Best Practices

Lessons for Communities

In Supporting the Health, Well-Being, and Independence of Older People

Center for Home Care Policy and Research
Visiting Nurse Service Of New York®

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About the Center for Home Care Policy and Research

Established in 1993, the Center for Home Care Policy and Research of the Visiting Nurse Service of New York works to advance knowledge that will promote the delivery of high quality, cost-effective care in the home and community and support informed decision-making by policy makers, providers, and consumers of home- and community-based services.

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About the Evergreen Institute on Elder Environments

The Evergreen Institute on Elder Environments is a nonprofit community development organization utilizing applied research and citizen participation to help localities plan for the lifespan community – a community that works well for young and old alike.

The Evergreen Institute on Elder Environments

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Foreword

This publication grew out of an initiative of the Center for Home Care Policy and Research of the Visiting Nurse Service of New York to help communities become more "elder friendly." Established in 1999, the AdvantAge Initiative: Improving Communities for an Aging Society is a community-building effort focused on creating vibrant, "AdvantAged" communities that are prepared to meet the needs and nurture the aspirations of older adults.

The Visiting Nurse Service of New York created the AdvantAge Initiative in response to the changing needs of an aging population. As the number of older adults in the United States grows – the overwhelming majority will remain in their own homes – and they prefer it that way. Although the vast majority of older adults manage quite well, others will need supportive services to remain independent, such as help with cleaning, shopping, and preparing meals. At the same time, those aged 85 and older are likelier than younger seniors to have disabilities that require more intensive levels of health care and support.

But older adults have more than just health care and support needs. Like people of all ages, they need and want opportunities for socialization and community engagement, among myriad other activities. The challenge for communities in the coming decades will be to create new ways of helping to meet the many needs of older individuals, while harnessing the unique contributions that older people have to make. In short, the approach to helping older adults "age in place" comfortably will need to change considerably.

The AdvantAge Initiative is a national collaborative project that seeks to help communities meet this challenge. At the heart of the initiative is a survey that can determine how well older adults are currently faring in their communities. Local groups can use the data gathered through the survey effort to help build broader awareness about aging, inform service and other planning efforts, and spur needed community-wide action in the nonprofit, public, and private sectors.

The AdvantAge Initiative focuses on four key areas where communities can make a difference in the lives of older adults:

- Basic needs for housing and security
- Maintenance of physical and mental health
- Independence for the frail, disabled, and homebound
- Opportunities for social and civic engagement

As researchers at the Center for Home Care Policy and Research began developing this project, they came across groups across the country engaged in a wide variety of efforts to address the needs of their older individuals. While the researchers' initial goal was to collect background information to help them create measures in the four key areas, they began to note the outstanding array of programs that were already achieving success in reaching their goals. From those observations, this study – to identify, explore, explain, and share a collection of "best practices" with others in the field – was born.

It is our hope that this publication, the result of this "best practices" study, will provide individuals and groups working to better meet the needs of their older adults with practical information to help guide their own efforts. Our aim, by presenting summaries of successful projects, along with lessons learned, is to help give readers a "head start" by identifying what other communities have done and what has and has not worked for them. Also, understanding how daunting it can be to create new programs, especially in an environment of budget constraints, we hope that the stories presented here provide some measure of inspiration and assurance that such undertakings are not only possible, but also can be enormously successful and can transform the lives of older adults and the nature of communities where they are aging in place.

Penny Hollander Feldman, Ph.D.

Director, Center for Home Care Policy and Research

Acknowledgments

First and foremost, we would like to thank all of those on the other end of the phone, tape recorder, and/or notepad who graciously took time to talk and meet with us. Many of these people helped pull together lists of individuals for us to interview, arranged meetings, and patiently got us from point A to Z during our site visits and phone interviews. This publication would not have been possible without their logistical support and enthusiasm for the initiatives in which they participate. For their collective unstinting hospitality and patience, we extend our heartfelt gratitude.

Due thanks also goes to The Robert Wood Johnson Foundation for providing the generous support that enabled us to conduct this project in the first place. We also extend our thanks to the Foundation for its key support of the AdvantAge Initiative, from which this publication was born.

We would also like to thank David Stevenson, who helped get the project off the ground; Vicky Ko, who kept the research team organized and on track; and our editor, Ray L. Rigoglioso, for his keen eye and commitment to bringing out the best in this material.

How To Use This Publication

This publication is written for a wide variety of individuals who are engaged in the process of helping their communities better meet the needs of older people: community activists, social service professionals, nonprofit leaders, government representatives, members of the business community, clergy, funders, and many more. It is designed to serve as both on-demand reference material and a comprehensive reporting on the work that 17 communities have undertaken to become more elder friendly. As such, each section contains information that may be of interest to readers at different times.

For a quick look at all of the 17 projects discussed in this publication, see the "Snapshot of the Projects Featured" section. It contains a short description of each project, including its goals, strategies, communities served, and lead organization, along with the page number where a longer description appears.

The "Project Briefs" and "Project Profiles" sections provide descriptions of the community projects. Overviews of ten initiatives are included in "Project Briefs"; "Project Profiles" includes more detailed descriptions of an additional seven initiatives.

If you want to get to the bottom line – what you can learn from the experience of these community initiatives – see the "Lessons Learned" section. Distilled from interviews and site visits, these lessons have broad applicability to people who are engaged in an effort to make their community more elder friendly.

And finally, the "Contacting Programs" section lists each project's contact information for those who would like to know more.

While this publication can be used as reference material, the authors encourage readers not to limit their exploration only to community issues or projects that mirror their own. All of the projects discussed here offer valuable lessons and helpful hints for communities interested in better understanding and meeting the needs of their aging citizens.

However you decide to use this publication, the authors wish you the best in your endeavors.

Introduction

Communities throughout the country are changing – and aging. Today, the number of people aged 65 and older is increasing significantly across the United States. Indeed, those aged 85 and older represent the fastest-growing segment of our population. By 2030, one of five Americans will be over age 65, and approximately 8.5 million will be 85 or older.

As the number of older people grows, the overwhelming majority will remain in their own homes – and they prefer it that way (AARP, 2000). In fact, contrary to popular perception of older adults relocating to retirement communities, those aged 65 to 85 are the least likely of any age group to move. This rapid growth of older individuals "aging in place" will present new opportunities and challenges to communities.

Many communities will have a larger population of vital, independent older residents who can be a source of substantial civic, social, and financial "capital," serving as volunteers and activists, board members and elected officials, funders and community leaders. Communities may also have to provide services to an increasing number of frail and disabled older adults, some of whom may have substantial health care, housing, transportation, and other needs.

The Center for Home Care Policy and Research of the Visiting Nurse Service of New York City wondered how community responses to these shifting demographics could inform one of its newest projects, the AdvantAge Initiative, which helps communities around the country become more "elder friendly" – more aware of the needs and aspirations of their older citizens and more responsive to them. In 2000, the Center teamed up with the Evergreen Institute on Elder Environments to identify and study promising community strategies to maximize the potential for older residents to remain active, engaged, and independent. This publication is the result of that study.

Ultimately, the team selected 17 community efforts to study, each of which has succeeded in bringing the needs of older citizens to the forefront of community agendas and creating change at the local level. These initiatives and the implementation strategies that community members have used represent what the research team considers "best practices" in the field. The team hopes that, by highlighting these strategies, this publication will serve as a helpful resource for other communities who are currently engaged in or are considering undertaking similar efforts.

Unfortunately, because of limited resources, the research team could not study all 17 projects in the depth that it would have preferred. For projects that are more narrowly focused, the team decided to assign one researcher to conduct a telephone survey with one or two key project members. These projects are summarized in this publication as "Project Briefs." For projects that have a broader scope and are more complex or that have faced more complex challenges, a team of researchers conducted multi-day site visits. These projects are featured as "Project Profiles." As such, the "Project Briefs" focus on key implementation strategies and outcomes from one set of projects, while the "Project Profiles" provide more detailed information on another group of projects. Experiences of and outcomes from all 17 projects are synthesized in the "Lessons Learned" section.

Because we had to be brief to create a readable and manageable publication, not every detail of the evolution and achievements of the projects could be included. "Project Briefs" are meant to give readers a taste of the topics addressed and key accomplishments. Though more in-depth descriptions than the briefs, "Project Profiles" may leave some readers still wanting to know more. Because we fully expect that some readers will want additional information about the projects described, we have included contact information for key personnel at the end of this publication and encourage readers to follow up with them if questions arise.

A Cross Section of Strategies

In an effort to present a cross section of promising community building strategies, the research team chose "best practices" that include a representative range of geographic locations, sizes and types of communities, scopes of work, groups involved, and institutional versus grassroots initiatives.

The projects featured in this publication are situated in small towns, large cities, and suburban neighborhoods. They include communities that range from a single high-rise housing complex to entire counties. They focus on issues such as transportation, home care, education, long-term care, information and referrals, older individuals who are at risk of nursing home placement, the well-elderly, older adults whose independence is compromised, and more.

Successful efforts often depend on broad-based collaboration, and the "best practices" featured here reflect the involvement and leadership of a variety of organizations and stakeholders. Collaborators include city and county governments, area agencies on aging, health and mental health care providers, social service agencies, advocacy groups, housing and transportation authorities, neighborhood and faith-based organizations, businesses, and philanthropies. Their initiatives range from single-handed efforts to highly coordinated initiatives involving dozens of organizations and individuals. And they include those that were begun at the grassroots level by a handful of dedicated volunteers and others that were initiated from the "top down."

Criteria for Inclusion as a "Best Practice"

To identify promising programs to study, the research team developed a set of criteria based on a theoretical "ideal" – the "essential elements" a community initiative should include to make it successful. The team fully expected that few, if any, projects would include all of these essential elements. Rather, the aim was to explore which of these elements a project had made a priority and why, and to identify how these elements were operationalized within each project. Articulating the selection criteria as "essential elements" may provide an added advantage: communities and organizations can use them as guidelines for designing their own initiatives.

In the search for exemplary community initiatives, the research team sought initiatives that would

1. Help older individuals with one or more of the following:

- Remaining active in their communities
- Living in a place of their own choosing for as long as possible
- Obtaining care and support when needed

2. Facilitate and encourage collaborative partnerships across

- Social service, health care, and other delivery systems
- Government entities
- Funders
- Advocacy groups
- Policy and planning organizations

3. Track a program's outcomes by measuring

- Numbers served
- Ability to reach new constituencies or participants
- Efficiency
- Effectiveness

4. Demonstrate sustainability in at least one of the following ways:

- Fostering local leadership and community ownership
- Becoming integrated into existing activities or networks
- Influencing the development of state and/or local policies that better support older adults

5. Have the potential for one or both of the following:

- Replication
- Generalization of results

Each community initiative highlighted in this publication fulfills the first two selection criteria. All are committed to helping older people remain in their communities and ensuring that they have the support to do so. To accomplish these goals, each also strived to achieve broad community participation by reaching across service systems and moving beyond traditional service and partnership boundaries in the community. Of course, the definition of "community" can vary tremendously: it can be a political entity, a cultural group, a geographic area, a group of like-minded people, and so on. The research team therefore deferred to the individual projects to determine how they defined their community. For example, a few projects defined it as the catchment area that the area agency on aging serves. Another project defined it based on feedback from consumer – for example, the 15-mile radius around a city that older individuals wanted to access. Thus, each of the projects featured here demonstrates broad community participation based on the project's own definition of community.

The extent to which each initiative fulfilled or even addressed the remaining criteria varies greatly.

Representatives of all of the community initiatives acknowledged the importance of **tracking outcomes** and affirmed their intention to do so, but few are doing it yet. Two factors likely contribute to this phenomenon. First, the concept and practice of outcomes-based measurement is relatively new to most service providers. While they are used to tracking "outputs" – the number of people who called a hotline, for example, or the number of people that have come through the facility – most are less experienced in tracking true outcomes, such as whether a project has extended the amount of time a person can live independently in the community, or whether it has improved someone's health status. And second, tracking outcomes is simply more time consuming, exspensive, and challenging than tracking "outputs."

Not surprisingly, outcomes measurement is not always a priority for these groups. While everyone interviewed acknowledged that it could help track progress and improve quality, they also maintained that, given the realities of limited resources, their funds and efforts were better spent getting critical services to those in need. Thus, evaluations focused more on tracking outputs and on gathering and responding to feedback from stakeholders to help improve service impact and quality and the collaborative relationships that are at the core of most of these efforts.

All of the initiatives recognize the importance of **sustainability** and are working toward it in different ways, but one common theme that arose was the concern about ongoing funding. Most initiatives operate through a patchwork of public and private financial support, in-kind donations of staff, space, equipment, etc., and volunteer time and expertise. Long-term viability means juggling funding for competing needs and navigating shifts in community and governmental priorities. While all of the initiatives are surviving and many are thriving, each expresses concern about the future and recognizes that ensuring funding is a continuous effort

Replication and generalization of results, the research team discovered, are not synonymous. All of the initiatives had ideas worth sharing and concepts that could apply in other contexts (see the "Lessons Learned" section).

Replication, however, is more complicated. Programs that work in one community may or may not work elsewhere. Ultimately, while all of the initiatives highlighted here have lessons to share and can be replicated, success will be based on the skill and sensitivity with which they are adapted to local conditions.

In the end, the research team observed that successful community initiatives exhibit excellence in

- Working with stakeholders
- Using knowledge and information effectively
- Selecting leadership
- Cultivating and maintaining relationships
- Communicating effectively
- Adapting to change

Each of these factors is discussed fully in the "Lessons Learned" section and placed in the context of the individual initiatives. These lessons are broadly applicable and essential to *all* community efforts to create more elder-friendly communities. By sharing these lessons, along with the strategies and innovations that these 17 communities developed – in addition to the challenges they faced – the authors hope that this publication will help other communities improve their capacity to meet the needs of their aging citizens.

Snapshot of the Projects Featured

Project Briefs

Project Name & Location	Type of Community	Type of Lead Organization	Project Purpose & Strategy	Page Number
Creating an Aging Prepared Community Capital Region of New York State	Suburbs and rural communities around Albany	School of social welfare	To enhance the regional service infrastructure to help maintain older people in the community through a broad-based coalition that addresses concerns identified in the community.	11
Elder Alliance Waynesboro, Virginia	Rural community	Area agency on aging	To meet growing needs with shrinking resources by offering a forum for providers to develop new service strategies, share resources, and coordinate efforts.	12
Elder Friendly Communities Project Calgary, Alberta, Canada	Neighborhoods in a metropolitan city	School of social work	To see if the community development process can help make neighborhoods more elder friendly by launching a community change project in four different neighborhoods.	13

Project Profiles

Project Name & Location	Type of Community	Type of Lead Organization	Project Purpose & Strategy	Page Number
Champlain Long-Term Care Coalition Burlington, Vermont	Urban/rural community	Community-based citizens' committee	To support people as they age in place and decrease nursing home admissions by providing services on-site in senior housing complexes.	21
Elderhostel Pittsburgh Program Series Pittsburgh, Pennsylvania	City and surrounding area	Private foundation	To enhance the quality of life of well elders by adapting an existing program model and capitalizing on local resources.	24
Gatekeeper Program of Multnomah County Portland, Oregon	Portland and surrounding area	County Aging and Disabilities Services Department, which also serves as the area agency on aging	To identify at-risk older people and provide assistance before a crisis occurs by replicating a successful program model that trains service people in the community to make referrals.	28
Heritage Harbour Health Group Annapolis, Maryland	Private retirement community	Nonprofit group created by residents	To allow residents to remain at home as they age by creating a home care and supportive service model "from the ground up."	31
Independent Transportation Network™ Westbrook, Maine	City and surrounding rural area	Independent organization	To provide transportation, and encourage older people to stop driving when they should no longer do so, by researching and creating a new program geared to the very specific transportation needs of a rural community.	34
Rothsay PARTNERS Program Rothsay, Minnesota	A small town comprised of 7 sparsely populated townships	Independent organization	To provide support to older people in extremely rural communities through better coordination and more effective use of existing resources and increased community support.	37
Plan 2000: Visions for the Future Baltimore County, Maryland	Suburban County	Area agency on aging	To successfully compete for recognition and resources within a large government bureaucracy by bringing attention to aging issues and the needs of older people through citizen-run committees.	40

PROJECT BRIEFS

Project Name: Creating an Aging Prepared Community, Capital Region of New York State (the area surrounding Albany, New York)

Lead Organization: Center for Excellence in Aging Services, University at Albany

Purpose: To create a community that is prepared to meet the needs of its aging members

Description

This project was established in November 2001, with foundation support, to address long-standing community concerns about the needs of its older residents. At the time of this writing, it was in its start-up phase. The project aims to create an exemplary community environment that is well prepared to meet the needs of its members as they grow older and to help them age in place. With the guidance of the Center for Excellence in Aging Services, an advisory group examined the service needs and preferences of older people in the greater Albany area. A region-wide strategy has emerged, focusing on two issues: 1) reducing initial hospitalization and institutionalization among older people in the community who have health care needs; and 2) reducing re-hospitalization and re-institutionalization among older adults with continuing health care needs who are discharged home from the hospital. Addressing these two issues is viewed as critical to addressing the needs of older people residing in the Albany area.

