



## Creating Supportive Communities for Colorado Seniors: Strategies for Successful Implementation of Community-Based Aging Programs

*Prepared by the Colorado Health Institute for the Strategic Action Planning Group on Aging*

## Introduction

Between 2016 and 2030, Colorado's 65-plus population will grow by 68 percent, with some regions reaching growth rates as high as 131 percent.<sup>1</sup> Developing a strong network of support for this demographic will help individuals age within their communities, something nearly 90 percent of older adults say that they hope to do.<sup>2</sup>

If more adults opt to spend their later years at home rather than in an institutional setting, both individuals and the state have the potential to benefit financially.

In 2016, the median annual price of adult day care or a private home health aide in Colorado is substantially less than nursing home care. The median annual price of adult day care provided by a community organization comes in at about \$17,000 and a home health aide costs roughly \$55,000. Compare that with \$100,000 for a private room in a nursing home and it's clear that aging in place is an attractive option for older adults and their families.<sup>3</sup>

Similar cost differences hold true when it comes to Medicaid. In fiscal year 2013-14, the state paid an average annual cost of about \$16,100 for Medicaid clients receiving home and community-based services compared with about \$58,800 for nursing facility clients.<sup>4</sup> While clients in these different settings have very different needs, receiving services in the community is a more cost effective option.

Some older adults will need higher levels of skilled care provided in nursing facilities as they age. Those who remain in their homes will require a robust network of supports. Consequently, many communities are asking — and others will be soon — what they can do to assist stay-at-home seniors. While needs vary by individual and community, there are common components of an age-friendly environment: accessible outdoor spaces and buildings; a variety of safe mobility options; affordable housing; opportunities for social and civic engagement and more.<sup>5</sup>

The Colorado Health Institute (CHI) developed a strategic framework for community leaders — both within and outside of the aging field — for developing and implementing programs to help meet the full spectrum of service needs of older adults who wish to age in place. The framework provides guidance on how to assess community assets, identify unmet needs and carry out aging programs to address those needs. In addition, the framework recognizes that initiatives should include older adults and their families in planning, be thoughtfully selected based on community resources, involve robust partnerships, be evaluated on ongoing basis and obtain diverse funding streams.

## Research Approach

CHI was charged with identifying critical factors that contribute to successful implementation of community-based programs that support aging in place.

First, we leveraged existing data to create a Colorado Vulnerability Index for older adults. Based on the literature and key informant interviews, CHI identified six vulnerability factors among non-institutionalized seniors, such as the percentage living in poverty or with a disability. We then aggregated these factors and created an index that highlights counties with a disproportionate percentage of underserved or at-risk seniors.

Then, CHI researched several implementation frameworks developed by national organizations, both within and outside of the aging field, as well as academic studies that have examined and evaluated various rollout strategies.<sup>6,7</sup> In particular, insights from the Community Research Center for Senior Health<sup>8</sup> and the National Council on Aging<sup>9</sup> were invaluable. Web-based research yielded additional understanding of programmatic accomplishments and what it takes to effectively carry out aging programs.

Next, we conducted eight key informant interviews with experts from the State Unit on Aging, an Area Agency on Aging and a variety of community-based aging programs to understand barriers to implementation, lessons learned and best practices. Key informant interviews provided concrete examples of concepts highlighted in the framework.

The qualitative and quantitative research were synthesized into a framework for successful implementation of programs that support independent living.

The framework identifies the following key elements for implementing programs to promote independence for older adults who age in place:

### Figure 1. Framework for Implementing Healthy Aging Programs



Figure 1 is used throughout this report to guide readers through the framework. The framework itself highlights components of programs that specifically serve older adults as well as those aimed at a broader population. It also includes strategies for local leaders, professionals, service providers, foundations and state policymakers to smooth barriers to implementation and create environments that support aging in place in Colorado.



Informing Policy. Advancing Health.

CHI does not advocate for one approach or program over others. Identifying ingredients of the “secret sauce” for effective implementation will help community leaders throughout the state as they create aging-friendly environments for their residents.

Lastly, it is important to note that the research project evolved over time based on the SAPGA’s priorities. CHI included some of the initial research in an appendix (Items 1 and 2), because it may still be useful as the SAPGA develops its recommendations.

## A Framework for Implementing Healthy Aging Programs in Colorado Communities



The first step for community leaders is to have a clear understanding of the critical components of an age-friendly community. The World Health Organization (WHO) created a model that classifies the diverse needs of older adults into eight categories (see Figure 2).<sup>10</sup>

**Figure 2. Key Elements of an Age-Friendly Community**



Various services and supports fall within the eight categories in Figure 2. What works for one community may not work in another. A community assessment can help evaluate the size and scale of needs locally and identify available resources to address them. Assessments support communities in prioritizing and targeting programs.

