

The Role of AAAs in Promoting Health for Seniors: A Preliminary Research Report

Lawrence Force^{*,1}, Jeffrey S. Kahana^{1,2} and Valerie Capalbo¹

¹Center on Aging and Policy, Mount Saint Mary College, 330 Powell Avenue, Newburgh, N.Y. 12550-3494, USA;

²Mandel School for Applied Social Science, Case Western Reserve University, USA

Abstract: This paper presents results of a national survey of directors of Area Agencies on Aging (AAA) regarding provision of innovative community services. We sought to understand factors that impede and those that encourage provision of preventive service programs and facilitation of independence and proactivity in late life. We also contextualize priorities within the aging network by describing the historical and policy frameworks that gave rise to development of AAAs in the US through legislative mandates of the Older Americans Act. Findings of our study, based on responses to a web based survey by 112 directors indicate that, even while meeting their primary mission of assisting frail elders, AAA directors seek innovation. They assign high priority to introduction of preventive services that can promote health and empowerment of elders. Facilitators of this type of program innovation included forging partnerships with other community agencies, including hospitals, churches and schools. Having a dedicated staff member and success in external fundraising efforts were also associated with endorsement and implementation of service innovation.

Keywords: Aging policy, area agencies on aging, health promotion and disease prevention.

This paper explores the attitudes of Area Agency on Aging (AAA) directors toward health promotion and disease prevention programs. AAA's are conduits for services provided to vulnerable older adults under the authority of the Older Americans Act (1965). There are currently more than 650 AAAs throughout the U.S. whose purpose is to both promote the independence of at risk seniors and to assure that they receive appropriate care within a communal setting.

The choice of AAAs as a site for investigation, and their directors as key informants, was made based on their role under the Older Americans Act as "advocates" for the elderly – not just as service providers. Area agencies are involved in planning, service coordination and advocacy across five broad service domains: access (e.g. transportation), nutrition, home and community based long term care, disease prevention and health promotion, and protection of seniors. Within this "planning" framework there is room for innovation and program development. At present, however, little is known about the attitudes of agency directors to such innovation in the context of health promotion and disease prevention, the feasibility of new programs, and the constraints which might limit innovation.

This paper offers a preliminary assessment of these questions. To gauge the attitudes of agency directors and their experiences in health service provision we conducted a web based survey of area agencies throughout the United States. Our research is based on the initial 112 responses from agency directors across a wide spectrum of urban and rural AAAs. Prior to presenting findings from our survey, we give an overview of the contexts – population, familial, and

policy that help situate the issues and challenges facing AAAs as advocates for disease prevention and health promotion by seniors.

A brief word about AAAs is warranted at the outset. These entities are unique to the American aging system or "network" and reflect the alliance between federal, state and local government that is known as "cooperative federalism" [1]. While federal law stipulates the mission and priorities to be pursued by area agencies, implementation takes place at the state and local levels. The main services provided to seniors by AAAs are: information assistance and case management; transportation to physician appointments; congregate and home delivered meals; nutrition counseling and health education. Additional services include day care programs and family support. Total federal funding for the OAA is approximately two billion dollars per year. Area agencies also receive support from state and local governments, but are increasingly expected to engage in private fundraising initiatives [2].

POPULATION CONTEXT

At present, almost 13% of the US population is sixty five or older. Demographers expect that over the next ten years this figure will reach 20% [3]. Americans are not alone in seeing significant population growth among older individuals. Life expectancy rates are growing worldwide as people live healthier lifestyles and health care providers adopt preventive orientations. This increase in longevity has broad implications for the institutions of these societies. In the United States, individuals today are living much longer than the architects of American public policy for the aged envisioned [4]. The average life expectancy in 1935 when Social Security was passed was 61.7 years. The average life expectancy increased by about ten years to nearly 70 in 1965 when Medicare became law. Since then, the average life expect-

*Address correspondence to this author at the Center on Aging and Policy, Mount Saint Mary College, 330 Powell Avenue, Newburgh, N.Y. 12550-3494, USA; Tel: 845-569-3164; Fax: 845-569-3507; E-mail: force@msmc.edu