Achievements Thus Far

- More than 40 organizations and individuals are on the project advisory board, a good indication that a variety of community voices will be heard and their needs and preferences considered.
- The governor's office is supporting the effort, which will help attract other institutions to participate, including hospitals and health systems.

Why It Works

- When the Center for Excellence conducts outreach for the project, whether it be through individual meetings, presentations at groups, or in written materials, it makes a concerted effort to convey to members of the community that, as participants in the project, they will have an active role in shaping the aging preparedness agenda.
- Foundation support pays for a dedicated, full-time coordinator for whom this project is the sole priority.
- The project has set a goal – to identify at least five aging-related community issues that need to be addressed – and established a timeline for having an action plan in place.

Fringe Benefits

- The project is working on developing a transportation network to help older people get to and from medical and other appointments during the week. The faith community has expressed interest in expanding this system by purchasing trips on weekends to enable older members to attend religious services.
- Discussions about discharging older people from the hospital have led to a new collaboration between hospital discharge planners and a parish nurse. The nurse will work with discharge planners to ensure that health care and social services are in place for older people when they arrive home from the hospital. The nurse will continue to manage these individuals' care and will serve as a liaison between them and the hospital.

Future Objectives

- To ensure the ongoing, active involvement of key decision makers who exert influence in the community and control resources. "The kick-off is always exciting," one member of the project said. "It's keeping people involved for the long haul that's hard."

Project Name: Elder Alliance, Waynesboro, Virginia

Lead Organization: Valley Program for Aging Services (Area Agency on Aging)

Purpose: To pool resources to ensure service provision in a resource-poor community

Description

Valley Program for Aging Services headed up the development of the Elder Alliance, a network of community service providers, businesses, and community members interested in developing a more aging friendly community. The Alliance's goal is to improve the health and well-being of Waynesboro's older adults by working together to fill in the gaps in aging services in the area. The Alliance identifies needs and service gaps and develops collaborative solutions, maximizing and leveraging the area's limited pool of resources.

Achievements Thus Far

- A speaker's bureau comprised of local experts from Alliance member organizations provides information on everything from adaptive equipment to depression. (See http://shentel.net/elderweb/ and click on "Elder Alliance Speaker's Bureau"). Speakers are available to any group interested in learning more about aging issues. The speaker's bureau has fostered greater cohesion among participating member organizations and has increased their commitment to the Alliance.
- *Seasons Plus*, the Alliance's bi-monthly insert in the local newspapers, provides information about productive aging and community services available to older people. Because it is part of the local newspapers, *Seasons Plus* reaches community members of all ages and keeps the "aging agenda" on everyone's mind.
- A database of area home care providers makes locating home care much easier for older people and for long-distance family caregivers, an issue in most rural areas.

Why It Works

- Valley Program for Aging Services serves as the lynchpin for Elder Alliance, providing staffing, fleshing out the Alliance's ideas, and coordinating the efforts of various providers.
- Elder Alliance acknowledges turf issues and openly addresses them. Members take the time to discuss whether new ideas threaten existing programs or providers and find ways to work together toward the "ultimate goal"– to provide the best services they can to older people in the community.
- The Alliance maintains regular communication among its members, including meetings and monthly newsletters, to keep all members in the loop and to serve as a reminder of its activities.

Fringe Benefits

- Familiarity breeds cooperation. As member organizations have worked more together, they have developed greater trust and a willingness to lend each other a hand.

Future Objectives

- To develop a multi-generational day care center.
- To get more older individuals involved in the Alliance. "It's been an uphill fight," one member said. "Younger seniors are busy, and those who are frail and older often can't get to our meetings."

Project Name: Elder Friendly Communities Project, Calgary, Alberta, Canada

Lead Organization: University of Calgary, Faculty of Social Work

Purpose: To empower older people to change their communities to better meet their needs

Description

The Elder Friendly Communities Project is a multi-year research effort examining how the community development process works when addressing the needs of older citizens. In early 2001, the Faculty of Social Work at the University of Calgary held focus groups and community meetings throughout Calgary to identify issues of concern to older people. The Elder Friendly Communities Project then helped four communities prioritize their concerns and develop committees to address those concerns. Besides conducting research, the project provides training and technical assistance to help these four communities put their ideas into action.

Achievements Thus Far

- Committees have formed in each of the four communities, and each has prioritized the concerns of older adults within its own community.
- During a monthly forum, developed by the Faculty of Social Work, representatives from all four communities come together to learn more about the foundations of community development and to brainstorm how to make it work for them.

Why It Works

- Focus groups and community meetings helped identify formal and lay leaders of all ages who would be likely to step forward and spearhead the effort in their communities.
- From the beginning, the focus has been on selecting partners who lend credibility to the project and who have something meaningful to contribute in terms of ideas and energy, in-kind contributions, staff, hard dollars, and access to other people and resources. This practical approach also ensures that stakeholders are committed to the project because they have invested something in it.
- The Faculty of Social Work offers a level of expertise and free technical assistance that communities would probably otherwise be unable to access.
- The reputation of the Faculty of Social Work brings a level of credibility and importance to the project that helped win the attention of both older adults in the community and potential project partners.

Fringe Benefits

- Older adults are connecting with one another in new and different ways. Many have never met before, and those who had are now learning about each other's skills and strengths.
- More older people are realizing that they have a voice and can effect change for themselves and their peers.
- Social service providers and others involved in the project are honing community development skills "in the trenches," with the guidance of members of the Faculty of Social Work.

Future Objectives

- To develop strategies and interventions that address the needs identified in each community
- To identify additional communities in Calgary in which to implement the community development model
- To replicate the model and study it in other cities in Canada and in other countries

Project Name: Just1Call, Mecklenburg County, North Carolina

Lead Organization: Just1Call

Project Purpose: To better connect older people and their family caregivers to the information they need about social and supportive services

Description

Just1Call is a free, one-call way to access information about programs and services for older and disabled people in Mecklenburg County, North Carolina. It is available to older people, adults with disabilities, family caregivers, service providers, care managers – anyone who wants information about services in the area. In addition, the Just1Call emergency line, staffed by professional social workers, is available 24 hours a day, seven days a week. Just1Call also maintains a website with a comprehensive database of area services. Just1Call staff follow up to ensure that callers received the information they needed and were able to access services. Staff also provide home assessments, when appropriate.

Achievements Thus Far

- In its first four months of operation, Just1Call received 2,400 calls and made 6,800 referrals to more than 500 agencies throughout Mecklenburg County.
- Just1Call provides assistance in more than 140 languages.

Why It Works

- Planners sought and used input from potential consumers to shape the service. Older people said that they wanted a "live person" to pick up the phone and that they did not want to be put on hold, transferred, or given another number to call. As a result, callers to Just1Call immediately speak to a social worker who knows the community and available services.
- When planners could not find a software package on the market that met their needs, they hired a software consultant to create a system "from the ground up." This process also helped them clarify their goals and identify strategies to achieve those goals.
- Just1Call constantly markets its service to the community through television advertising, articles in the print media, and face-to-face contact with staff. It has found that, over time, word-of-mouth and referrals from "satisfied customers" have been quite effective in spreading the word.

Fringe Benefits

- The website makes it easier for long-distance family caregivers to provide for their older loved ones' care.
- Members of the Just1Call advisory group remain committed to and excited about the project. They are the "eyes, ears and mouths in the community." They "talk it up" and bring issues and concerns, as well as ideas for project expansion and improvement, back to Just1Call staff.

Future Objectives

- To better reach underserved older people, including racial and ethnic minorities and non-English-speakers
- To extend current information line hours from 8:00 a.m. to 5:00 p.m. weekdays to 8:00 a.m. to 8:00 p.m. and add service from 8:00 a.m. to 2:00 p.m. on Saturdays
- To identify and measure outcomes related to marketing and to the service's impact on consumers and providers. "It's easy to measure outputs – the number of calls, referrals made, and the like," one staff member said. "It's much harder to identify and measure if you've really made a difference in people's lives"

Project Name: Lapham Park Venture, Milwaukee, Wisconsin

Sponsor: Housing Authority of the City of Milwaukee

Project Purpose: To improve service delivery and coordination for older people in a city housing project for low-income older adults

Description

Lapham Park Venture created a coordinated care model that includes disease prevention, socialization, assisted living, and health care services. It provides a higher quality and more comprehensive array of services to Lapham Park's 212 residents than did the previous, loosely integrated model. Today, residents receive coordinated care on site from more than 20 provider agencies and 200 specialists. In addition to medical services in a newly renovated on-site facility, residents asked for amenities that encourage recreation and social interaction, which Lapham Park staff recognize are also important to residents' social *and* physical well-being. Lapham Park now boasts a craft room, Golden Gloves Gym, congregate dining area, barber and beauty shop, movie theater, billiards room, and therapeutic whirlpool facility.

Achievements Thus Far

- Most (75%) of residents surveyed reported they have most of their health care and supportive service needs met on site.
- With the assistance of Lapham Park Venture staff and other resources, 91% of residents experiencing lease violations were able to preserve their tenancy.
- According to Lapham Park Venture's research, more than $1 million in Medicaid nursing home costs are saved annually because residents receive earlier and less costly care at home.

Why It Works

- The group did its homework. In its planning process, it identified the resources – both personal talents and existing service capacity – in the building and throughout the surrounding neighborhood and community. Lapham Park engaged individuals and organizations in the planning process and continues to work with them.
- The project employs an "investor model" of participation in which everyone must bring an asset to the table. Partners are informed upfront what is expected of them. "All partners understood their stake in the project ahead of time," a staff member explained, "and came to the table prepared to offer the resources that were necessary to get the job done."

Fringe Benefits

- Residents feel a stronger sense of community and concern for one another. They now look out for their neighbors and knock on their doors if they have not seen them in a few days.
- Lapham Park has developed relationships with foundations that were previously improbable. Although most foundations will not directly fund a city housing authority, several have recognized the value of the project and are providing funding to support the involvement of Lapham Park's partners and collaborators.

Future Objectives

- To replicate the project in another low-income senior housing facility in Milwaukee
- To develop a more rigorous evaluation plan using outcome measures to track cost savings of medical and social services as well as changes in residents' quality of life

Project: Mather Café Plus, Chicago, Illinois

Lead Organization: Mather Lifeways

Project Purpose: To serve older people who are not interested in attending traditional senior centers

Description

Mather Lifeways created attractive storefront venues that have become "hang-out" places for older adults, with food as the chief lure. Designed by an architect who successfully avoided the institutional look, the cafés offer reasonably priced, varied menus and opportunities to take advantage of programs and services that older adults find interesting and/or vital to their independence. Offerings include exercise programs, computer classes, information and assistance, and opportunities to meet with a nurse or social worker to discuss individual concerns. Becoming a member provides access to classes at a discounted rate. The café menu and the services and daily programs offered were all created based on feedback provided by older community members through needs assessments, surveys, and focus groups.

Achievements Thus Far

- Three cafés are open and operational in three neighborhoods in Northwestern Chicago.
- Mather Lifeways has opened an additional "Café Without Walls" in a church in another community, offering lunch and a lecture or another activity once a month. An average of 300 older people attend each month, suggesting that this neighborhood may be a site for an additional café.
- More than 2,800 have taken computer classes at the cafés, 80% of whom have gone through multiple levels of the classes – there are four levels, plus some specialty classes. Ages of class participants range from 55 to the early 90s.

Why It Works

- A great deal of attention was paid to the design of the cafés, and the cozy environment draws people in.
- Because older people were involved throughout the planning process, they feel ownership of the project and have become its spokespersons.
- Older adults contributed the ideas and the Mather staff did the planning and "legwork"– an arrangement that capitalized on each group's strengths.
- The Mather staff did the preparation they needed to do. To help identify safe and accessible café locations, staff conducted "stake outs" to examine where older people in these neighborhoods go and how they get there. They also consulted with the police about the safety of each of the potential café sites.

Fringe Benefits

- Cafés have raised the three neighborhoods' level of activity, increasing pedestrian and automobile traffic and providing more customers for area businesses.
- Younger people who work in the areas come to the cafés for lunch, making the atmosphere more intergenerational.
- The local alderman has become very supportive of the concept and states he is proud to have them in his district. Older residents (who vote!) tell him how much they like the cafés.

Future Objectives

- To integrate a health care component into the cafés and to find a health care partner that excels in community outreach and shares the cafés' commitment to member-driven services
- To get older people more involved in teaching classes and staffing the cafés
- To keep programming current and interesting
- To use the cafés as bases of operations to serve homebound community members

Project Name: The Millennium Project, Tompkins County, New York

Lead Organization: Tompkins County Office for the Aging (Area Agency on Aging)

Project Purpose: To engage service providers and older adults in a rural county in developing and supporting a community-wide aging services plan

Description

The Tompkins County Office for the Aging brought together a broadly representative group of professional and lay community members to conduct a survey and information-gathering effort. Their goal was to identify the critical and emerging needs of older people in the area. The Office for the Aging created eight task forces, which gathered information about older adults and their caregivers in the following areas: health status; health care financing; housing; income and employment; leisure and volunteerism; long-term care; mental health; and transportation. The Office for the Aging facilitated the task forces, provided staffing and expertise, and developed a timeline and administrative structure for the overall effort. Task force findings and recommendations were collected and published as the *Millennium Report*. The Office for the Aging is now implementing the report's recommendations.

Achievements Thus Far (based on *Millennium Report* recommendations)

- Information on benefits and entitlements for older people is now available at the local Social Security office and through the human resources departments of the county's larger employers.
- The local print media carry better information about transportation options for older people.
- The local high school is implementing a gerontology curriculum.
- The county implemented a dental care program for low-income older individuals who had been excluded from a dental plan available through social services.
- After the *Millennium Report* recommended disseminating information on herbal remedies for older adults, a local hospital put this information on its website and routinely assesses herbal remedy use in all new older patients.

Why It Works

- The *Millennium Report* required the input of and ownership by the community, which collected the information and determined priorities. Early buy-in ensured ongoing support for implementing recommendations.
- The Office for the Aging provided a structured plan, timeline, and staffing support so that task force members could focus on collecting information and generating ideas.
- The director of the Tompkins County Office for the Aging is known and respected throughout the county. People look to her as a leader and expert on county-wide issues.

Fringe Benefits

- Sitting on task forces together helped solidify relationships between organizations, ensuring better working relationships and collaboration beyond the defined scope of the project.
- The very act of implementing the report's recommendations requires ongoing public relations and outreach efforts that not only highlight specific new projects but also continue to raise awareness about the needs of older county residents and the services available to them.

Future Objectives

- To develop arrangements with private cab companies or drivers for picking up older adults who cannot walk or find rides to public bus stops
- To develop a medical day-care facility
- To examine issues regarding guardianship for nursing home residents

Project Name: The Novato Independent Elders Program, Novato, California

Lead Organization: Margaret Todd Senior Center

Project Purpose: To help isolated older people maintain their independence and to eliminate cultural barriers to accessing services

Description

The City of Novato Independent Elders Program (NIEP) is a coalition of stakeholders – concerned older adults, community representatives, and service providers – who are interested in supporting the independence of Novato's older citizens, who comprise almost 15%, or 7,000, of the city's 48,000 residents. NIEP offers programs to support those who are frail and isolated, as well those who may encounter ethnic and cultural barriers in accessing services in the community. Examples of services include disaster preparedness information for older people and community education workshops on aging issues for older people, their caregivers, and families. NIEP also provides neighborhood outreach programs such as a postal carrier alert program (in which mail carriers report activities that might indicate a health or other emergency), a yard maintenance program, and information about senior housing. Providers work together to ensure that programs and services are available and accessible not only to the English-speaking majority, but to non-English speaking and minority populations.