The most thorough assessments cover all eight categories included in the WHO model. Needs assessments can be informed by both quantitative and qualitative data; the two approaches complement one another and provide a holistic perspective on the needs of a community's seniors.

The AARP Network of Age-Friendly Communities, an affiliate of WHO’s Age-Friendly Cities and Communities Program, is working with 121 communities nationwide to assess community assets and needs with the goal of supporting age-friendly practices. Boulder County, Colorado Springs, Denver and Larimer County are involved in this initiative.<sup>11</sup> Other Colorado communities can benefit from the comprehensive array of self-assessment resources developed by WHO and AARP, such as the Checklist of Essential Features of Age-Friendly Cities.<sup>12</sup>

The expense and rigor of administering a survey or conducting key informant interviews can deter communities from implementing new programs. Fortunately, Colorado has several resources for assessing the needs of older adults. Some of these resources are specific to seniors; others have information from populations of all ages that can be also be helpful.

**Table 1. Data Sources with Older Adult Information**

	Survey Topics	Geography	Most Recent Year	Administrator
Community Assessment Survey for Older Adults (CASOA)	Community engagement, health care, financial wellness and affordability, home services, transportation, housing	State, 16 Area Agencies on Aging regions and some municipalities and counties.	2011 (statewide). Some AAA regions and localities have more current data.	Colorado Department of Human Services and Colorado’s Area Agencies on Aging
American Community Survey (ACS)	Demographics (income, education, race, ethnicity), housing, employment, social isolation	State, county, city and census tract	2014. Some county, city and census tract data require pooling multiple years.	U.S. Census Bureau
Colorado Health Access Survey (CHAS)	Health care (access and use of care, affordability, self-reported health status, oral health, behavioral health)	State, 21 Health Statistics Regions	2015	Colorado Health Institute
Behavioral Risk Factor Surveillance System (BRFSS)	Health behaviors and chronic disease prevalence	State, 21 Health Statistics Regions; census tract estimates.	2014	Colorado Department of Public Health and Environment
National Core Indicators— Aging and Disabilities (NCI-AD)	Health and wellness, inclusion and employment of older adults and individuals with disabilities who are enrolled in public programs	Statewide	2015-16	Colorado Department of Health Care Policy and Financing, Colorado Department of Human Services, National Association of States United for Aging and Disabilities

Communities can also consult existing assessments for additional insights into older adults' needs. These include: The Area Plans on Aging that each AAA completes every four years; local public health agencies' Community Health Assessments and Community Health Improvement Plans; and nonprofit hospitals' Community Health Needs Assessments. These sources offer a wealth of information that is often overlooked. Identifying organizational partners that collect these data can reduce the time and financial burden of conducting a new assessment. Planning grants from agencies as well as local foundations also provide an opportunity to acquire supplemental funding.

Examining data sources during the assessment phase can reveal high-need areas, such as fall prevention, mobility or access to healthy foods, and tailor the geographic scope of an initiative. The Denver Regional Council of Governments (DRCOG), the Denver metro area's AAA, used existing census tract-level data for its service region to map measures of vulnerability, such as poverty and race/ethnicity, to focus the agency's financial resources efficiently and effectively.<sup>13</sup>

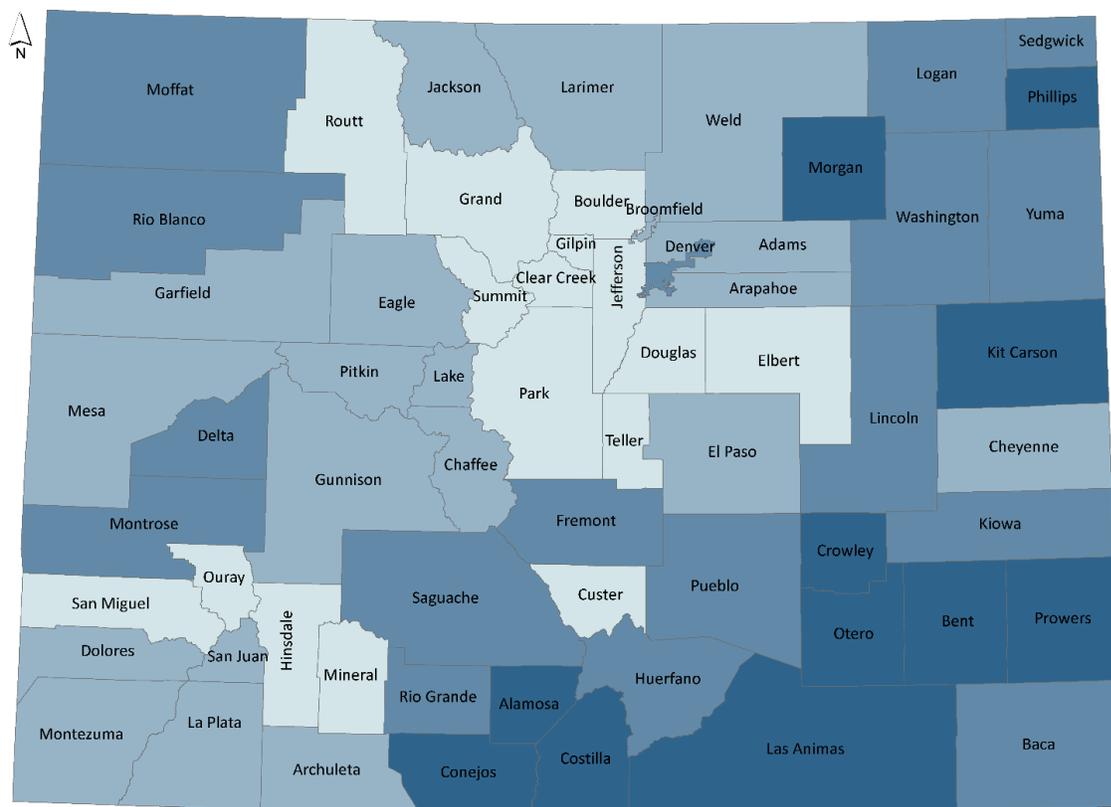
Information harvested from focus groups or key informant interviews can capture perspectives that may be underrepresented in quantitative data and demonstrate how needs vary within older adult populations in a given community. Certain seniors may have greater barriers to aging in place and require customized services and strategies. Colorado-specific data from the Community Assessment Survey for Older Adults and peer-reviewed literature suggest the following groups experience heightened vulnerability as they age in place.