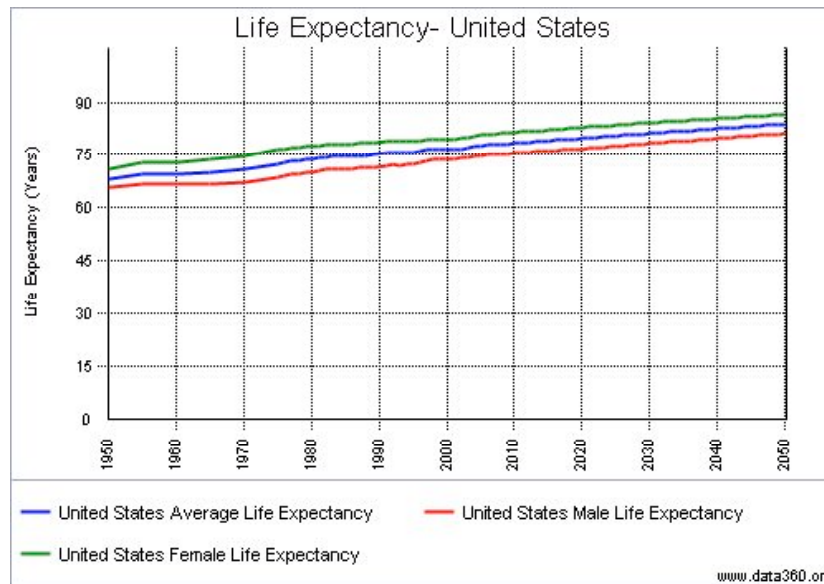


Fig. (1). U.S. Life-Expectancy Projections.

tancy has jumped almost ten more years to nearly 80, although for minorities and individuals with low incomes, life expectancy has significantly lagged these averages.

The 'longevity-shift' outlined above has implications for older individuals, their families, and policy-makers [5]. Theoretical models of aging, practice intervention approaches and service delivery systems will need to adapt to growing life-spans. Those providing services to seniors – such as AAAs - will also have to appreciate the complex connections between age, disability and disease. Longer life expectancy means that many individuals can expect to spend significant *years* of their late lives managing physical disabilities, dealing with psychological depression, and living in nursing homes [6].

Longevity has highlighted issues of senior independence, maintenance and enhancement of quality of life in old age as well as best practices for avoiding and managing disabilities [7, 8]. Policy-makers and social service practitioners are also more aware of the manifold challenges posed by longevity. It is not just physical limitations or disability that often accompanies advanced age, but losses of spouses, friends and social networks. Physicians, nurses, social workers and psychologists are all being sensitized to the importance of “quality of life,” which cannot be reduced to categories of health/wellness versus illness/disease [9].

Longevity clearly comes with a high price for many seniors. A major goal for the service delivery system is to explore and evaluate strategies that can empower older people to gain control over their health care decisions in order to strengthen their role in decision-making and to make informed choices in the latter part of life [10]. The problem from a policy perspective is that current aging policies – Social Security, Medicare and Medicaid and the Older Americans Act – were not designed to address the challenges of disability and loss of independence which are common features of living to a very old age. The absence of social policies and programs focused on aging well and longevity can

be traced to the historic role/responsibility of the family as caregiver to older adults facing health challenges.

FAMILY CONTEXT

The extended family has historically played an important role in the care of the elderly and infirm [11]. As a result of inheritance-rules and normative principles, children and parents had mutual responsibilities and obligations. In traditional societies the “combination of economic, demographic and cultural arrangements maintained the usefulness of children to their parents... while family structure and ideology maintained the dominance of the older generation with the family” [12].