Achievements Thus Far

- The home delivered groceries project allows older people to send in their orders, which are bagged and delivered to them. This is essential to older area residents who can no longer drive, since convenient public transportation is not available.
- NIEP-hosted forums raise awareness of elder abuse and let professionals and citizens know how they can help identify and prevent it in their community.

Why It Works

- Creative funding methods help ensure the program's long-term viability. The program employs a full-time supervisor, whose salary is funded by the Parks and Recreation Community Services office, a relatively stable funding source. Operating expenses come from grants from a community foundation, as well as other sources. The program supervisor works out of a senior center that also provides clerical assistance, meeting space, and phone and fax services. The city Finance Division helps with fiscal reporting and paperwork.
- NIEP is based on partnerships with local public and private organizations, and this division of labor makes the program successful. This collaborative approach to funding helps ensure the commitment of a broad group of partners in the community, all of whom are invested in the program's success.
- NIEP aggressively seeks media attention. It is constantly reminding the entire community about important aging-related issues and letting older people and their families know that NIEP is there to help.

Fringe Benefits

- Constant activity keeps aging issues at the forefront of the community agenda. This builds even more momentum for additional activities.
- Older adults have become very active in the program, doing much of the work that paid staff in the community do not have the time to do. For instance, some make presentations on falls prevention to groups based on a pre-established curriculum.
- The program has promoted community involvement in ways it never anticipated – many of its clients have become volunteers. "They came to us for help," a staff member explained, "and then realized they had a lot to offer."

Future Objectives

- To continue to nurture and sustain partnerships and the support of volunteers
- To continue to identify and address the gaps in service to Novato's older residents

Project Name: Planning for Elders in the Central City (PECC), San Francisco, California

Lead Organization: Planning for Elders in the Central City

Purpose: To mobilize service providers to collaborate and work creatively to better serve older people and their caregivers in San Francisco

Description

Planning for Elders in the Central City (PECC) was established in 1991 as one of ten coalitions funded by a group of San Francisco Bay Area foundations interested in promoting collaborative work on issues related to aging and independence. PECC began as a steering committee of nonprofit organizations and senior groups working toward one goal – making a sustainable difference for frail elders and family caregivers in San Francisco's Tenderloin and South of Market district. PECC provides leadership and advocacy, bringing together older adults, service providers, government agencies, and other stakeholders to enhance the independence of area older adults and people with disabilities. Serving as a catalyst for change, PECC brings ideas to the forefront and helps the community turn those ideas into programs and services that help older people. Through a needs assessment, PECC identified four areas where community members saw a need for action: 1) improving the funding for and availability of home care services; 2) increasing funding for and coordination of health and supportive services in older adults' homes to help them successfully "age in place"; 3) creating empowerment training and advocacy opportunities for older adults in a range of languages; and 4) rebuilding a sense of community, regardless of age, disability, or language.

Achievements Thus Far

- Senior Survival School is a multilingual education and training program that teaches older adults how to access community-based health and supportive services. (See www.seniorsurvivalschool.org for more information.)
- Empower University (Empower U!) provides education, training, and support for long-term care consumers of all ages and teaches self-advocacy for daily life.
- The Homecare Empowerment Research and Organizing Project (HERO) works to improve home care workers' job skills and offers leadership training to home care and long-term care workers.
- Healthcare Advocacy Team (HAT) is a coalition of seniors, people with disabilities, caregivers and community agencies working together to advocate for the increase and expansion of homecare services and affordable, supportive housing and improvements to discharge planning. HAT uses theater, song, storytelling and other popular education and participatory research models to raise awareness of the growing need for quality services and housing and the important role they play in the community.

Why It Works

- PECC stays true to its community organizing philosophy, helping older citizens to manage their own needs, act as their own advocates, and to have a voice in identifying and solving the problems in their own neighborhoods and communities.
- Partners, providers, and stakeholders are active participants in decision-making, and the group is open to anyone who wants to be there. All new initiatives are researched, planned, launched, and sustained with broad-based community support.
- PECC keeps its messages interesting and memorable. Specially written songs, skits, and other creative tools are used to hone issues to their most important components, raise public awareness, and build community.

Fringe Benefits

- PECC's wide range of programs has resulted in creative partnerships that cross traditional service boundaries.

Future Objectives

- To better develop and strengthen its board of directors and advisory structures to ensure its long-term growth and viability
- To diversify funding sources, including expanding its funding base to include more major donors and grassroots supporters
- To take full advantage of the Internet to share PECC's consumer- and work-oriented information

Project Name: Project Access (Med-ZIP)

Lead Organization: Special Transportation Services, Inc. (STS), Nashville, Tennessee

Project Purpose: To provide affordable transportation to medical appointments for older adults who no longer drive

Description

Project Access, which is run by Special Transportation Services (STS), is a patient transportation program combining creative scheduling of trips with a subsidy program. Approximately 100 medical offices and clinics within a 15-block area in Nashville have agreed to refer to a patient ZIP code chart before scheduling an older patient's appointment. This chart displays when specific carriers have vehicles pre-positioned in different ZIP codes throughout the city, usually due to other passenger commitments.

Since all the clinics and offices in one destination area use the same ZIP code chart, many passengers can be scheduled inbound at the same time with the same carrier. Cost reduction is possible because of several factors: 1) financial incentives from programs such as the federal Congestion Mitigation and Air Quality (CMAQ) program and the state's Coordinated Transportation Assistance Program (CTAP) encourage group travel; 2) the area agency on aging, city and state human resource agencies, the United Way, and others subsidize trips by offering coupons that passengers can purchase at a discount and use with participating taxi companies; and 3) some clinics subsidize Project Access as a way to enhance their patients' well-being *and* help eliminate costly no-shows and late cancellations due to transportation problems.

Achievements Thus Far

- Project Access has been able to reduce clients' taxi fares by as much as 85%.
- Using ZIP codes for scheduling has allowed transportation providers to plan and batch transportation and improve the efficiency of each trip. Since they get to their appointments on time, clients' transit and wait time to see their health care providers is reduced.

Why It Works

- STS framed the issue of missed medical appointments as a controllable factor with a cost impact on health care and transportation providers.
- STS was prepared. To prove it would work, it went to transit providers armed with data about the number of people who needed transportation and to medical providers about the cost of no-shows.
- Everyone wins. STS has shown medical providers that collaborating to schedule appointments by ZIP code and subsidizing patients' travel costs can help avoid lost revenue by reducing missed appointments due to patient transportation problems. Transportation companies are also assured of passengers. Clients are less worried about whether they can get to and from appointments and whether they can afford it.
- STS is diligent about identifying the transportation subsidies and assistance for which clients are eligible, such as Medicaid-funded and Americans with Disabilities Act (ADA)-mandated transportation, and making sure they receive it. Those not eligible for publicly subsidized transportation receive private subsidies in the form of coupons from local health care providers and others.
- The administrative costs associated with Med-ZIP are modest because STS does not directly coordinate trips. Health care providers and patients call STS to find out when discounted transportation is available and then call the carriers directly to schedule a trip.

Fringe Benefits

- The opportunity for shared rides encourages social contact.
- Medical support staff spends less time coordinating transportation services and following up with clients who miss appointments.

Future Objectives

- To extend the Med-ZIP model to hospitals by placing Med-ZIP transportation resource desks, staffed by STS staff, in or near hospital lobbies
- To use vehicles during low rider demand for home health monitoring
- To encourage carriers to offer non-medical transportation, such as shopping and bank visits, based on the same ZIP code strategy and economies-of-scale rationale

PROJECT PROFILES

AT A GLANCE

Champlain Long-Term Care Coalition

Burlington, Vermont

Project Purpose: To meet specific community-based needs within the parameters of a state-run initiative

Background: Vermont has a history of supporting the expansion of home- and community-based services. In 1996, in keeping with this tradition, the state passed Act 160, which required the state's Department on Aging and Disabilities to create 10 regional long-term care coalitions. One goal was to shift Medicaid funding away from institutional long-term care and into home- and community-based services. The second was to ensure that national managed care companies did not usurp local control of the service delivery system by giving the local community more decision-making power. The challenge for the community coalitions was to meet their older citizens' service needs while meeting the state's mandate and reporting requirements.

Description: The Champlain Long-Term Care Coalition (CLTCC) was one of the community coalitions created as a result of Act 160. Its initial project provided health care and supportive services to relatively well elderly in two housing projects in Burlington. CLTCC's goal was to prevent hospitalizations and nursing home placement, and the state was interested in the model, but it did not adequately demonstrate cost savings. The state's adjustments to the model include focusing on at-risk elderly who are more likely to need institutional care if not treated proactively in the community.

Highlights:

- The Champlain Long-Term Care Coalition's "Wellness Project" was the basis of a state-wide model of community-based care.
- RNs provide a range of services, from baseline health assessments to preventative care to hands-on care if it is not available from other sources in the community.
- The Champlain Long-Term Care Coalition is the recipient of a Robert Wood Johnson Foundation "Community Partnerships for Older Adults Development Grant," which will allow them to plan for expansion of their coalition and the range of services they offer to older adults in their community.

Champlain Long-Term Care Coalition

Burlington, Vermont

Background

Vermont's Act 160, passed in 1996, requires "consumer representation, participation and oversight . . . in the planning and delivery of long-term care services." In accordance with this mandate, Vermont's Department on Aging and Disabilities (DAD) authorized the creation of 10 regional long-term care coalitions. The State's efforts were motivated by two primary factors. The first was their long-standing desire to shift Title XIX (Medicaid) funding for long-term care to non-institutionalized, community-based settings. The second was the Department's concern about national managed care organizations impinging upon or possibly usurping local service planning and delivery.

Why it works: The state of Vermont created a context and structure in which to start the initiative and provided local coalitions with the latitude to do what was needed in their communities.

The Champlain Long-Term-Care Coalition (CLTCC) and the Department on Aging and Disabilities have collaborated to design and implement a locally meaningful service plan within the framework mandated by Act 160. The Coalition and DAD have worked together to: 1) identify and negotiate a number of issues related to the tensions between the needs of state policy initiatives and local autonomy; 2) meet state reporting requirements while investing as much as possible in service provision at the local level; and 3) craft a consensus on defining and targeting the most effective health interventions for older adults.

In 1997, the CLTCC (which covers much of the Champlain Valley area in Northwestern Vermont) applied for and received a planning and program development grant from the Department on Aging and Disabilities. Its goal was to involve a broad range of community members (service and health care providers, policy makers, citizens of all ages, legislators, and business representatives) in designing and overseeing the implementation of a new service to meet the health care and supportive services needs of older people living in the greater Burlington area.

Why it works: The state gave coalitions the resource they needed most – money – and trusted each community coalition to involve the people they needed to get the job done.

Potential project topics were drawn from a previous regional long-term care planning effort known as "CAILS" (Community Assisted Independent Living System). A thread of continuity was maintained between those active in the CAILS process and those who participated in the early formation of the Coalition. This helped ensure that ideas brought forth as a result of CAILS were adequately considered by the newly emerging Coalition.

After reviewing the CAILS report, the Coalition selected ten issues that appeared particularly important, developed criteria to rank projects, and created a grid to help recognize an emerging consensus. Examples of the criteria include: 1) whether the proposed project was something new for the community; 2) whether the project was likely to be successful; and 3) whether the project could make a meaningful difference within the Coalition's budget limitations. While this process fulfilled the Coalition's understanding of its mission and charge, the program it chose to develop and implement did not necessarily meet the requirements of Act 160, which the Department on Aging and Disabilities felt obliged to enforce. This engendered a need for the reassessment and clarification of goals at both the local and state levels.

The Program

The CLTCC decided to focus on maintaining the well-being of relatively healthy older people. The plan? Provide health care services by having a part-time RN working in two congregate housing facilities in Burlington. This effort was geared to assessing and monitoring the population generally known as "well elders" in order to prevent or delay their potential future transfer to a nursing home environment.

Originally called the "Wellness Project," it provides residents with baseline health assessments and preventive and educational services, including blood pressure checks, glucose screenings, foot care, and smoking cessation and exercise classes.

Although the DAD was interested in the model developed by the Coalition, it was compelled to change the intent of the Coalition's wellness program because Act 160 requires DAD to demonstrate how it saves long-term care dollars by utilizing home and community-based care. Accordingly, using a risk assessment tool endorsed by DAD, RNs must now focus on semi-independent and frail elders who are more immediately at risk for nursing home placement. These residents are referred for appropriate services or care in the community; if unavailable, the RN may provide them. Ongoing monitoring helps ensure that at-risk residents continue receiving the services they need to keep them out of nursing homes. The Department's model has become institutionalized statewide and is known as "HASS," the Health And Supportive Services program.

The Coalition's initial pride in the state's adaptation of its original model has been somewhat tempered because the HASS program has virtually replaced the Coalition's original Wellness Project. DAD ultimately required the Coalition to embrace its focus on at-risk elderly rather than on relatively well elders. According to DAD Commissioner Patrick Flood, "All coalition proposals and projects have to show us how they are reducing nursing home utilization, and the Wellness Program didn't necessarily do that. If we can't demonstrate a savings from nursing home to community based long-term care, we're dead in the water."

This change in focus had consequences for local reporting requirements, record keeping, and assessment tools. DAD and the Coalition struggled together to clarify their evolving goals and contend with Vermont's historic ideological support for strong local autonomy within the limits of state bureaucracy. Despite their growing pains, the Coalition has been sought out by the local hospital and the DAD to help with aspects of their respective strategic planning efforts. The Coalition is, therefore, increasingly recognized by other health care providers as an important partner in planning initiatives. Coalition members view this as a clear sign that the Coalition is "maturing" and becoming a critical link in the area's community-based long-term service network.

Partnerships and Collaborations

The original team of collaborators that applied for and received funding to launch the CLTCC included representatives from the local Visiting Nurse Association, the hospital (Fletcher-Allen), a faith-based affordable housing development firm (Cathedral Square), and the regional Area Agency on Aging. Once funding was awarded, this core group recruited additional members representing consumers and other providers and advocates, including representatives from a transportation agency providing services for the disabled, a local legal aid provider, a human services agency, a nursing home, a local community economic development entity, and another community-based nursing service.

Funding

In addition to funding from DAD, the Coalition has received in-kind support from Fletcher-Allen Hospital and from the senior housing facilities in which the HASS programs now operate. The RNs working in the housing facilities are hospital employees and Fletcher-Allen picks up a portion of their salaries. The housing facilities provide office space for the nurses and additional space for classes and screenings organized by the RNs.

Future Plans

The Coalition has intensively focused on identifying and bringing "to the table" as many stakeholders as possible. Coalition members know that future planning and program development initiatives will not be as successful as they might be without broad based input and support.

In the late summer of 2002, the Coalition was awarded a multi-year "Community Partnerships for Older Adults Development Grant" by the Robert Wood Johnson Foundation. These grants will "assist individual community partnerships in developing strategic plans to improve the systems developing long-term care and supportive services."

AT A GLANCE

Elderhostel Pittsburgh Program Series

Pittsburgh, Pennsylvania

Project Purpose: To enhance the quality of life and well-being of Pittsburgh's active older adults and to attract and retain older adult spending in the Pittsburgh region

Background: Pittsburgh's Jewish Healthcare Foundation became interested in the quality of life of active older adults in the community. The Foundation saw this as related to its goal of creating a new paradigm of aging highlighting older people's wellness, independence, and security, as well as the contributions they make to the civic, spiritual, and economic life in their community.

Description: The Elderhostel Pittsburgh Program Series, in collaboration with universities, cultural institutions, economic development organizations, libraries, and others, offers one-day "learning adventures" to explore the many educational and cultural treasures in the Pittsburgh area.

Highlights:

- Since its inception in the spring of 2000, more than 5,000 area residents have participated in at least one program.
- In the spring of 2002, nearly 50 programs were offered, 35 more than when the program was launched two years earlier.
- Elderhostel Pittsburgh Program Series staff have developed "how to" materials, making it easy for local "vendors" to develop and run programs.
- Since its inception, the Elderhostel Pittsburgh Program Series has generated nearly $400,000 in revenue for local vendors.

Elderhostel Pittsburgh Program Series

Pittsburgh, Pennsylvania

Background

In 1997, the Jewish Healthcare Foundation began looking for ways to enhance the educational, cultural, and social quality of life for well elders in the Pittsburgh region. It had two goals: to enhance the quality of life and well-being of Pittsburgh's active older adults, and to attract and retain older-adult spending in the Pittsburgh region.