- **Socially isolated older adults.** Social isolation — being disconnected from family, friends and social supports — can result in poor health and invite financial abuse. While these adults often have the most to benefit from supportive services, they tend to be the hardest to reach.
- **Lower-income older adults.** Many lower-income older adults could benefit from community-based supports but may not meet eligibility requirements for Medicaid home services. Some people are just above the financial eligibility threshold while others may not qualify because their physical or cognitive needs aren't great enough.
- **Older adult residents of rural communities.** In rural areas, the number and variety of programs can be limited. People may have to travel a long distance to attend educational events or programs or access health care services. Older adults in rural communities also may have few available transportation options.
- **Oldest seniors.** Age is closely related to demand for supportive services. As seniors age, they face a heightened risk for falls and certain conditions and may benefit from additional supports.<sup>14</sup>
- **Older adults with unique health care needs.** Older adults with multiple and/or complex health care needs who are independent enough to live within the community may require a more robust support system. This group may include people with multiple chronic conditions, disabilities or dementia.
- **Older adults of racial or ethnic minority groups.** Cultural barriers and health disparities can impede access to community services for many minority seniors. Research shows that minority seniors are at a heightened risk for missed diagnoses, disabilities and prevalence of certain health conditions. Distrust of the system and language barriers are some of the reasons contributing to poor access to care.<sup>15</sup>

CHI developed the Colorado Vulnerability Index, similar to DRCOG’s local mapping assessment, which identifies counties that have a disproportionate percentage of older adult residents who meet several of the vulnerability criteria described above. A composite measure was calculated based on the rates of all six vulnerability factors. The index shows that counties on the Eastern Plains and in the San Luis Valley have a higher-than-average percentage of older adults who may have a great need for supportive services but face barriers in accessing them. These people are often some of the hardest populations to reach.<sup>16</sup>

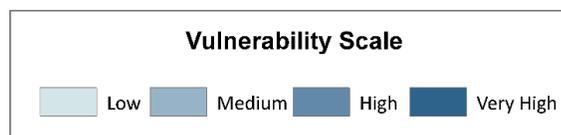
Counties clustered around the Front Range and in counties in the southwest have lower than average percentages of vulnerable seniors, according to the index.

**Map 1. Vulnerability Index for Colorado Seniors**



**Measures Included in the Vulnerability Index**

- Rural, Frontier and Urban County Designations
- Percentage of all Older Adults who are Ages 80+ (2016)
- Percentage of Adults Ages 65+ Living Alone (2009-2013)
- Percentage of Adults Ages 65+ Below Poverty (2009-2013)
- Percentage of Adults Ages 65+ Who Have a Disability (2009-2013)
- Percentage of Adults Ages 65+ Who Are a Racial or Ethnic Minority (2016)



The Colorado Vulnerability Index can serve as a tool for local leaders assessing the relative needs of older residents in their community. Item 3 in the appendix includes all the data feeding into the Index,

providing insights for those looking to understand more about the prominent vulnerability factors in a certain county.