By the middle of the nineteenth century, however, forces of modernization, especially the greater availability of land and increased social mobility, weakened paternal authority and reduced the number of close-knit, extended families [13]. By the end of the nineteenth century older adults were already being relegated to a subordinate position in the family as new forces – most notably the influx of women into the work place – put additional stress on traditional notions of family care taking of seniors. Throughout the twentieth century demographic, economic, and cultural forces would further alter the traditional family system, leaving seniors with fewer family based supports [14]. Even with these social changes many older spouses, adult children and other family members have been actively involved in caregiving to frail family members. However, the burdens of caregiving may overwhelm financial, social and psychological resources and or physical capacities of informal caregivers. [15]. These trends accelerated the need for publicly sponsored family care services, however, the underlying role and responsibility of family was never meant to be replaced by a public policy response.

POLICY CONTEXT

The dominant motifs in health policy for the aged over the last thirty years have been three-fold. First, diseases have been conceptualized beyond their biological bases and to-

ward the social, behavioral and economic factors that underlie them [16]. Second, a wide body of literature has shown the importance of individual autonomy for the physical and emotional well-being of seniors [17]. Third, there is a realization that public policy efforts should focus on health promotion and disease prevention rather than medical care alone [18].

These developments were not prominent when policy-makers fashioned old age policy around income maintenance and care for the sick and disabled [19]. Indeed, such policies seem reactive to assumptions of physical decline and inevitable loss of economic independence. The new orientations are more proactive, as indicated by the Wanless Report [20], issued in England where public health is defined as “the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organizations, public and private, communities and individuals.”

This proactive model places the focus on broad determinants of health (including income, educational, occupational and social factors), and makes longevity and wellness priorities equal to provision of medical services for treating disease and illness. Research also shows the salience of social well-being for physical wellness. Lack of “social capital” and lower “status” scores have been linked to higher rates of morbidity and disability among the elderly [21, 22]. While public health models have incorporated these social determinants since the early 1970s, aging policy and service models in the United States have been slow to incorporate them. The one policy domain where health promotion and disease prevention are prominent, at least in theory, if not funding, is the Older Americans Act and the Aging Network.

THE HISTORICAL CONTEXT

The Older Americans Act (1965) was ambitious in its aims but modest in its funding [23]. Its goal was to better integrate older adults into the mainstream of American society. Title II of the Act established an Administration on Aging; Title III created a federal grant program for states; Title IV supported research on aging; and Title V provided resources for training individuals in the field of aging. A leading scholar has recently noted that while “a relatively small proportion of the older population receives services directly funded by the Act ... the infrastructure created by the Act can influence service programs that reach a far larger proportion of the older population” [2].

One of the most significant features of the Act was set forth in Title I which stated the Act’s ten objectives in “keeping with the traditional American concept of the inherent dignity of the individual in our democratic society.” These objectives included providing the “best possible physical and mental health,” for the elderly; promoting “community services” and “research knowledge which can sustain and improve health and happiness,” and providing for “freedom, independence, and the free exercise of individual initiative.”

Viewed from an “agenda building” perspective [24], the Older Americans Act signified the arrival of aging as a policy area *sui generis* -- no longer tethered to the economic security issues that under-girded passage of the Social Security Act. The purpose of this legislation was grounded in

principles of social solidarity. Thus, the Older Americans Act marked a new turn in the trajectory of American public policy toward the aged.

Amendments to the OAA in 1973 created local agencies (Area Agencies on Aging) which were charged with implementing the Act and providing services directly or indirectly (through local service providers) to individuals over 60 years of age. The initial plan of the OAA was expansive, was built on the social citizenship agenda of Lyndon Johnson’s Great Society program, and was framed between the historic 1961 White House Conference on Aging and legislation in 1965 creating the Medicare and Medicaid programs.

The relationship between the national government and the states in administering this program through the AAAs was conceived as a partnership, with federal money flowing to the states and states having flexibility in spending these funds to meet their specific needs. In the intervening years, however, amendments to the OAA have modified the original universalistic design of the program and directed federal funds to the neediest seniors – a process of movement away from age based benefits to need based criteria that has been part of a more widespread shift in American aging policy [25, 26].

Social policy has not kept up with demographic changes such as increased longevity, diversified families, and changes in family roles. Equally, there has been a failure to develop social policies and services to adequately meet the needs of older adults and their families. Since the AAA’s have the capacity and network for conducting outreach and follow-up with families, additional community outreach could be added to existing structures [27]. In light of the historical development of the OAA, a reasonable question is: to what extent can AAA’s play a leading role in outreach and health advocacy for the senior population?