As a first step, the Foundation collaborated with two local organizations to collect information about older people in the region and to create an action plan based on a new paradigm of aging. This paradigm highlighted older people's wellness, independence, security, and the contributions they make to the civic, spiritual, and economic life in their community, and countered common cultural views about "the aged" as frail, ill, isolated, and lonely. The information they gathered produced considerable evidence to support this new paradigm.

The organizations found that more than 35% of the approximately 470,000 people in Allegheny County (which includes the city of Pittsburgh and the surrounding areas) are 50 years of age or older. Nearly half of these are well elders over age 65 who have few mobility limitations. Market and other research data indicate that many area older adults are longtime residents who want to remain in the Pittsburgh area and that the median income for Pittsburgh residents between ages 55 and 65 is 10% higher than the average U.S. household.

The discretionary income that many area older adults enjoy, combined with their relative good health and desire to continue living in the Pittsburgh area, gave the project's leaders the data they needed to approach other partners. They proposed creating an Elderhostel[1] Pittsburgh Program Series, which would consist of one-day "learning adventures" to explore the many educational and cultural treasures in Pittsburgh's backyard.

Program organizers secured an initial investment of approximately $400,000 from five local foundations. After some coaxing and negotiations, they also successfully secured the support of Elderhostel, Inc. for this new one-day, regionally based program model.

The Program

In 1999, the Jewish Healthcare Foundation, as the lead organization, helped form the Elderhostel Pittsburgh Advisory Committee, which continues to guide the initiative today. Members represent the local United Way, cultural institutions and arts advocacy groups, foundations, economic development entities that focus on tourism and regional travel, the media, and the county's library association. Many of the committee members from universities are involved with "life-long learning" or "learning in retirement" programs at their institutions and provide advice on curriculum development.

The first Elderhostel Pittsburgh Program Series was offered in the spring of 2000 and consisted of approximately 15 offerings by 15 *community program partners* (a term later changed to *vendors* to reflect the entrepreneurial aspects of the program). These included the Heinz Regional History Museum, the Pittsburgh Zoo, the Greater Pittsburgh Community Food Bank, the Steel Industry Heritage Corporation, and the Pennsylvania Trolley Museum. By the spring of 2002, the number of offerings had expanded to nearly 50, covering a five-county area around Pittsburgh.

Since its inception, more than 5,000 area residents have participated in at least one program. Although Series staff have identified 10 programmatic categories, the overwhelming majority of "hostelers" patronize three types of learning adventures: those at historical museums or societies, the performing arts, and those held in restaurants and dinner theaters.

Elderhostel, Inc., in Boston handles participant registration, while Series staff in Pittsburgh are responsible for program development, marketing, and all other administrative tasks. Pittsburgh staff can turn to Elderhostel, Inc., for advice, and they acknowledge that the Boston office's support is a great help.

A typical "learning adventure" lasts between three and six hours and costs between $40 and $90. It includes a meal appropriate to the time of day and may include transportation. Programs start with an introduction that includes an orientation to Elderhostel, Inc., and then an expert in the topic area usually presents a lecture or demonstration. A formal performance is also included if the program involves one of the performing arts. After each adventure, hostelers receive an evaluation form with a postage-paid envelope and are urged to complete and return it at their leisure. The response rate is nearly 80%, and the vast majority are satisfied customers.

Although most offerings are based on the one-day "learning adventure" model, the Series is gradually offering more multi-day programs. This format more closely reflects the Elderhostel, Inc., model that typically offers a sustained educational encounter for at least a week. In addition, several of the former one-day programs have now been extended to a "series" of meetings (usually offered weekly or biweekly), in which a topic like photography, forensics, or astronomy is explored in greater depth. Program Manager Pamela Vingle notes that, "Evaluations told us that some people wanted more sustained contact among enrollees and between them and the presenter(s). We learned that socialization was at least as important as content, so our programming had to reflect that."

Why it works: Series staff listen to what hostelers have to say and incorporate their ideas into future plans.

Most hostelers are retired women. They are generally well educated, with at least a college degree, have the financial resources to participate, and are attracted to the high quality of programming content. Hostelers also consistently make positive comments about the social nature of the programs. One woman said, "My husband died last year, and this is the first time I've done something like this without him. I feel safe with this program. I like the one-day programs and the fact that I don't have to travel too far from home."

Partnerships and Collaborations

The success of the Series depends heavily on developing and sustaining win-win relationships with area vendors who develop and run the programs, attractions, and events that Elderhostel Pittsburgh offers. All vendors work closely with the program manager to brainstorm about ideas, logistics, and marketing strategies. Series staff have developed a packet that details how to create a program description and budget (which are required), outlines the roles and responsibilities of each vendor, and offers "tried and true" pointers on program itineraries, including logistics, program presentation outlines, and recommendations for food and beverage providers.

The Elderhostel Pittsburgh Program Series receives a $15 administrative fee from each paid registration. The vendor receives the balance and is responsible for all costs, including the instructor's fee, instructional materials, food and beverages, transportation, and admission/performance fees, if applicable.

Why it works: Vendors are eager to participate in the Series. They see it as a potent marketing, membership, and volunteer recruitment tool. They also view it as an opportunity to develop stronger relationships with the 55+ population.

Vendors can usually keep their costs to a minimum because their presenters are often employees who contribute their expertise as part of their normal responsibilities. Since its inception two years ago, the Series has generated nearly $400,000 in revenue for participating vendors.

Why it works: Vendors make money. The more creative they are and the more hostelers they attract to their event, the more successful they are.

Now that the Series offers so many programs, the participation of hostelers-turned-volunteers is essential to the program's smooth operation. Volunteers function as site coordinators at most program venues and, according to Series staff, are also responsible for suggesting more than 30% of new programming ideas. Volunteers can participate in a program of their choice in exchange for their services.

Funding

The $15 overhead fees cover the cost of catalog design, production, printing, and mailing and the expense of program registration incurred by the main office in Boston. If a program runs longer than a day, the overhead fee is calculated on a daily basis. Support from the foundations that helped launch the program still makes up a good portion of the remainder of the budget, covering costs such as rent, utilities, salaries, and office equipment, although the Series has been steadily accruing corporate sponsorship to relieve the foundations of some of this burden. In addition, several of the most popular performing arts programs that regularly sell out help support programs that are less fully subscribed.

Future Plans

The program's primary challenges are to increase the overall appeal of the local Series and make it affordable to a greater number of people. The program would like to serve older adults who currently attend Allegheny County's senior centers, but very few of those older adults actually attend Series events. Keith Kondrich, assistant vice president of the Series, suggested that the average cost of a Series program is prohibitive for some Pittsburgh area seniors, but also mentioned that current offerings "certainly do not appeal to the broadest spectrum of people." By offering a broader range of programs and activities, staff hope to make the Elderhostel Pittsburgh Program Series accessible and attractive to more of the area's older population.

[1] Elderhostel, Inc., is the world's largest not-for-profit education and travel organization with more than 25 years of experience. It is based in Boston, Massachusetts, and its programs take place in more than 100 countries besides the United States.

AT A GLANCE

Gatekeeper Program of Multnomah County, Oregon

Portland, Oregon

Project purpose: Proactively identify and connect older community members with services. These are people who may need help but do not want or know how to get the help they need

Background: The traditional approach to identifying older adults who need services involves waiting for them to contact social service agencies and health care providers or obtaining referrals from other agencies that already serve them. The problem with this approach is that older people may not recognize that they need help or may not know whether or how to look for help when they do want it.

Description: The Gatekeeper program identifies employees of community businesses that have regular contact with the public, trains them to recognize the signs that might indicate that an older person needs assistance, and encourages them to call the program to make a referral. The program then routes the referral to the appropriate service agency or provider.

Highlights:

- Constant community outreach ensures that a broad array of "frontline" employees is trained to recognize the signs and symptoms indicating that an older person may need help.
- Making a referral is easy and takes only a five-minute phone call. A single referral can be routed to a broad range of agencies that serve older adults.
- Referrals made after business hours are handled by a private agency, which faxes the information to the program the next morning. After-hours calls that require an immediate response are routed to an on-call social worker, who responds immediately.

Gatekeeper Program of Multnomah County

Portland, Oregon

Background

In 1978, Ray Raschko, a mental health counselor who became the director of elder services at Spokane Mental Health in Washington, pioneered an innovative model for connecting older adults with needed services. He called it the Gatekeeper Case Finding Model. It provides an alternative to the conventional "passive" approach of providing services to older adults that involves either waiting for them to contact social service agencies and health care providers or obtaining referrals from other agencies that already serve them. The problem that Raschko saw with this approach is that older adults sometimes do not take the initiative to get the help they need or they simply do not know how to get assistance. With the Gatekeeper model, he envisioned that any group of employees that has regular contact with the public could serve as a critical link between people in need and those who can help.

In 1987, the Fred Meyer Charitable Trust, a regional foundation in the Northwest, funded a neighborhood demonstration project in Portland, Oregon, that became the first program in the region to use the Gatekeeper model. The demonstration project was so successful in increasing outreach to older people in the community that Multnomah County (which includes Portland and the metropolitan area) decided to adopt the model and create a countywide Gatekeeper program.

Since then, many communities across the country have developed Gatekeeper programs, which are usually housed in one of three types of organizations – a mental health agency, an area agency on aging, or a health department – or an entity that combines at least two of these functions. The programs train employees of local businesses who come in contact with older people to recognize the signs that might indicate that an older person needs assistance. Employees then make referrals to designated agencies.

Why it works: People in need don't have to find the Gatekeeper program and ask for help. The program finds them through referrals from employees in the community, such as bank tellers, postal carriers, firefighters, and supermarket employees.

Since the early 1990s, Multnomah County's Gatekeeper program has been housed within its Aging and Disability Services Department (ADSD), which also functions as the area agency on aging for the Portland metropolitan area.

The Program

Portland's Gatekeeper program provides training sessions to employees of local businesses. The trainings teach employees to recognize warning signs that indicate a person might need help, such as confused or disoriented communication, anger or hostility, confusion concerning money matters or difficulty paying bills, unkempt appearance or weight loss, or a neglected yard, house, or pet.

Employees are then walked through the simple process of calling the Gatekeeper phone line to make the referral, which usually takes no more than five minutes. The caller only needs to provide basic information about the person being referred, such as name, gender, approximate age, address, phone number, and a short description of the situation that prompted the call. Information is entered into a database and dispatched to the appropriate office(s) for further assessment and action. If the caller wishes, the referral can be anonymous.

Calls that come in after normal business hours are handled through a contract with a private for-profit agency, and the information is faxed to the program the next morning. After-hours calls that require an immediate response are referred to an on-call social worker who responds immediately.

Why it works: "We always take calls, no matter what time of day or night," said Paul Iarrobino, coordinator of the program. "We get a lot of after-hours calls from emergency responders, like police and firemen. When you use voicemail, you lose people. You want to take the call right away so the person making the referral won't think twice about doing it again."

During regular business hours, the Gatekeeper program can provide an immediate response to emergency referrals and work to stabilize these situations as quickly as possible. A multidisciplinary team, consisting of a geriatric mental health specialist, a community health nurse, and a staff

member from Adult Protective Services, stationed in each of the ADSD's five branch offices, can drop all other responsibilities to meet, discuss a case, and decide on a course of action.

Why it works: Gatekeepers who make referrals are always sent a thank-you note and, if they wish, are apprised of how the referral was handled. Gatekeepers who refer multiple times are specially recognized by employers and given a "Great Gatekeeper Award."

Partnerships and Collaborations

The Portland General Electric Company has been a strong supporter of the Gatekeeper program from the start and has been instrumental in helping recruit new businesses to the program. In addition to Portland's major utilities, other participants include banks and credit unions, pharmacies, libraries, public and private transportation entities, firefighters, health care providers, senior congregate housing program managers, and tax preparation businesses.

The success of the Gatekeeper program depends not just on employers and their employees who serve as gatekeepers, however. It relies on a strong, coordinated network of service providers that can effectively respond to the referrals that have been made.

Why it works: The goal of the Gatekeeper program is not to "make referrals," but to make referrals that result in people receiving the support they need to remain in their homes.

Just more than half of all referrals are routed to ADSD, Adult Protective Services, or to Medicaid caseworkers, but they are also routed to the nine senior centers in the county. The provision of appropriate and timely service to older adults who have been referred to the program requires a level of trust and understanding among these organizations, as well as formal working agreements.

Why it works: The program has interagency agreements to share certain information among all the county's social service offices, senior centers, police departments, and the district attorney's office. Without this cooperation, the model could not work, since delivering services often requires the cooperation of a number of organizations.

To keep everyone informed, the program has developed several communications tools. It distributes a newsletter, *Gatekeeper Update*, twice a year, to all partners and related agencies. It has developed public service announcements for radio and television, which help spread the word and keep the program in the public eye. It produces a quarterly statistical review of referrals for all ADSD offices and managers of the area's senior centers. The program has also produced informational brochures for prospective partners and a video, which it uses in trainings.

Funding

The program receives roughly 30% of its funding from the city of Portland, 20% from the county, 30% from Title XIX (Medicaid mental health funding), and 20% from Title IIIB of the Older Americans Act, which funds case management. Businesses that support the program provide the funds to cover the cost of printing and disseminating the *Gatekeeper Update* newsletter.

Future Plans

The program continues to seek out employers of potential new gatekeepers and have them become involved. In 2001, for instance, the program's coordinator conducted more than 70 training sessions and reached nearly 2,500 employees. But the acquisition of local businesses and utilities by regional or national companies poses a challenge for these ongoing efforts. Likewise, automated services such as ATM machines, direct deposit, and utility problems that can be fixed from the central office without dispatching a service person to the home mean less face-to-face contact and fewer opportunities for gatekeepers to identify problems and make referrals.

The program staff also want to upgrade the Gatekeeper database software, as the current system cannot track information about repeat referrals and some service use. An upgraded system will help target outreach efforts and better assess the kinds of services that older people who are referred to the program use and the extent to which they use them.

AT A GLANCE

Heritage Harbour Health Group, Inc.

Annapolis, Maryland

Project purpose: To provide in-home and on-site medical and supportive services to residents of a retirement community so they can continue living in their homes as they age

Background: A group of residents recognized that aging meant the potential for physical problems and disabilities, and they wanted to plan for possible future needs.

Description: When information gathering did not yield any models that the group could adapt to the community, they developed their own home health care and supportive services program. Heritage Harbour Health Group, Inc. (HHHG), provides on-site and home-based health care and supportive services to community members. Health care services are available to all residents for an annual membership fee of $85.

Highlights:

- Active participation and leadership by HHHG members ensures that the program addresses the needs and preferences of those it serves.
- The group recognizes that remaining in the community as one ages requires more than just medical services. A range of programs supplements the medically oriented services so that members' supportive and socialization needs are met as well.
- HHHG continues to develop creative partnerships to support existing programs and launch new ones.

Heritage Harbour Health Group, Inc.

Annapolis, Maryland

Background

Heritage Harbour is a 300-acre suburban retirement community located on the edge of Annapolis. In 1989, a group of residents came together around a common desire to remain in their own homes as they aged. They recognized that aging meant the potential for physical problems and disabilities, and they wanted to plan for potential future needs. The group sought to ensure that residents would have access to health care and support services that were based in the community, driven by consumers' needs, and available in their own homes.

Why it works: From the beginning, the residents' mission was clear – to have both medical and non-medical services available to members either in their homes or on site in the retirement community 24 hours a day, seven days a week.

As a first step, Heritage Harbour residents began searching for a model they could adapt to provide home health care services in their community. They visited several nationally known retirement communities and met with gerontology research centers at two universities. After a year-long search, they came up empty-handed. Existing home care models were not designed for adults living in a retirement community. The model Heritage Harbour was looking for did not exist. So residents decided to design their own.

The research group created support for their idea by getting other residents interested early on. During the planning and start-up phases, one of the most successful strategies was a series of "coffees" for residents. As one of the original planners explained, "I'd say, 'Well, I don't know about you, but I've put a lot of work into my house and my garden and I don't want to move. I don't want to go to a nursing home or an assisted living facility. And that means I'd like to know I can turn to somebody to get good, responsible help when I need it.'"

The Program

Established in 1990, the Heritage Harbour Health Group, Inc. (HHHG), is a privately run, charitable nonprofit organization. The first service it provided was home health care, partnering with a home care agency that agreed to finance the salary of a part-time nurse based at Heritage Harbour. The nurse provided in-home skilled nursing care to residents and referred requests for home health aide and other paraprofessional supportive care to the home care agency. HHHG funded the salary of a support staff person to work with the nurse. Creating this collaboration between the community and the professional organization that could provide needed services proved critical to HHHG's success.

