant la catégorie de stratégies la plus fréquemment déclarée (dans 77 % des CLSC et 95 % des centres de jour). Par ailleurs, la santé physique (87 %) et les problématiques communautaires (58 %) sont les deux thématiques déclarées par une majorité de CLSC. Du côté des centres de jour, les habitudes de vie (92 %) et les problématiques sociales (92 %) émergent comme étant les thématiques les plus fréquentes.

Discussion : La PPS pour les aînés semble être un secteur d'intervention relativement bien exploité, du moins lorsqu'on considère l'offre de services dans les deux types d'organisations étudiées ici. Toutefois, la gamme des interventions disponibles devra être élargie si l'on veut accroître le potentiel de la PPS eu égard aux nombreux défis que pose le vieillissement de la population.