The AAAs are mandated to serve individuals sixty and over [28]. However, services are targeted to those seniors with “greatest needs,” a group that includes the economically and socially disadvantaged. Recent data shows that nearly 30% of those receiving services represent the very poor (federal poverty level), while approximately 20% are minorities, and 30% live in rural areas [2]. This means that the majority of elderly are not being served by AAAs (roughly 75% of those over sixty), especially those individuals who are currently well and whose income and social status does not put them in the “greatest needs” category.

Presently, Area Agencies on Aging vary in terms of their organizational structure. Some are private not-for-profit corporations (41%), others are situated within local and municipal governments (32%), and others operate directly through government councils (25%) [2]. The agencies also differ in how they provide services. Some do so directly; others operate indirectly through contracts with service agencies; and some provide a combination of direct and indirect services [29, 30]. The resources available to AAAs represent a third area where there is divergence between AAAs. Such resources can be derived from three sources: federal funds under the OAA, state and local funds, and monies raised from private sources, including contributions from seniors for services.

The main services offered by AAAs and funded by the federal government are contained in Title III of the Older Americans Act. They include supportive services (senior centers), nutrition services (congregate and home delivered meals), disease prevention and health promotion services, and caregiver support. Yet, in terms of federal spending on these Title III programs (which consume 66.7% of the total OAA budget) only 1.1% is dedicated to disease prevention and health promotion. Nutrition services comprise 39.6% of the budget, family caregiver support 8%, and supportive services 18.3%. Thus, the question of how important AAA directors perceive disease prevention and health promotion and their willingness to pursue these programs notwithstanding limited federal funding is one that deserves investigation.

AREA AGENCY SURVEY: METHODS AND RESULTS

We contacted AAA directors by email and those who responded to the survey (n=112) submitted their results *via* an online program. Respondents represented a cross-section of directors from urban and rural communities as well as agencies of larger and smaller sizes. Directors also reported on the financial backgrounds of their clients, with 25.2% of agencies serving a population that was below the federal poverty level; 52.5% of agencies serving populations that ranged from one quarter to one half below the federal poverty level and 22.2% of agencies serving populations where fewer than one quarter of clients were below the federal poverty levels. A majority of directors (55%) also indicated that one quarter to one half of their clients could be characterized as homebound. The semi-structured survey instrument addressed issues of service provision, staffing characteristics, client characteristics, agency director background and projected future directions in programming by agencies.

Directors were specifically asked a series of questions relating to their attitudes toward health promotion and disease prevention services. These attitudes were measured using a five point scale ranging from very important to not at all important. Directors rated health promotion and disease prevention as very important (60.6%) which was exceeded only by basic needs (81.7%). This contrasts with ratings of very important for social activities (24.8%), educational programs (23.1%), civic engagement (20.2%) and financial management (29.4%). And, even in the face of budgetary constraints, directors indicated that it was very important (56%) to introduce new programs for disease prevention and health promotion.

Health promotion and disease prevention programs offered by these AAAs included: exercise programs (78%); nutrition counseling (89.5%); health screenings (76.2%); dental screenings (17.8%); falls prevention (88.1%); mental health counseling (50.5%); health care consumer education (81.8%); and consumer advocacy (87.6%). These programs are offered either directly by the AAA or through subcontracts. Area agencies were most likely to offer exercise, nutrition and health screening through subcontracts and fall prevention, health care consumer education and advocacy directly. Many of these health promotion and disease prevention programs are offered in senior centers. Transportation to these centers was provided by 84.8% of AAAs. Most agencies (69.5%) subcontract for these transportation services.

The specific programs offered for health promotion and disease prevention were varied. They generally reflected the AAA recognition of an empowerment approach whereby seniors were expected to take an active role in their own health management and to utilize services as active partners. Programs to facilitate health maintenance included diverse exercise programs and encouragement of good nutrition. Approaches to encouraging exercise ranged widely from weight training programs for healthy bones, to senior Olympics, Tai Chi, and line dancing to the development of state-of-the-art fitness centers complete with walking tracks and personal trainers.