Since then, the range of services that HHHG provides has grown substantially. Members now pay annual dues of $85 for a package of services and amenities that, in addition to home care, includes outpatient care provided at the HHHG on-site office; assistance with Medicare and other health insurance issues; referrals to area doctors, dentists, lawyers, and tax advisors; blood pressure screenings; flu shots; a monthly speaker's forum on health and lifestyle issues; and an annual health fair. HHHG also provides information about funeral arrangements and has negotiated several "preferred provider" contracts with a local hearing aid business and with insurance companies for dental and long-term-care discounts.

As residents of Heritage Harbour have aged in place over the last 15 years (the average age of residents is now 75, up from about 60 in the early 1980s), residents' needs for case management have grown. HHHG always provided some degree of case management with home health care services, but, in recent years, it has expanded these services. By 1999, it became financially imperative for the group to establish an additional charge. For members requiring ongoing paraprofessional or skilled nursing care, the group now charges $150 for an initial assessment and development of a care plan and $60 per month to manage and evaluate the care provided.

Why it works: Programs and services change, based on the needs and preferences of HHHG members and the group's resources.

The group also offers a variety of programs and services to meet residents' social interests, such as trips to local museums and performances, cruises, and shopping expeditions. *Matters of the Heart*, the group's monthly newsletter, keeps members up to date on HHHG projects and activities and is distributed to all Heritage Harbour residents free of charge.

One key to the group's success has been the trust that the HHHG's board of directors places in its staff. Maeve Ostrowski, executive director since the program's inception, said, "I have never felt like I was under the thumb of the board, and I think that's important to retaining a good executive director."

Why it works: The board of directors gives the executive director a high degree of latitude and does not micromanage the health group.

Partnerships and Collaborations

The group has collaborated with an association of volunteers at Heritage Harbour, called Caring Network, which predates the Heritage Harbour Health Group by several years. The partnership between the group and Caring Network has been essential to providing a broad range of supportive services to residents of Heritage Harbor. Volunteers provide free, non-professional services, such as transportation to medical appointments, shopping for food or prescriptions, arrangements for limited meal service and pet care, and access to the Network's "medical closet" of aids such as walkers, shower and toilet seats, and an electric cart. Volunteers also staff a telephone reassurance program that operates out of HHHG's office.

Why it works: An existing, unrelated network of volunteers provides additional, valuable services that complement what HHHG offers.

Member representation on the HHHG board of directors is also critical to its long-term success. Active participation by members has helped HHHG maintain its consumer-oriented focus and guided the development and expansion of services as community members' needs and preferences have changed.

Why it works: Community members are actively involved in overseeing the health group, and in fact serve as program partners. In addition to paying dues, many sit on the board and its committees, support fundraising efforts, and help organize social events offered by the health group.

Managing growth has been a "mixed bag," the executive director acknowledged. When HHHG began, about 800 people lived in the community. Now, Heritage Harbour boasts a population of more than 2,800 residents, 1,600 of whom are HHHG members. At first, the question was how to grow quickly and efficiently enough to serve Heritage Harbour's burgeoning population. Now, the issue is whether HHHG has reached its saturation point.

Funding

When the group was first forming, planners held a fundraising campaign within Heritage Harbour to raise the $50,000 it needed to get the program off the ground. For every $500 contribution made to the initial campaign, the contributor received a free year's membership. Many couples gave $1000. At the same time, many of the health group's 100 original members provided interest-free loans, which they saw as a wise investment in their future.

Currently, membership dues finance a large part of HHHG's activities. In addition, the group uses several other fundraising strategies, such as its annual health fair, which generates up to $12,000. The group organizes a yearly auction of household goods and hosts a popular winter gala dinner-dance featuring a nationally known comedian or singer. Residents also designate HHHG as the beneficiary of memorial contributions.

Future Plans

In 2000, the group took on a new major initiative. It is seeking to build a 10-bed respite facility on a three-acre piece of property adjacent to the commercial complex in which the group has its office. The group has already received a donation from a member-resident to purchase the land, and it has won a commitment from the state legislature of $150,000 and funding of $50,000 from the county for the project. Additional large donations have come from local utilities and a regional bank. The group has launched a capital campaign to raise the remaining $500,000 it needs to create the respite facility. When it is completed, the facility will provide 1 to 30 days of care to any Heritage Harbour resident or eligible county resident who requires significant care while recovering from an illness, injury, or surgery. It will also provide family caregivers with a break from continual caregiving so they can become re-energized.

The group also hopes to produce a comprehensive set of materials that will help other communities around the country replicate the program.

AT A GLANCE

Independent Transportation Network™

Westbrook, Maine

Project purpose: To create a transportation option for older adults that is so attractive they will willingly move from the driver's seat to the passenger seat and pay for the service

Background: Older people are expected to make responsible decisions about their ability to drive safely, even though giving up their cars often means losing their independence. Seventy-five percent of older people live in rural or suburban areas without comprehensive public transportation, so without their cars, most older people cannot get to the grocery store, to medical appointments, or out to socialize. They cannot "live their lives." Many, therefore, keep driving longer than they can safely do so.

Description: Independent Transportation Network™ (ITN) is a community-based service operating within a 15-mile radius of Portland, Maine. Using innovative computer software to coordinate trips, map trip routes, and calculate fees, ITN offers demand-responsive transportation that closely approximates the comfort and convenience of the private automobile.

Highlights:

- The program has both volunteer and paid drivers.
- Trips are charged against passengers' accounts so no money or vouchers change hands.
- Destinations are not limited by city, county, or funding boundaries.
- Some businesses and health care providers contribute to cover the cost of rides.
- Passengers can travel alone or share a ride.
- Riders can book ahead or call at the last minute.
- The passenger determines the destination; there are no preplanned routes or stops.

Independent Transportation Network™

Westbrook, Maine

Background

In 1989, Katherine Freund, a community organizer in Southern Maine, saw her son struck and injured by a car driven by an older person. Her first response ("He shouldn't have been driving!") was emotional and personal, but she soon realized that the accident was also the result of a public policy failure. Older adults are expected to voluntarily give up driving when they can no longer safely do so, but they have few acceptable alternatives. Thus, many continue driving longer than they should.

Seventy-five percent of older people live in rural or suburban areas where there is insufficient population density to support traditional public transit. This means that shopping, medical appointments, and most routine activities necessitate a car trip. While up to 67% of older adults who currently drive expect that they can rely on friends and family when they can no longer drive, the reality often looks very different. Aside from the difficulties inherent in depending on others for basic transportation, reliance on "favors" moves older people from an independent to a dependent role, complicating relationships and making them reluctant to express any unhappiness or dissatisfaction for fear that they might appear ungrateful.

A founder of two other grassroots organizations, Freund was determined to find a solution. In 1996, when she was a graduate student at the Edmund S. Muskie School of Public Policy, she received funding from the National Academy of Sciences' Transportation Research Board (TRB) to conduct research about what consumers, especially older people, want in terms of what she called "personal transportation." Her research found that older people are willing to

- Join a membership organization dedicated to meeting their transportation needs
- Use and pay for such a service
- Share rides with other older adults
- Schedule rides in advance to save money
- Pay for rides in advance through a transportation account
- Participate in innovative payment plans

That year, the Southern Maine Agency on Aging gave Freund an opportunity to create the Independent Transportation Network (ITN), which became a program within the larger organization.

Why it works: ITN was designed based on consumer input and according to consumer preferences.

The Program

Independent Transportation Network is a nonprofit, community-based organization that provides people aged 65 and older and those with visual impairments with flexible, affordable transportation within a 15-mile radius of Portland, Maine. Using innovative computer software to coordinate trips, map trip routes, and calculate fees, ITN delivers more than 20,000 rides each year to 1,200 older individuals.

ITN users become members, paying $35 annual membership dues and $20 to open a prepaid transportation account. Trips are charged against the balance of the account so that no money or vouchers need to change hands. Fees are based on the distance of the trip, whether the ride is shared, and whether the reservation was made in advance or the same day. The system preserves consumer choice and independence, helps to cover the cost of the rides and reflects the level of service the customer requests. Passengers receive a monthly statement of their charges and their balance. A "road scholarship" supports transit for those who cannot afford ITN's fees.

All trips are treated equally, regardless of their purpose, and are provided in cars – no buses or minivans. Passengers themselves plan their trips according to their destinations, preferences, and timetables; there are no preset pick-up routes. Passengers can choose to travel alone or can opt to share a ride to save some money. The choice is theirs.

Why it works: Because ITN is a community-based organization, it offers transportation across jurisdictional boundaries. Most publicly funded transit operates only within the boundaries set up by funding sources.

ITN drivers include a pool of volunteers who drive their own cars, as well as paid drivers who use the organization's four vehicles. All drivers are insured and are trained by ITN using guidelines from the Maine Safety Council to support the mobility needs of their passengers, including loading wheelchairs into their trunks and escorting passengers, when needed, from the door to the vehicle.

ITN volunteers range in age from 20 to 70 and must have at least three years of driving experience. Most are aged 40 to 60 and have an older family member or friend who has struggled with the issue of mobility at some time in their lives. Service organizations such as the Rotary have been an excellent source of volunteers, but regular media exposure tied to ITN events has proven to be the most effective recruitment tool. For example, ITN held a "March of the Members," which generated publicity, raised community awareness about the program, and created a surge in new volunteers. Whenever a prominent community member volunteers, such as the chief of police, ITN pitches a "Look Who's Driving Now" story to the local media, which has been very receptive to running the features. These features generally spur a new crop of community members to volunteer. ITN also hosts Community Teas at churches and assisted living facilities, which serve the dual purpose of recruiting new volunteers and spreading the word about the program to older individuals.

Why it works: Media exposure raises community awareness and attracts consumers and volunteers.

Partnerships and Collaborations

Freund's leadership and ability to win support from a wide range of stakeholders were instrumental in the creation of ITN. While Freund earned her graduate degree, she also worked at the Greater Portland Council of Governments and chaired a task force on transit issues with the state legislature. Through these activities, she met key leaders in the transit and aging communities, whose support was instrumental in creating ITN: they provided material assistance, such as administrative help and a robust referral network, which enabled the young organization to get off the ground. Without her leadership and sustained partnership-building efforts, it is unlikely that ITN would have the success it currently enjoys.

Funding

Developing long-term sources of support is an ongoing challenge, especially in an environment of intense competition for limited public transit dollars. Given this reality, ITN generally relies on other sources of support.

ITN receives support from foundation grants, individual donations, and user memberships. In addition, supporters purchase trips for others or add to the scholarship fund. Local businesses donate items, such as road atlases, oil changes, and flashlights or provide them at wholesale rate. These items are given as incentives to become a member or supporter. The Shop and Ride program allows health care providers, grocery stores, and other shops and organizations that riders frequent to contribute by purchasing trips for consumers. ITN is also exploring corporate partnerships.

ITN receives funding from a patchwork of public and private sources, much of which is earmarked for transportation solutions. For instance, the TRB provided a grant for a feasibility study to determine whether ITN would work. Major support came from the Federal Transit Administration, which enabled the purchase of the first vehicle and funded a project to develop a model to enable other communities to replicate the program. The organization's computer software program was developed through support from the Great Bay Foundation for Social Entrepreneurs, with help from industry through the Environmental Systems Research Institute (ESRI).

Future Plans

An appropriation before Congress, if passed, will fund the first of three efforts toward replication of the ITN model. Roanoke, Virginia, will be the first replication community. Also planned is taking the ITN technology to the internet as ITNAmerica™ and launching the National Endowment for Transportation for Seniors, whose goal is to generate philanthropic support for dignified mobility for seniors. Because Freund has always focused on ITN as a model for older adult transportation, she is also actively working to shape national transportation policy and an economic approach to sustainable, community-based older adult transportation.

AT A GLANCE

Rothsay PARTNERS Program
Living at Home/Block Nurse Program

Rothsay, Minnesota

Project purpose: To help the older residents of a very small, rural community remain as independent as possible

Background: Rothsay, Minnesota, is a community with minimal resources and few residents. As is the case in many rural areas, younger people are leaving and local businesses are closing, leaving older residents with fewer family supports and fewer local stores and services. Residents decided to band together to meet the needs of Rothsay's growing population of older people.

Description: In 1992, Rothsay residents created the People Living Around Rothsay That Need Routine Services (PARTNERS) program, which uses the Living at Home/Block Nurse Program model. This model has fostered a network of more than 40 programs throughout Minnesota, Colorado, and Texas that coordinate community resources to help older people remain at home. With a small staff, volunteers, and the support of the business community, the program provides some services directly and coordinates other existing services so that older community members can be served more efficiently. PARTNERS serves a 7-township area with approximately 900 residents, approximately 250 of whom are aged 65 and older.

Highlights:

- In the 2000-2001 program year, PARTNERS provided 36 older people with in-home nursing services (more than 15% of the older population in the catchment area). This was twice the service goal for the year.
- On average, 70 older people receive services from PARTNERS volunteers each year.
- PARTNERS is a very successful small community fundraiser. Close to half of its annual $41,600 budget is raised through donations, memorial contributions, raffles, and rent from a tenant that leases a portion of its office space.
- PARTNERS knows its customer base. It has a map of its seven-township service area and marks all the homes where people aged 65 and over live. Not all older individuals use PARTNERS services, but they know PARTNERS is there if they need help.

Rothsay PARTNERS Program
Living at Home/Block Nurse Program

Rothsay, Minnesota

Background

The Living at Home/Block Nurse Program, Inc., (LAH/BNP), established in St. Paul, Minnesota, is a network of more than 40 programs in Minnesota, Colorado, and Texas that have mobilized to coordinate community volunteers and health and social service professionals to help older neighbors remain living in a place of their own choosing, usually their own homes. Services include skilled nursing care, personal care, help with household chores and repairs, transportation, and socialization opportunities. Founders of the model describe it as "community based" rather than "community focused," meaning that the programs are designed and run by local residents who "own" the project rather than being directed "at" a community, which can create a sense of entitlement instead of a sense of ownership. Because of this "community ownership" approach, the success of a program depends on the participation of community leaders and volunteers from all sectors of the community. Although LAH/BNP was originally designed for an urban community, it has been successfully adapted to very rural ones. The Elderberry Institute, the "outreach and support" arm of the program, provides education and technical assistance to communities that want to replicate the model.

Rothsay is a small rural town in Northwestern Minnesota with a population of approximately 450 people. In the fall of 1991, Roberta Ouse invited town residents to a meeting in her basement to discuss whether starting a Living at Home/Block Nurse Program would benefit their community, with its high percentage of older people. Ouse was well known in the community because of her volunteer work and because she had married into a farming family with long-established ties to the area. After an evening of discussion, the group decided to pursue the idea of developing a program to serve 6 townships in the area, with a total population of 700, 30% of whom (210) were aged 65 and older.

The group applied for assistance to the Living at Home/Block Nurse Program in St. Paul, which was especially pleased to assist Rothsay, given the concerted efforts it had been making to expand the program model to rural Minnesota. The Rothsay group spent eight months writing grant proposals, securing matching grant support, drafting by-laws, lining up an entity that would serve as its fiscal agent, devising a marketing plan, finding office space, and hiring two part-time staff people to serve as program director and volunteer coordinator. In May 1992, People Living Around Rothsay That Need Routine Services (PARTNERS) was formally launched.

The Program

PARTNERS staff coordinate or provide direct access to meal delivery, transportation, nursing assessments, in-home nursing, foot care, flu and blood pressure clinics, and respite services. The program also hosts a weekly "Ask a Nurse Clinic," during which older residents can come to the PARTNERS office with their medical questions. The clinic also provides information and education about Alzheimer's disease to community members. PARTNERS organizes friendly visits to the homes of older adults living alone, plans a wide range of social events that take place throughout the year, runs an annual health fair hosted by the local high school, and helped initiate an Alzheimer's support group that meets biweekly at the PARTNERS office.

PARTNERS also provides community members with education and information about alternatives to institutional care. Sharon Torkerson, PARTNERS program director, recounted the story of two sisters who came to PARTNERS to discuss their 91-year-old mother who was still living alone. "They were close to putting their mother in a nursing home because they didn't know how to deal with the fact that she could no longer cook. They weren't aware that there's a lot we can do for their mother to keep her at home if that's what she and they want."

In fact, PARTNERS can do a lot for older community residents. In the 2000-2001 program year, PARTNERS provided 36 older people with in-home nursing services (more than 15% of the older population in the catchment area). This was twice the service goal for the year. And, on average, 70 older people receive help from PARTNERS volunteers each year. And while not all older residents in the area use PARTNERS services, the program keeps abreast of its customer base in case someone needs help. It maintains a map of its service area and marks all the homes where people aged 65 and over live.

A key to PARTNERS' success has been its ability to incorporate local values into its programs and services. Reciprocity is highly prized in the community, and older residents are expected to contribute to community life like everyone else. PARTNERS reinforces this value. It organizes

"Grandma's Day" at the local elementary school. Older adults work with students for a few days to sew polar fleece hats that students can keep or donate. Torkerson organizes PARTNERS elders to donate and assemble "birthday boxes" containing cake mixes, frosting, candles, balloons, and small gifts for distribution at a food pantry in "nearby" Fergus Falls (40 miles away). Says Torkerson, "The birthday boxes are a chance for the elderly to give back to the community. We're very strong on that here." There is also a "Cookie Day," during which students bake cookies and deliver them to homebound older people.

Why it works: PARTNERS is built around local values – reciprocity, community pride, and respect for older members – reinforcing the ethics that bind the community together. Community members support PARTNERS, in part, because it reflects the nature of their community.

Partnerships and Collaborations

Developing partnerships and collaborations and working with volunteers are at the heart of the LAH/BNP model. This is especially critical in rural and underserved communities. The goal is not to duplicate services, but to help coordinate services that are already available, and to help fill the gaps so that people have the support they need to remain at home. For example, PARTNERS has contracted with Lake Regional Hospital for a nurse who provides in-home services and sees patients at the PARTNERS office as well. Working with the hospital allows PARTNERS to select the nurse they feel would best serve the community and to provide services in town so that older people do not have to travel 40 miles to the hospital every time they need medical attention.

PARTNERS also relies on the business community to help older adults. Its Meals on Wheels program is a creative model utilizing both business and volunteer resources. A local truck stop makes meals that the Lions Club delivers to homebound older individuals. Says Sharon Torkerson, "If we can keep elders' money in town, businesses can afford to stay here. If elders leave and few move here to take their place, that affects the bank, the grain elevator, which operates the only gas station in town, the truck stop which is also the only restaurant in town, and the beauty shop. The businesses here have been very faithful to us."

Why it works: By keeping older residents in the community, everyone wins. Businesses realize that fact and are willing to help support PARTNERS.

When Rothsay's only grocery closed, PARTNERS reached out to the next closest market, which is 40 miles away. Now, older people call their orders in to PARTNERS, which collects them and faxes them to the grocery store. Store employees do the shopping and bag and label the groceries for each customer. A PARTNERS volunteer picks up the groceries and returns to Rothsay, where additional volunteers bring them to the customers' homes.

Funding

Like many other LAH/BNP programs, Rothsay PARTNERS receives some funding from the Minnesota Department of Human Services (DHS). Start-up programs are given priority for support, and DHS funding usually continues for the first three years of operation and sometimes longer, as is the case in Rothsay.

PARNTERS raises all other funds, nearly half of its annual $41,600 budget, in the community. An annual raffle of a quilt made by Ouse and other PARTNERS volunteers provides some support that is supplemented by a local Lutheran charity, which provides a partial match to the funds raised. PARTNERS has also been successful in generating memorial contributions and receives some support from other faith-based organizations. A local entrepreneurial family donated the building that houses PARTNERS when the program became a nonprofit in 1992, which helps keep costs low. And rent from a tenant helps offset some of the program's costs.

Future Plans

PARTNERS is seeking to strengthen its funding base and extend its geographic boundaries to serve more people in the area. In 2002, it included another township within its jurisdiction, raising the total number of townships covered to seven. The total population of the area it serves is now close to 900 people, approximately 30% of whom are aged 65 or older.

Ouse, who remains involved with PARTNERS, is now a Living at Home/Block Nurse Program "coach." She works with the Elderberry Institute, providing technical assistance to other communities in the Midwest that are interested in implementing the LAH/BNP model.

AT A GLANCE

Plan 2000: Visions for the Future

Baltimore County, Maryland

Project Purpose: To help a public aging services department increase its visibility and service capacity within the structure and fiscal limits of municipal government

Background: The Baltimore County Department of Aging wanted to position aging as a priority and expand its role and presence in the community, despite a "no new government funding" constraint that characterizes many municipally based senior programs.

Description: The department's 20th anniversary provided an opportunity to engage the community in developing a plan that would serve as a blueprint for the department's future direction and services. It formed six subcommittees to examine the current and future needs of Baltimore's older residents, which were chaired and staffed by community leaders and citizens. The department compiled the subcommittees' findings and recommendations into a publication called *Plan 2000: Visions for the Future.* By engaging a wide range of community stakeholders in this collaborative process, the department secured wide political, financial, and in-kind support for its mission and programs.

Highlights:

Plan 2000 has resulted in many new programs and initiatives, including

- National accreditation for all 18 senior centers in Baltimore County
- Expanded transit services for older adults to and from local hospitals
- Improved marketing efforts through paid advertising and wider dissemination of informational materials for older people and their families and caregivers
- Expanded counseling and education services for family and other informal caregivers of older residents

Plan 2000: Visions for the Future

Baltimore County, Maryland

Background

In Baltimore County, Maryland (which includes the area surrounding Baltimore but not the city itself), the Department on Aging, a branch of local government, is the primary provider of services for older people. Positioning aging programs as a priority within the structure of local government is a never-ending job. The department's director, Charles Fisher, Jr., recognized that, as part of a larger government bureaucracy, the Department of Aging faces many challenges. First, it was hard to effectively compete for internal government resources. In addition, the department had to be prepared to weather change and sustain continuity across political administrations. Securing new, external funding without jeopardizing internal support was also a challenge.

Fisher and his staff decided that the Department of Aging's 20th anniversary in 1998 would provide a unique opportunity to celebrate past achievements and design a plan for the department's future direction and services. They called it Plan 2000: Visions for the Future.

Before seeking approval from the City Council for the formal planning process, Fisher and his management team did a lot of behind-the-scenes work, such as inviting members of the community in to discuss the process. This ultimately provided critical backing for the effort.

Why it worked: Department of Aging staff knew that if community leaders supported the project, others would follow. Fisher used his extensive experience and network of contacts to recruit key community leaders who agreed to support the project.

Once the project received formal approval, six subcommittees were officially established to gather information about demographics and trends, long-term-care services, community-based services, support services, legislation and advocacy efforts, and finance and marketing issues. Some of the community leaders whose support Fisher sought for the plan chaired the subcommittees. Overall, 62 citizens participated, representing a broad base of community support.

Why it worked: A kick-off dinner provided an opportunity for media attention and to begin building excitement among the broader community.

The Plan 2000 subcommittees were assigned three tasks. The first was to review the current and future needs of older citizens and their family caregivers in Baltimore County. The second was to understand the current service delivery system in the context of the changing lifestyles of older adults. Finally, the subcommittees were charged with developing recommendations for an enhanced role for the Department of Aging to support and promote the independence of older people in Baltimore County.

Each subcommittee determined its own guidelines and internal timetables, the focus of its inquiries, and the way its findings and recommendations would be presented. This autonomy allowed each subcommittee to meet the scheduling needs and interests of its members and increased the responsibility they felt for the outcome. A staff person from the Department of Aging served as a liaison for each subcommittee, keeping minutes, providing information, conducting necessary research, and coordinating the completion of the subcommittee's report.

The members of each subcommittee brought their organizational and personal resources to the table, which helped the project get around its "no additional expenditures" mandate. For instance, one committee conducted research to provide the other five committees with the baseline data they needed to start. Donna Wagner, Ph.D., a national leader in the field of gerontology, chaired this subcommittee. An instructor in the Gerontology program at Towson University, she involved her students in conducting a randomized telephone survey of area older adults. Department of Aging staff organized a second survey and a series of five focus groups that included seniors, municipal leaders, and representatives from ethnic and minority groups in Baltimore. These data, along with a demographic chart book developed by Wagner's students, facilitated the work of the other committees.

The Program

The subcommittees submitted their reports by June of 1999. Together, the reports contained more than 350 recommendations, which the Plan 2000 steering committee then distilled into a set of 90 action steps for consideration by the Department of Aging. The department consolidated these steps into a single document outlining the current and future issues on aging in Baltimore County, entitled *Plan 2000: Visions for the Future*, and presented it to the County Executive for approval.

Department leaders had requested that the subcommittees identify desired outcomes rather than specific programs. Each subcommittee thus submitted a set of goals, which the department prioritized and translated into "assignments" for its different divisions. In-house forums provided an opportunity for all staff to discuss the organizational implications of the plan.

Five major goals emerged:

- Develop an improved marketing program to make the department more competitive, responsive, and consumer friendly
- Enhance the role of senior centers by making the 18 senior centers in Baltimore County focal points of service for older people
- Enhance the educational role of the department, including emphasizing pre-retirement planning for individuals
- Expand the department's advocacy role, with a new concentration on supporting family caregivers
- Expand service delivery through new external partners and sponsors

The subcommittees clearly heard the "no new government funding" message, and the framework that they provided suggested re-engineering certain services and, where new resources were needed, developing external partnerships and new grant-writing activities. The process resulted in several new and reorganized initiatives. In addition, several subcommittee members and leaders became actively involved in new partnership agreements because of their involvement with the process.

The Department on Aging has been implementing the plan's recommendations and producing successes:

- Plan 2000 reinforced the relationship with Patuxent Publications and other organizations with significant marketing payoff. Patuxent provides free advertising in community papers for the annual senior creative writing contest. In addition, the company has provided printing, advertising, and distribution services for four publications on older adult issues, including the *Senior Resource Directory*. Other organizations, such as hospitals and the daily newspaper, have provided similar support for individual publications.
- The Department of Aging engaged more than 450 participants and the leaders of its 18 senior centers in a process that resulted in accreditation of all 18 centers by the National Institute of Senior Centers, a constituent unit of the National Council on the Aging.
- The Department has expanded its offering of pre-retirement planning publications and other consumer education efforts through partnerships with a variety of organizations, ranging from hospitals and the media to the U.S. Department of Justice and the National Sheriff's Association. Topics include funeral planning, telephone fraud, health care, and legal planning
- The Department redefined a program manager position and began expanding family caregiver counseling and education. With new funding from the National Family Caregiver Program, staffing was expanded to include a full-time coordinator and three part-time staff. The Department now sponsors an annual family caregiver fair, quarterly lectures, and a brown-bag series. Partnerships with Patuxent Publications and Towson University will support the publication of the guidebook, *Taking Care of Mom and Dad*, in both CD-ROM and print formats. Gerontology students will conduct family caregiver focus groups to determine "frequently asked questions" to be answered in the publication.
- By expanding its partnerships with 18 area hospitals, the Department provides improved transportation services for older adults. Each of the participating hospitals pays Baltimore County $12.50 per round trip for eligible rides, which generates $100,000 per year in revenue.

Partnerships and Collaborations

The Department of Aging reached out broadly throughout the community to ensure that the subcommittees were staffed with representative groups of stakeholders. It also sought to build broad-based support among these stakeholders for the work that each subcommittee would need to undertake, for the findings they produced, for the Plan 2000 report, and for the ultimate implementation of the recommendations. Subcommittee volunteers were drawn from multiple service provider groups, including aging services, hospitals, home care agencies, the insurance industry, elder law, disability organizations, and municipal planning and service units. Retirees and senior advocates were drawn primarily from the ranks of organizations, such as AARP and aging commissions, and from the leadership of the senior centers. Representatives of higher education, the business community, and the marketing/media sector were also included. It is noteworthy that subcommittees included both high-ranking officials and front-line workers.

Funding

The costs associated with the Plan 2000 meetings and subsequent report were absorbed by the Department of Aging, which provided staff support and covered other related expenses. Subcommittee members made in-kind contributions as well, as evidenced by Donna Wagner and the students from Towson University who conducted surveys of area seniors. Currently, the department brings in approximately $1 million annually from its various partnership activities. Partnerships, which range from corporate sponsorships to relationships with local hospitals to advertising revenue, are used to support the above-mentioned initiatives, as well as others that benefit Baltimore County older adults and their families

Future Plans

While it is unlikely that the Department will undertake such a large planning process in the near future, an annual review of Plan 2000 will be conducted, and department staff are constantly looking for new opportunities to fulfill the goals set forth in the plan.

LESSONS LEARNED

Despite the diversity of programs and communities represented in this publication, their experiences provide some general lessons that apply to any organization seeking to undertake an effort to improve the quality of life for older adults. As mentioned in the introduction, the community groups that led successful programs all demonstrated expertise, creativity, and, at times, tenacity in

1. Working with stakeholders
2. Using knowledge and information effectively
3. Selecting leadership
4. Cultivating and maintaining relationships
5. Marketing their projects effectively
6. Adapting to change

Maximizing efforts in each of these areas makes good sense for any community group seeking to create a program to make its community more elder friendly.

Lesson 1: Engage Stakeholders

Stakeholders are the people or entities that have (or should have) an interest in an issue or project. They fall into three categories (Revans 1980):

- Those who may be *affected* by a problem or by its solution
- Those who may have specific *information* about an issue or problem
- Those who may be able to *do* something about a problem

Stakeholder support is critical to the success of community-based programs and this "community of interest" needs to be engaged from the beginning. Although most communities told the research team that identifying and engaging stakeholders took time, they agreed that it was worth the effort. The full range of stakeholders may not be evident at first, and even if you reach out broadly to include everyone possible at the beginning, more stakeholders may emerge over time. When in doubt, be as inclusive as possible. It is much easier to get people involved in the beginning when they can help shape the initiative. Getting people involved later on is much harder. They may not feel part of the team and may lack a sense of ownership. Be as inclusive as possible. The more stakeholders that are involved, the larger your base of support. Imagine what could happen if the entire community identified a stake in your issue!

Most communities reported that obtaining and retaining stakeholder involvement was an ongoing effort. This was especially true in dealing with older people, who were critical stakeholders in all of the communities studied. Ensuring their ongoing involvement was, as one person commented, "an uphill battle." Healthy older adults are busy with paid employment, volunteer work, social and leisure activities, and travel. Frail older people sometimes find it difficult to attend meetings or actively participate in a project. Some communities reported that reaching older people in specific cultural and ethnic groups was a challenge. Other issues included language barriers, family obligations, and distrust of social services. Communities addressed these issues by creating many ways to participate, such as town meetings, surveys, websites, and email, reaching specific groups through organizations with which older adults were already familiar and comfortable, and conducting constant outreach.

1.1 Cast a Broad Net

"Older people can't always make their voices heard, but our advocates can speak on their behalf." (Charles Fisher, Plan 2000)

Build the broadest possible base of stakeholders for your initiative. The more people you involve, the larger the network that will stand up for and support your cause. Start by listing the "usual suspects" – people who would have an obvious interest in your issues. This includes consumers (the people you hope to serve and their families); the business community; social service and health care providers; community advocates; faith communities; government officials (local, state, and federal); and representatives from schools, libraries, fire and police departments, emergency services, and the postal service.

Then reach beyond your typical network of colleagues, contacts, and partners. Try to cross generational, geographic, political, and service boundaries. Use this as an opportunity to strengthen alliances and identify new ones. You will learn that not everyone sees the issue the way you do. This provides an excellent opportunity to learn more

about the issue in question – through the eyes of others. Later, when you craft a marketing strategy (see Lesson 5), this information will be invaluable.

For Just1Call, an information and referral project, creating and maintaining broad-based support has been essential to its financial viability. Without the initial, intensive support of the local social services department, Just1Call never would have gotten off the ground. Planners quickly realized, however, that long-term survival depended on securing support from stakeholders throughout the community. Having done so has given them credibility and helps them access funding streams that would otherwise be closed to them. As a result, they are creating a broad revenue base that includes multiple funders.

Lastly, when considering stakeholders, don't forget your own staff. While they do a lot of the work and set the tone for other stakeholders, they are often overlooked. Not only do staff at all levels have something to contribute (including their enthusiasm), their commitment can be critical to long-term success. According to Shelly Garten, Regional Manager, Division of Senior Centers and Community Services of the Baltimore County Department on Aging, "Staff embraced change rather than resisting it," because they were involved in the planning process for Plan 2000.