Programs to facilitate healthy diets included farmers' market programs and nutritional counseling. In addition to physical exercise and healthy diets, aimed at those elders who are still in good health, agencies also offered special programs for the more frail or "at risk" elderly. Balance training exercises were often coupled with fall prevention initiatives. These programs reflect recognition that the risk of falling increases with age and threatens health and well being of this population. Similarly, reflecting concern about prevalent health risks of late life, education for prevention and control of diabetes was offered by several area agencies.

A second important focus was on preventive health services and early disease detection, through screening. Programs reflecting this orientation included clinics offering flu shots, mobile vans to facilitate dental health, foot care programs including nail trimming and massage services. Traditional health screening programs were also offered by some AAAs. These included screening for osteoporosis, breast cancer and diabetes. A number of programs were also oriented at reduction of risky behaviors such as smoking cessation. But these were a distinct minority.

A third group of health promotion programs was oriented toward promoting self-management of prevalent chronic diseases such as diabetes or arthritis. Numerous agencies reported utilizing techniques developed by Stanford University for illness self-management. This more corrective orientation to health promotion was often described as directed at limiting physical impairments or further deterioration of health through early intervention after the diagnosis of chronic illnesses. Many of the programs noted focused on medication management and utilized services of pharmacists.

In describing the innovative nature of these diverse health promotion programs agency directors, often noted, forging alliances with community agencies, including hospitals, churches and universities. Securing funding for these programs often represented major challenges and the triumph of implementing "discretionary" programs within a climate of funding limitations was a source of pride to area agency directors. Another important dimension of program innovation related to the active involvement of seniors both in program development and implementation. Many innovative programs comprised a partnership among community representatives, public agencies and elderly program participants.

It is noteworthy that innovative programming related to health promotion and disease prevention was typically associated with having a dedicated staff member working on these issues. Some directors indicated that using volunteers

due to funding limitations does not allow for carrying out substantial preventive programming. Our findings also underscore the creativity of AAA leadership in forging ahead toward innovative program development even within an environment of fiscal constraints. Directors indicated that they engage in private fundraising (51.8%), seek private grants (69.8%) and state grants (76.6%) and partner with other agencies (92.2%). In the case of public agencies, fundraising often requires the creation of a separate not-for-profit corporation that can accept private donations.

While solicitation of private funds and grants is pursued by AAAs, they most often (49%) identified lack of appropriate federal and state funding as an obstacle to program development for health promotion and disease prevention. Indeed, obstacles related to lack of staff acceptance, political environment or client demand, were seldom endorsed as significant problems. In their comments, directors frequently referred to the need for on-going funding for disease prevention and health promotion rather than funding of specific demonstration projects. They also indicated that they understood that “prevention is always cheaper than treatment.” However, when the conflict was between basic needs and preventive service, they were emphatic that basic needs would be given priority. As one director stated, “when you have to choose between giving someone a bath and printing a brochure on the latest food pyramid, the bath will win out every time (or at least it should).”

Area agency directors also provided useful information about the ethical dilemmas they face as they endeavor to ensure that critical basic needs of frail elderly can be met within existing funding parameters. While at the same time they also want to maintain a forward looking orientation directed at more discretionary preventive and health promotion services.

SUMMARY AND RECOMMENDATIONS

The demographic profile of the American population is changing. There were 35 million persons age 65 or older in the United States in 2000. It is expected that over the next thirty years the population age 85 and older will grow faster than any other age cohort. This “longevity revolution” will force policy-makers to reconsider how to use the aging network to enable seniors to lead longer, healthier and productive lives within their communities. The impetus for such action need not be based purely on altruistic motives. Financial considerations are already leading to major reassessments of health care delivery in the United States. The concern that Medicare and Medicaid programs will not be able to meet the needs of seniors by the middle decades of the century has already been raised in both conservative and liberal quarters of the American polity. Thus, it is likely that policy-makers will look to existing arrangements, such as the aging network, in the hope of finding common ground to build solutions that will maintain seniors in their communities longer in a cost effective manner.