1.2 Start Early and Keep It Up

"If you don't get buy-in from the beginning and maintain it, it won't work." (Alan Geltman, Just1Call)

Involve stakeholders from the beginning and keep them informed throughout the planning process, implementation, and life of the project. Whether you set up task forces or committees, conduct surveys or hold town meetings, or use a combination of these approaches, the key is involving constituents early and maintaining their meaningful involvement. Don't just pay lip service to stakeholders. Pretending to seek their ideas and support is worse than ignoring them altogether. They need to be actively involved and know they are important to the success of the project.

When Mather Lifeways began planning for the Mather Cafés, which serve as alternatives to traditional senior centers, it was clear that the most crucial stakeholders were the older people it hoped to serve. Older community members were involved at every stage of the project. According to Carla Windhorst, a staff member, "Older people need to make the decisions, own the project, and become spokespersons for it." A committed group of stakeholders can be your strongest support. It will provide knowledge, resources, political strength, and great publicity.

Phillip McCallion, who is overseeing the Creating an Aging Prepared Community project, a community-wide initiative to better meet the needs of aging members in upstate New York, spoke of the "chicken-and-the-egg" phenomenon of early stakeholder involvement. "You want people to feel involved and to help shape the agenda, but you must have an agenda to get things moving and to keep people involved." Monitoring and readjusting the balance between the need for structure and the need for an open collaborative process are key to successful stakeholder involvement.

1.3 Identify Key Stakeholders

"Take the time to engage key stakeholders early on in the process. Once they become involved, the prestige associated with the project ensures their ongoing, active involvement and encourages others to get on board." (Irene Stein, the Millennium Project)

Who are the "movers and shakers" in your community, the ones whose lead others will follow? Identifying these people early and securing their commitment was important to many of the projects studied. And getting these key stakeholders to become actively involved – to do more than lend their names to the project – was critical. The more involved these stakeholders became, the more others followed and felt they were missing out on something if they did not participate.

Often, the key stakeholder is not a person, but an organization or entity. In rural Waynesboro, Virginia, the community often looked to the regional hospital for leadership. Once the hospital became involved in the Elder Alliance project, a coalition of service providers that came together to better serve older adults and maximize the community's relatively few resources, others knew it was an important initiative. The Creating an Aging Prepared Community project in the Albany, New York, area found that having the governor's office and other key legislators involved ensured that area health care providers came to the table as well.

Charles Fisher, Director of the Baltimore County Department on Aging, used his extensive and longstanding network of contacts to personally ask community leaders to chair six key planning committees for Plan 2000. Upper management at the Department used the same direct approach and banked on the prestige of the committee leaders to fill the six committees with 62 citizens. Using the phone or face-to-face contact to solicit involvement was 100% successful. The lesson? Use your personal networks and build on them to create momentum for the project.

1.4 Recruit the Right People

"Select task force members who bring knowledge of the community and its service systems to the table, as well as in-kind and hard-dollar resources and a collaborative spirit." (Irene Stein, the Millennium Project)

Involving the right individuals is just as important as having the right agency representation. Allowing agencies to simply send "designees" as participants in a collaborative effort, for example, is a recipe for failure. First, designees often do not have the freedom to make decisions without consulting higher authorities, which bogs down the process. Second, whether a committee or task force is productive truly depends on the personal qualities and resources of the participants, not the agencies they represent.

While all stakeholders should have a voice that is heard, a core group of people is ultimately going to have to do the actual work, whether they sit on task forces or committees, do the project planning and implementation, or raise funds. Be sure you have the people you need to get the job(s) done. Just1Call took a very practical approach. Says Alan Geltman, Project Coordinator, "You have to take advantage of people's expertise. Think creatively about who may know how to get things done. Our planning group got assistance from a flowchart expert to help us chart administrative and frontline workflow for the information and referral line. Even though his experience was in the corporate world, his skills could be applied to our needs."

1.5 Keep Everyone Focused

"Keep everyone focused on the common goal." (Ken Barbeau, Lapham Park Venture)

Any project involving multiple stakeholders can get sidetracked and stray from its original mission. People may bring personal preferences, organizational considerations or hidden agendas to the table. It is important for a project's leaders to keep all stakeholders' "eyes on the prize." For the planners of Just1Call, this meant making sure that every decision supported their "dream" – to create an information and referral service that older people and their family caregivers would use. Their market research told them that people want to talk to one person when they call, and if they get voicemail or are transferred, they hang up. So although a service with an automated phone system and paraprofessionals would have been cheaper and easier to design, it did not fit their goal. During the planning process, they made sure to check each decision they made against this goal.

2. Knowledge Is Power

Two types of knowledge essential to the success of any community-building endeavor are: 1) savvy, and 2) getting the right information from the right people. Savvy means knowing:

- Who in the community is directly affected by this issue and how
- Who in the community would be offended by not being asked to be involved or provide an opinion
- Who in the community has worked on this issue in the past
- What the history is of this issue in the community
- Who in the community can sanction or legitimize this effort
- What forces in the community can undermine the effort
- Where the resources will come from to address the issue
- What it will take to generate enthusiasm and buy-in from various individuals and organizations

Savvy means knowing well the overall context in which you are operating. The more you know about the context, the better prepared you are. This shows the community you care about "getting it right." Information expeditions are also a great way to engage stakeholders – people love to be asked their opinions and to be called upon for their expertise. Conversely, people hate it when someone new fails to consult the past when drumming up support for a supposedly new program. Watch out for that killer phrase, "We've tried that before and it didn't work."

The second kind of knowledge involves getting the right information from the people who will contribute to and be affected by your project – the full range of stakeholders you are engaging. This kind of knowledge, described in lessons 2.1 through 2.3, is integral to the success of your effort.

2.1 Get It From the Source

"We went where older people are, to churches and synagogues, health care institutions, shopping malls, and the AARP, for example." (Carla Windhorst, Mather Café Plus)

Be sure to get your information from the right people. Don't assume that professionals know what their consumers need or want, or that family caregivers know what frail elders want. If you are targeting services to the frail homebound, don't just talk to their family caregivers and home-care workers. Involve frail older people in the planning as well.

The people from whom you may need information can include those you hope to serve, people in the neighborhood in which you hope to work, potential funders, and other supporters, to name a few. Be sure to include all target populations and stakeholders. Don't leave anyone out. Be creative about getting the information you need.

In planning for the Mather Café, older adults stressed the importance of housing the program in a safe and accessible place in the neighborhood. Staff involved in the planning phase held "stake outs" throughout the community. They examined traffic patterns in the neighborhood – where older people went and how they arrived there. They also worked with the police to ensure that the areas they were considering were safe. The result was a storefront facility in a neighborhood that was highly populated, highly accessible, and on a major bus route.

2.2 Don't Assume It Is Already Out There

"Do your homework, but don't assume that what you want is out there. Some things really haven't been thought of already!" (Margery Ettlinger, Heritage Harbour Health Group)

Don't assume there's another program "out there" that you can replicate to fit your particular circumstances and goals. After a yearlong search for model home-care programs they could replicate in their community, the planners for Heritage Harbour Health Group realized that what they wanted had not yet been created. They learned a lot about what worked and did not work in other programs and communities but found nothing they could easily adapt to meet their needs. So they designed their own program.

Planners for Just1Call found themselves in a similar situation when they went in search of a computer database for their information and referral service. The databases they researched could not meet their needs. Existing systems did not provide the flexibility they wanted or allow the creativity they hoped to build into their system. While designing a database from scratch was a lot of work, it was worth it because they were able to build in most of the features they wanted, and working through the process helped them further refine their program plans.

2.3 Use the Information You Get

"Find out what they want and build around it." (Alan Geltman, Just1Call)

Just1Call took its planning and implementation strategies directly from the focus groups it held with older people and their family caregivers – the two main consumers of the service. Whenever a question came up in designing the service, how to market it, or how staff would respond to inquiries and requests for assistance, the first question was always the same, "What would the consumer want?" In many cases, what the consumers said they wanted – no automated answering systems and a 24-hour response by "a real live person," for example – was not easy to fulfill but was essential to the ultimate success of the project. "We knew that if we didn't give them what they wanted, they wouldn't use it, so what was the point of planning something no one wanted?" asks Geltman.

Knowing how consumers actually experience services can be invaluable in designing services that are acceptable, and even desirable. The Independent Transportation Network™ (ITN), a regional transportation service in the Portland, Maine, area, started from an understanding of the difficulties that older people face in using standard public transportation services. Public transit does not offer the flexibility, comfort, and convenience of a private car, which makes it an unattractive alternative for older adults. Thus, older people drive longer than they safely are able to do so. Rather than designing a service and then trying to get older people to adapt to it, ITN leaders came up with solutions that fit the values and lifestyles of their senior consumers.

Lesson 3: Choose the Right Agency and People to Get the Job Done

As almost every interviewee reminded our research team, "Committees can only do so much." While you may have many stakeholders interested in having a voice in the project and helping to shape the plan for change, some entity and, ultimately, some person or persons will be responsible for doing a lot of the work and for making sure things move forward.

3.1 Select the Right Lead Agency

"Select a coordinating organization and staff that are connected to the community and have the time, resources, and enthusiasm to get the job done." (Philip McCallion, Creating an Aging Prepared Community project)

Without the right lead agency, the project may have difficulty succeeding. There is no set definition of "right"; it depends on the project, community, and situation. Sometimes, the right lead agency is the one with the political clout to get a project started. This was the case both for Plan 2000 and the Millennium Project. In both cases, area agencies on aging had the political savvy and connections to manage a potentially contentious process. Due to their size, these agencies were also able to provide staff support, consistent oversight, and other resources. In other situations, the right lead agency is the one with the staff time to do the legwork. This worked for the Mather Café group. Seniors in the community contributed the ideas for the café, and staff did the background work and planning, constantly bringing their ideas back to the older adults to ensure they were on the right track.

In another case, a foundation was the right lead agency because it had the resources to organize, fund, and launch a program. The Jewish Healthcare Foundation's support was critical in creating the Elderhostel Pittsburgh Program Series, a program that provides older individuals with opportunities to explore the educational and cultural offerings in the area. Its leadership encouraged others to join the effort, which resulted in partnerships with many local organizations and institutions. The program had such wide success in part because the foundation shared power, allowing partnering organizations from throughout the community to contribute their ideas and creativity to the initiative.

3.2 Select the Right Person

"Find the right person to coordinate the project – someone who knows the community at all levels and has the skills and personality to make things happen." (Jenefer Duane, Novato Independent Elders Program)

As with selecting the right lead organization, the "right" lead person will vary, depending on the project and the community. Often, the right person is the one who knows the issues, the community, its people and its politics, and has the savvy to get things done. This person may be a natural, charismatic leader who inspires the best in others and makes people want to become involved, or he or she may stay in the background, making sure things run smoothly and letting others stand in the limelight. The right lead person is also the one who is not afraid to ask for help if unsure of something or if additional resources are needed.

Lesson 4: Build and Sustain Relationships

Working together and getting to know one another better is a double-edged sword. Time together strengthens relationships, builds new ones, and can sometimes tear relationships apart. On the one hand, people and organizations can work more effectively together, combining resources and ideas and creating a comprehensive program or service network. On the other, togetherness can create tension and competition, which, if not identified and managed, can destroy a project.

4.1 Fostering Trust and Cooperation

"Patience and working out the issues over time have been important. People learn to trust one another over years of working together. The norm has become that everyone gives a little for the greater good." (Karen Diehl, Elder Alliance)

Working together changes the nature and intensity of relationships. In many projects profiled here, being part of a new initiative renewed the commitment of people and organizations to meeting the needs of older people in the community. It reminded them of what they could accomplish if they worked together. This resulted in cooperation *and* competition, both of which can be positive forces.

Over time, the staff of departments within an agency, or of agencies within a larger service network, can become "estranged" from each other. While they may communicate (in referring clients, for example), they may not spend any time discussing what they do, their accomplishments, and difficulties they face. Just meeting with colleagues and knowing that everyone is working toward the same goal can be reinvigorating. And knowing what other people are doing and how hard they try can make one try harder, too. In Waynesboro, Virginia, Karen Diehl, who staffed the Elder Alliance, said, "Working together has raised the bar for service quality throughout the community. People feel accountable to one another now."

The challenge is to manage this tension – the pull between the need to work together and the protectiveness that people and organizations feel about their turf. This tension, if acknowledged and properly managed, can be an asset to the planning process. Conflict can provide a fertile ground for stakeholders to better understand key issues, forge common ground, and develop solutions that work for everyone.

Interviewees reported that the most common source of conflict was turf issues. This is inevitable. Many stakeholders and project partners will be competing for resources, including money, clients, political favor, and the rush to be "the first" or "the best." Ask yourself, "Is a new initiative infringing on another organization's turf? Are people feeling threatened?" How people work together and the level of trust they have with one another sets the tone for the project. It is important to recognize these issues from the outset and to revisit them often. As Karen Diehl from the Elder Alliance suggests, "Discuss turf issues openly when they arise. Continually clarify roles, responsibilities, and project parameters so people don't feel threatened or taken by surprise."

4.2 Creating New Opportunities

"Agencies and service systems that had not worked together before got to know one another and began sharing information and resources." (Irene Stein, the Millennium Project)

For many of the programs studied, relationships that began with the original project grew beyond the formal scope of the initiative, stimulating the development of additional projects and services.

For example, the Allegheny County Library, in conjunction with the Elderhostel Pittsburgh Program Series, created "conversation salons" in which up to a dozen people gather monthly at participating libraries to "revive the lost art of face-to-face conversation among a diverse group of interesting, well-informed, and spirited people." An outgrowth of the more traditional Elderhostel guest speaker/audience format, and created by a volunteer who does the bulk of the organizing, the conversation salons provide an informal forum for "active participation in the discussion of the meaningful events of our time."

These additional efforts, while not directly related to the initiative that brought the partners together, enhance the elder friendliness of the community and demonstrate the benefits of bringing stakeholders together.

4.3 Community Spirit

"Residents are changing how they feel about their building. There's a stronger sense of community and concern for one another. Residents watch out for one another more now." (Ken Barbeau, Lapham Park Venture)

A continual common theme in many of our research team's interviews and discussions was that the projects had improved morale and boosted pride in the community. Mirroring the changes that occurred on the organizational level, community members in some projects got to know one another better and felt more connected to and responsible for each other. Knowing that others cared about them and their community profoundly affected many older adults. In some communities, such as in Waynesboro, Virginia, more older people began volunteering, both on projects related to the Elder Alliance and in unrelated efforts, as well.

Participants in Planning for Elders in the Central City's Senior Survival School are often so excited by the empowerment that comes with understanding how to navigate the system that they become advocates for their communities, as well as for themselves. Some participants apply the leadership skills they have learned to community organizing, conflict resolution, lobbying, and other efforts.

Lesson 5: Market Your Project Effectively

Effective marketing is a process of *engagement*, according to John Beilenson of Strategic Communications and Planning in Pennsylvania. He believes that communication is most effective when you communicate *with*, not *to* your audience. To engage audiences, he suggests following a three-step process:

1. Make sure that you completely understand the purpose and goals of your project and can explain them to others.

2. Frame the issue so that it appeals to the people, or stakeholders, you are trying to reach. Ask yourself, "What is in it for them? Why should they care about our issue and what we are doing?"

3. Reach your target audience. Craft a message that entices them and gets that message across. This may mean developing different messages for different stakeholders and different strategies to get the messages across.

For example, if you want to communicate about an initiative with health care or social service professionals and they have computer access, you might post messages to list serves or computerized bulletin boards that they frequent, using professional language that they might use. If you are trying to reach older people in the community, however, you may have more success by placing articles in the local newspaper and church bulletins, working through senior and community centers, or putting up flyers in supermarkets and banks. Here, it would be important to use lay language, not professional jargon.

There is plenty of information available on the Internet and other places about marketing and outreach for not-for-profits (see Resources). The projects studied use many different methods to communicate their messages and market themselves. What they all agree on, though, is that marketing is continually needed to ensure the initial and ongoing success of their projects.

5.1 Build On the Buzz

"People had been talking about the need for better information about aging services and more coordinated referrals for years and were primed to do something about it. We got the ball rolling and got them committed to the outcome." (Alan Geltman, Just1Call)

Often, the idea for a project stems from a challenge or opportunity that a community has already identified. Sometimes, efforts to raise awareness about an issue or the initial research or planning phase of a project will be what gets people talking. Whether the "buzz" precedes the project or happens as a result of it, take advantage of it and build on that momentum. Once people are excited and interested, it is much easier to keep them involved.