Research confirms that investments in health promotion have substantial long-term pay-offs [31] Policies that support health promotion and disease prevention among older adults are likely to produce public health benefits [32]. In responding to increased life expectancy, policy-makers will need to consider how to enable AAAs to provide more health pro-

motion services to younger seniors in order to prevent the health declines that prove so costly over the long run. At present, policy works in the opposite direction. Most federal money (understandably) is being spent by AAAs to serve those in the frailest health. Yet this leaves AAAs with few resources to invest in the types of health promotion and disease prevention programs that are likely to be most cost effective and beneficial.

Another significant challenge is bringing social support into the domain of health promotion. As Marmot and others have so convincingly shown, health and social status are closely linked together [16, 33]. AAAs will need to be able to offer seniors more social supports, and to construct these in ways that are sensitive to the cultural, ethnic and community norms of the populations being served [34]. The good news is that AAAs are already implementing programs that are sensitive to the heterogeneity of their communities, and are organized in such a way that they are well positioned to understand the local needs of the seniors they serve. But additional resources will be needed to integrate social supports within their health promotion and disease prevention programs [35].

The special needs of minority, disabled and other “at risk” groups of seniors are known to AAAs and resources are specially earmarked to aid these groups. Yet the current framework does not provide sufficient resources for the substantial services that are needed to appropriately maintain them within their communities. The process of developing special programs that are designed to support “at risk” seniors within their communities is an urgent priority.

Each of these cases illustrates the need for rethinking current policies and priorities related to AAAs. Our survey suggests that the challenge to “think outside of the box” is one that many AAAs are already taking up as they develop new avenues for service delivery, advocacy and administration. They have already recognized the increased life expectancy, the value of preventive programs and the role that technology plays in promoting longevity. In addition, they have expressed a strong commitment to conduct outreach efforts and to collaborate with a wide range of public and private “partners.”

Our survey also indicates that AAA directors appreciate that service delivery does not occur in isolation. They are working with numerous service providers to find solutions to the challenges of longevity. AAA directors are also overwhelmingly supportive of the importance of disease prevention and health promotion. Yet they struggle with how to find the resources and collaborative partners to best implement such programs. They also must contend with differing population patterns and the challenges this poses to finding appropriate service providers, and with offering seniors access to these services. It is clear from the responses to our study that AAAs are prepared to work toward constructive solutions to meet the health and longevity needs of their clients. It is also apparent that AAAs are sensitive to historical patterns, financial realities as well as the opportunities to make a positive impact on their communities with modest increases in resources. While the future cannot be known, it is very likely that AAAs will have a major role in the implementation of an aging policy geared toward longevity in years to come.

REFERENCES

- [1] Leibig PS. Federalism and aging policy in the 1980s: Implications for changing interest group roles in the 1990s. *J Aging Soc Policy* 1992; (4): 17-33.
- [2] O'Shaughnessy CV. The aging service network: broad mandate and increasing responsibilities. *Pub Policy Aging Rep* 2008; 18(3): 1-8.
- [3] Manton KG, Lamb VL, Lamb X. Medicare cost effects of recent U.S. disability trends in the elderly. *J Aging Health* 2007; 19(3): 359-81.
- [4] Van Tassel DD, Stearns PN. *Old age in a bureaucratic society: the elderly, the experts and the state*. Westport, CT: Greenwood Press 1986.
- [5] Preston SH. *American longevity: past, present, and future*. Policy Brief, No. 7. Syracuse, NY: Center for Policy Research, Maxwell School of Citizenship and Public Affairs 1996.
- [6] Verbrugge LM, Jette AM. The disablement process. *Soc Sci Med* 1994; 38(1): 1-4.
- [7] Ory MG, Cox DM. Forging ahead: linking health and behavior to improve quality of life in older people. *Soc Ind Res* 1994; 33(1-3): 89-120.
- [8] von Gunten CF, Ferris FD, Emanuel LL. Ensuring competency in end of life care. *JAMA* 2000; 284(23): 3051-7.
- [9] Martin DK, Emanuel LL, Singer PA. Planning for the end of life. *Lancet* 2000; 356(9242): 1672-6.
- [10] Lothian K, Philp I. Maintaining the dignity and autonomy of older people in healthcare setting. *Br Med J* 2001; 322: 668-70.
- [11] Laslett P. *Household and family in past time*. New York: Cambridge University Press 1972.
- [12] Axxin J, Stern MJ. Age and dependency: children and the aged in american social policy. *Milbank Q* 1985; 63(4): 648-70.
- [13] Easterlin RA. The conflict between aspirations and resources. *Popul Dev Rev* 1976; 2(3/4): 417-25.
- [14] Chafe WL. *Women and equality: Changing patterns in American culture*. New York: Oxford University Press 1977.
- [15] Biegel DE, Sales E, Schulz R. *Family caregiving in chronic illness: Alzheimer's disease, cancer, heart disease, mental illness and stroke*. Newbury Park, CA: Sage Publications 1991.
- [16] Marmot M, Wilkinson RG. *Social determinants of health*. New York: Oxford University Press 2004.
- [17] Clarke PJ, Marshall VW, Ryff CD, Rosenthal CJ. Well being in Canadian seniors: findings from the Canadian study of health and aging. *Can J Aging* 2000; 19(2): 139-59.
- [18] Stokols D. Translating social ecological theory into guidelines for community health promotion. *Am J Health Promot* 1996; 10(4): 282-98.
- [19] Achenbaum A. *Old age in the new land: the American experience since 1970*. Baltimore: Johns Hopkins Press 1978.
- [20] Wanless D. *Securing our future health: taking a long-term view*. London, England: HM Treasury 2002.
- [21] Putnam R. *Bowling alone: the collapse and revival of American community*. New York: Simon and Schuster 2000.
- [22] Marmot MG. *The status syndrome: how social standing affects our health and longevity*. New York: Henry Holt 2004.
- [23] Cutler N. Aging and public policy: the politics of agenda setting. *Policy Stud J* 1984; 13(1): 111-3.
- [24] Elder C, Cobb RW. Agenda building and the politics of aging. *Policy Stud J* 1984; 13(1): 115-29.
- [25] Gelfand DE. *The aging network: programs and services*. New York: Springer Publishing Company 2006.
- [26] Binstock R. Changing criteria in old age programs: the introduction of economic status and need for services. *Gerontologist* 1994; 36(4): 726-30.
- [27] Krout JA. *Providing community based services to the rural elderly*. CA: Sage publications 1994.
- [28] Public Law. *The Older Americans Act of 1965*; pp. 89-73.
- [29] Ozcam YA, Cotter JJ. An assessment of efficiency among Area Agencies on Aging in Virginia through data envelopment analysis. *Gerontologist* 1994; 34(3): 363-70.
- [30] Lebowitz BD, Light E, Bailey F. Mental health center services for the elderly: the impact of coordination with Area Agencies on Aging. *Gerontologist* 1987; 27(6): 699-702.
- [31] Institute of Medicine. *Health and Behavior: The Interplay of Biological, Behavioral, and Societal Influences*. Washington: National Academy Press 2001.
- [32] McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Aff* 2002; 21(2): 78-93.
- [33] Berkman LF, Glass T, Brissette I, Seeman TE. From social integration to health: Durkheim in the new millennium. *Soc Sci Med* 2000; 51: 843-57.
- [34] Campinha-Bacote. The process of cultural competence in the delivery of health care services: a model of care. *J Transcult Nurs* 2002; 13(3): 181-4.
- [35] Kahana JS, Force LT. Toward Inclusion: A public centered approach to promote civic engagement by the elderly. *Public Policy Aging Rep* 2008 18(3): 29-34.

Received: December 17, 2009

Revised: March 09, 2010

Accepted: March 10, 2010

© Force *et al.*; Licensee Bentham Open.

This is an open access article licensed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>) which permits unrestricted, non-commercial use, distribution and reproduction in any medium, provided the work is properly cited.