This principle applies to keeping interest in your project alive, too. Many projects indicated that keeping their public relations messages fresh was one of their ongoing challenges. Just1Call found that persistence has paid off. By continuing to conduct marketing and outreach activities over time, staff said, more people have become aware of the service and now use it. As the pool of people using the service grows, these "converts" spread the word themselves.

The Gatekeeper Program of Multnomah County, Oregon, which trains employees of local businesses to refer older adults to needed services, has also found ways to keep the program "fresh" in the minds of these employees and their employers. Newsletters, public service announcements, and thank-you notes and special awards for those who make referrals help remind people about the program and its importance to the health and well-being of older community members.

5.2 Acknowledge the Role of Self-Interest

"Perfect your sales pitch. Figure out what's in it for different stakeholders and why it would benefit them to be involved." (Jenefer Duane, Novato Independent Elders Project)

Tailor your sales pitch to your audience. The one thing that all stakeholders have in common is self-interest. They want to know what they will get out of the relationship.

Don't be timid about approaching other seemingly non-related organizations or businesses to collaborate with you. But you must be able to recognize and demonstrate the benefits of mutual self-interest. In many cases, this means appealing to something beyond people's altruistic natures.

For planners of the Heritage Harbour Health Group, identifying stakeholders meant looking for win-win opportunities. They knew they needed a home health agency to help them design and manage their community-based health-care program, and they understood that their community was a built-in referral source for home health care and supportive services, an attractive benefit for a home health care agency. So the planners successfully convinced

an agency to not only partner with them, but to also underwrite the part-time salary for an on-site registered nurse. Both sides got something they wanted – the home health care agency got new business, and the group got free staffing. The group also convinced the owners of a small commercial complex in the community to provide a small rent-free office for two years by arguing that it would draw residents who would patronize the other businesses and services in the complex.

The Creating an Aging Prepared Community project in Upstate New York secured partnerships by promising that participating organizations would actively shape the project's agenda and goals. In addition, the project demonstrated to potential partners how their participation would allow additional resources to flow into the community. And project leaders continually acknowledge their partners, putting them in the spotlight and giving them credit for their contributions to the project and the community.

Lesson 6: Leave Room for Change

We live in an environment of change. Needs, priorities, resources, and preferences are always shifting. Creating a program that can withstand change is important. And it is not always easy to anticipate change, since it can come from many directions at any time. The people that the research team interviewed gave the following advice: create a flexible structure that can respond to change; be aware of possible shifts in staffing, politics, funding, and sentiment that might necessitate change; and make these changes when needed.

6.1 Adapt to Political Realities

"After we started our program, we had to adjust it to adhere to the state's guidelines. By doing so, we ensured continued funding and support." (Beverly Boget, Champlain Long-Term Care Coalition)

For programs that are partially financed by public funds, political changes can present real challenges to continuity. If elected officials who support a program are voted out of office, for example, the program could lose its backing. Programs that have a broad base of financial support can weather political changes much more effectively than those who rely heavily on government funding. For programs that are completely funded by government or are part of government agencies, continuity can be a constant challenge.

The Baltimore County Department on Aging, which sought to update and expand its services in a fiscal environment with many competing priorities, took a creative approach to this challenge. The director, who had 25 years of experience in government, brought with him many personal relationships with public officials and business and community leaders. By reaching out to his contacts – outside of local government – his department secured external support from a broad range of stakeholders. This support gave elected officials confidence to justify supporting the Plan 2000 program. This approach, which was actually a delicate balancing act, is a prime example of adapting to political realities to maintain a program's ability to survive and serve its constituents.

6.2 Allow Programs to Evolve

"As our membership increases, we need more money to hire additional staff, and we must also develop new programs and services." (Meave Ostrowski, Heritage Harbour Health Group)

Programs need to be reassessed over time, and program leaders and stakeholders need to be open to change. Change is not necessarily bad; in fact, it may be necessary because of unexpected success. For instance, Heritage Harbour Health Group discovered that it was becoming a victim of its own success. As community members aged and more people joined the group, case management use intensified. While this helped the group fulfill its mission – to help community members remain in their homes – it began draining its resources. To continue meeting this growing need, the group began charging additional fees for case management services.

6.3 Anticipate Personnel Changes

"We're trying to look toward what would happen if Marie weren't here. At this point, PECC would exist. There are enough people that are committed to the vision she had, and we have a fine staff." (Norma Satten, Planning for Elders in the Central City)

Sometimes, a project's early success depends on the creativity and drive of one person. But developing a project around one personality is not a good idea. What happens when this "key person" is no longer there? Will the project survive? And can it be replicated without this "key person" in the lead? Many communities struggle with these issues.

The board of directors of Planning for Elders in the Central City recognize that dynamic, energetic leadership is central to the organization's success. Thus, the board is consciously working to ensure that PECC will continue to exist when its founding director moves on. It is conducting staff and board development to build a culture of common values and shared skills so that no one person is "responsible" for the vision and success of the organization.

The Department of Aging in Baltimore County, Maryland, faced a similar, unanticipated challenge with the recent death of its long-time director, Charles Fisher. Mr. Fisher was very invested in Plan 2000. He saw it as a way to institutionalize change, and his vision and connections in the community were invaluable in convening subcommittees and turning their recommendations into concrete programs and services. Fortunately, Mr. Fisher created a framework in which other staff became invested and committed, and this has proven critical to the success of the initiative. Because many people in the department participated throughout the Plan 2000 process, they are committed to ensuring its continued success.

CONTACTING PROGRAMS

CHAMPLAIN LONG-TERM CARE COALITION

Lead Organization: Champlain Long-Term Care Coalition

Address: 241 N. Winooski Avenue
Burlington, VT 05401

Contact Name: Syndi Zook
Executive Director, Champlain Senior Center

Phone: (802) 658-3585

Email: champscent@aol.com

CREATING AN AGING PREPARED COMMUNITY

Lead Organization: Center for Excellence in Aging Services
University at Albany

Address: Richardson 208
135 Western Avenue
Albany, NY 12222

Contact Name: Philip McCallion, Ph.D.

Phone: (518) 442-5347

Fax: (518) 442-3823

Email: mcclion@albany.edu

Website:
http://www.Albany.edu/ssw/research/centerforexcellenceinagingsrvs.htm

ELDER ALLIANCE

Lead Organization: Valley Program for Aging Services (Area Agency on Aging)

Address: P.O. Box 817
Waynesboro, VA 22980-0603

Contact Name: Paul Lavigne

Phone: (540) 949-7141

Fax: (540) 949-7143

Email: vpas@cfw.com

ELDER FRIENDLY COMMUNITIES PROJECT

Lead Organization: University of Calgary, Faculty of Social Work

Address: Professional Faculties Building, Room 3256
2500 University Drive N.W.
Calgary, Alberta, Canada T2N 1N4

Contact Name: Elizabeth DesCamp

Phone: (403) 220-8099

Fax: (403) 282-7269

Email: socialwk@ucalgary.ca

Website: www.fsw.ucalgary.ca

ELDERHOSTEL PITTSBURGH PROGRAM SERIES

Address: 5725 Forward Avenue, Suite 402
Pittsburgh, PA 15217

Contact Name: Keith Kondrich, Assistant Vice President

Phone: (412) 422-2060

Email: kkondrich@elderhostel.org

Contact Name: Pam Vingle, Program Manager

Phone: (412) 422-2167

Email: pvingle@eldershotel.org

Website:
www.elderhostel.org (search for Pittsburgh)

GATEKEEPER PROGRAM OF MULTNOMAH COUNTY, OREGON

Lead Organization: Aging and Disability Services Department
Address: 421 SW 6th Avenue, Suite 300
Portland, OR 97204
Contact Name: Paul Iarrobino, Program Coordinator
Phone: (503) 988-3620
Helpline: (503) 988-3646
Fax: (503) 988-3656
Email: paul.iarrobino@co.multnomah.or.us
Website:
http://www.multnomah.lib.or.us/ads/protect/gatekeep.htm

HERITAGE HARBOUR HEALTH GROUP, INC.

Address: 801-3 Compass Way
Annapolis, MD 21401
Contact Name: Maeve Ostrowski, R.N., C.M.S., Executive Director
Phone: (410) 224-5683
Fax: (410) 224-3339

INDEPENDENT TRANSPORTATION NETWORK

Address: 90 Bridge Street
Westbrook, ME 04092
Contact Name: Katherine Freund, Director
Phone: (207) 854-0505
Fax: (207) 854-1026
Email: kfreund@itninc.org
Website: www.itninc.org

JUST1CALL

Address: 301 Billingsley Road
Charlotte, NC 28211
Contact Name: Alan Geltman
Phone: (704) 336-7265
Fax: (704) 353-0651
Email: geltma@co.mecklenburg.nc.us
Website: www.just1call.org

LAPHAM PARK VENTURE

Lead Organization: Housing Authority of the City of Milwaukee
Address: 809 North Broadway
Milwaukee, WI 53202
Contact Name: Susan July
Phone: (414) 286-2177
Fax: (414) 286-3169
Email: sjuly@hacm.org
Website: www.hacm.org

LIVING AT HOME/BLOCK NURSE PROGRAM SPONSORING ORGANIZATION

Organization: Elderberry Institute
Address: 475 Cleveland Avenue North,
Suite 322
St. Paul, MN 55104-5101
Contact Name: Malcolm Mitchell, Executive Director
Phone: (651) 649-0315
Fax: (651) 649-0318
Email: mpmitchell@mtn.org
Website: www.elderberry.org

MATHER CAFÉ PLUS

Lead Organization: Mather LifeWays
Address: 1603 Orrington Avenue, Suite 1800
Evanston, IL 60201
Contact Name: Carla Windhorst, Director, Community Initiatives
Phone: (847) 492-6801
Fax: (847) 492-6789
Email: cwindhorst@matherlifeways.com
Websites:
http://www.matherlifeways.com (see "community programs")
http://www.wkarch.com/mather/mather.htm (for café photos)

MILLENNIUM PROJECT

Lead Organization: Tompkins County Office for the Aging
Address: 320 North Tioga Street
Tomkins County Courthouse
Ithaca, NY 14850
Contact Name: Irene Stein, Director
Phone: (607) 274-5485
Fax: (607) 274-5495
Email: istein@tomkins.org
Website: www.tompkins-co.org/cofa

NOVATO INDEPENDENT ELDERS PROGRAM

Lead Organization: Margaret Todd Senior Center
Address: 1560 Hill Road
Novato, CA 94947
Contact Name: Carol Ann Moore, Program Supervisor
Phone: (415) 893-7997
Fax: (415) 893-7953
Email: cmoore@ci.novato.ca.us

PLANNING FOR ELDERS IN THE CENTRAL CITY

Address: 1370 Mission Street, 3rd Floor
San Francisco, CA 94103
Contact Name: Marie Jobling, Director
Phone: (415) 703-0188
Fax: (415) 703-0186
Email: marie@planningforelders.org
Websites:
http://www.planningforelders.org
http://www.seniorsurvivalschool.org (Senior Survival School)
http://www.ciapasf.org (Empowerment University)
http://www.presentationseniorcommunity.com (Presentation Senior Community)

PLAN 2000: VISIONS FOR THE FUTURE

Lead Organization: Baltimore County Department on Aging
Address: 611 Central Avenue
Towson, MD 21204
Contact Name: Arnold Eppel, Director
Phone: (410) 887-2108
Fax: (410) 887-2159
Email: aeppel@co.ba.md.us

PROJECT ACCESS

Lead Organization: Special Transportation Services, Inc.
Address: 30 Nestor Street
Nashville TN 37210
Contact Name: Jack Jakobik, Executive Director
Phone: (615) 862-5965
Email: jack.jakobik@nashville.gov

ROTHSAY PARTNERS PROGRAM
Living at Home/Block Nurse Program

Address: Box 234
Rothsay, MN 56579
Contact Name: Sharon Torkerson, Program Director
Kathy Bilden, Volunteer Coordinator
Phone: (218) 867-1234
Toll-Free: (888) 867-3456
Fax: (218) 867-2806
Email: rpartners@rtelnet.net

RESOURCES

AARP. 2000. Fixing to Stay: *A National Survey of Housing and Home Modification Issues.* Washington, D.C.

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Urban Places Project. 2000. *The Youth Power Guide: How to Make Your Community Better.* Amherst: University of Massachusetts.

Winer, Michael and Ray, Karen. 1994. *Collaboration Handbook.* St. Paul: Amherst H. Wilder Foundation.

Websites

Community Development Resources

The Asset-Based Community Development Institute
http://www.northwestern.edu/ipr/abcd.html

The Madii Institute
http://www.madii.org/community/assetmapping.html

National Community Building Network
http://www.ncbn.org

University of Kansas Community Tool Box
http://ctb.ukans.edu/

Marketing and Communication

Help 4 NonProfits
4433 E. Broadway Blvd. Suite 202 Tucson, Arizona 85711
Phone 520-321-4433 Fax 520-321-1997
http://www.help4nonprofits.com/

Campagne Associates
800/582-3489
http://www.campagne.com/mktg101.html,
see especially: http://www.campagne.com/nonprofit_mktg.html

Charity USA, Inc.
203 Partridge Ct.
Rincon, GA 31326
http://www.Charityusa.org

Dr. Randall Hansen's Guide to Writing Successful Press Releases
http://www.stetson.edu/~rhansen/prguide.html

Press Release Pointers: Writing and Sending Press Releases
http://www.infoscavenger.com/prtips.htm

APPENDIX: Protocol for Phone Interviews and Site Visits

Name of Initiative:

Name of Lead Agency:

Address:

Contact Person(s):

Title:

Phone:

Fax:

Email:

Web Address:

1. Background/History

a) Please describe the intent and goals of your initiative. What issues, concerns, or problems does it address? How would you link these goals to the broader topic of how they advance your community's ability to foster independent living for older adults and others?

b) When was the initiative started and why? How did you determine that this initiative was needed? In other words, what research steps were undertaken to determine community needs (crisis, surveys, focus groups, etc.)? Do you recall any issues or concerns that stood out during this phase? How were they resolved? How long did the planning phase last?

c) Who was involved (individuals and groups) during the planning phase? How did you solicit and involve the participation of these groups? Has the project forged any unexpected alliances between different stakeholders? Conversely, has it weakened traditional alliances?

d) Do you know if other organizations or their leadership ever felt that the aims of this initiative competed with their own? If so, how did you address perceived "turf" overlap?

e) Were there certain organizations and/or individuals that stand out as having helped shape this initiative?

f) How long have you been involved with this project?

g) What kind of communications system did you set up so that all the collaborators could stay in touch with each other and with project developments (newsletter, listserve, regularly scheduled meetings, etc.). Was that effective?

h) If the initiative involved building collaborations during the planning phase or sustaining them through implementation, how did leaders learn to collaborate with each other (run meetings, organize and run focus groups, etc.)? Did they receive training on group processes, leadership development, etc., from outside consultants, or were they self-taught based on prior experience and/or trial and error?

i) What funding sources was the initiative able to secure during the planning stages? How is the initiative currently being funded, and what are your hopes for future funding sources?

2. Current Status

a) You've described the initial intent and goals of the project. Has the project changed or moved in other or additional directions since the planning phase?

b) Have you encountered any unexpected problems, obstacles, or outcomes thus far? If problems, how did you overcome or address them? What do you think worked or hasn't worked?

c) If the success of your initiative depends on the participation of volunteers, how have you managed to recruit, train, coordinate, and retain them? Have you utilized the expertise of other organizations or consultants for technical assistance?

d) Did new leaders in the community emerge from this initiative? Have they received training in leadership development, community development/organizing?

e) Was the initiative able to secure local funding?

3. Evaluation

a) What mechanisms have you used to assess/evaluate project outcomes? How are you tracking and documenting the results of the project? Would you tell me again what were some of the tangible accomplishments that helped spur this initiative along?

b) What mechanisms have you used to assess/evaluate internal processes? Do you have internal activities in place that allow you to critically monitor the course of the initiative?

c) What elements/factors do you consider key to the success of this initiative?

d) What do you think you've learned from having undertaken this initiative thus far?

4. Future and Replication

a) Do you think the program can be replicated in other communities? Under what circumstances? Are there particular local demographics, economic, political and/or social service histories that you think are unique to your locality or situation? Do you think that the success of your project is in any important way contingent on your community's history of citizen involvement in community development issues or with initiatives related to the concerns of seniors?

b) What would you have done differently? If other communities were to try this, what are three things you would tell them to do?

5. Referral: Can you think of any other organizations or communities that are involved in projects that might be of interest to us?

6. Interviewer Notes

➤Include descriptive materials sent, received, downloaded