**✚** *Lessons from the Field: Boomer Bond Initiative Helps to Identify Needs of Local Seniors*

DRCOG has developed a nationally recognized resource, the Boomer Bond initiative, that includes a survey to gauge how well a community's resources, programs and physical design serves older residents. The initiative highlights best practices and promotes regional cooperation to create age-friendly physical and social environments that help older adults stay in their homes.

The outcome of the survey, paired with findings from other data sources, can yield actionable results. For example, one city identified a lack of call boxes on its public trails through the Boomer Bond, a finding that was consistent with the results from its CASOA. Pairing these complimentary data points resulted in a potential solution.

Several Colorado communities have already used the assessment and others have expressed strong interest. The Boomer Bond program recently won an Aging Innovations Award from the national Association of Area Agencies on Aging.

*Critical Success Factors:*

Communities can consider these critical success factors when developing and implementing new programs for aging in place.

- Assess needs through multiple sources, including surveys, existing assessments, community members, service providers and older adults. Work with the regional AAA, local public health department and hospital(s) to leverage data that is already being collected.
- Use validated assessment resources such as the Boomer Bond and resources from the World Health Organization and AARP's Network of Age-Friendly Communities initiative. Leverage existing data sources, including the Colorado Vulnerability Index for older adults (Map 1).
- Seek out grants that provide funding and support for program planning.

**1. Understand the Needs of Older Adults in the Community**

**2. Choose the Right Program**

**3. Develop Community Partnerships**

**4. Measure Impact**

**5. Create Financial Sustainability**

Data can inform the direction of a new program, but success hinges on its contextual fit – whether the initiative matches the values and preferences of the community residents. Surveys and other data sources aren't always able to capture all of a community's unique characteristics, dynamics or preferences.

The U.S. Department of Health and Human Services' Office of Planning and Evaluation describes contextual fit as "the match between the strategies, procedures, or elements of an intervention and the values, needs, skills, and resources of those who implement and experience the intervention."<sup>17</sup> When selecting a program, consider the contextual fit for those who will be implementing, supporting and receiving the intervention.<sup>18</sup>

During the program selection process, many communities and organizations struggle with the desire to implement evidence-based programs (EBPs) while weighing local solutions, called emerging programs in this discussion, which may not have an established evidence basis.

CHI synthesized several resources, including materials from the National Council on Aging and the Community Research Center for Senior Health, to illustrate the benefits, drawbacks and considerations for organizations considering whether to implement an evidence-based program or a local solution.<sup>19,20</sup>

### **Benefits:**

- EBPs have a high likelihood of being successful because they have undergone rigorous study and have consistently demonstrated positive outcomes in a variety of settings.
- The proven outcomes and name recognition of EBPs are attractive to potential partners and can facilitate community buy-in.
- EBPs can be more efficient compared with a program grown from the ground up.
- EBPs often come with ready-to-go materials, including implementation manuals and specialized trainings.
- Implementing an EBP can increase funding opportunities; many public and private funders require this approach. The demonstrated outcomes of EBPs can help secure additional support.
- Implementing an EBP can improve program participation. According to the Community Research for Senior Health, potential participants are becoming increasingly drawn to programs that are evidence-based.

### **Drawbacks:**

- Guidelines are typically rigid and offer little room for experimentation or customization.
- EBPs are often specific to certain populations and are prescriptive in their program requirements. The positive outcomes of EBPs is limited to the target population and conditions and may not produce consistent results under different circumstances.
- The specific criteria for an EBP can differ across governmental agencies, creating red tape for a community seeking federal or state funding.
- While EBPs can expand funding opportunities, they also tend to come at a high cost. EBPs often require specific materials or staff to implement the programs according to the tested model.

The Administration for Community Living has identified what it considers to be the highest tier of EBP for older adults.<sup>21</sup> This can serve as a resource guide for communities exploring evidence-based options.

While there are clear benefits to implementing an EBP, it isn't always the right choice for a community. For communities that choose emerging programs, detailed evaluation metrics are critically important. Lessons learned from an evaluation can inform changes and guide other communities that are replicating the program.

Another important aspect of contextual fit has to do with whether a program can complement and coexist with existing aging services. Having a thorough understanding of the landscape can help advocates assess whether a new program is needed. That said, the existence of similar programs does not necessarily preclude a new effort that serves a slightly different, complementary need. Often there may be a spectrum of programs, each customized for a specific need or population.<sup>22</sup>

#### *Lessons from the Field: A Spectrum of Fall Prevention Programs in Cañon City*

Health care providers in Cañon City have created nearly 10 workshops and classes to meet the fall-prevention needs of seniors in their community.

The approach is based on the idea that a continuum of programs keeps older adults engaged in personal wellness. Fall prevention is a significant challenge for people as they age. "Stepping On," offered by the local public health agency and hospital, teaches people the fundamentals of fall prevention, including risk factors, safe footwear and how to practice strength and balance exercises.

Many participants are eager to stay informed and continue building on these skills. "Tai Chi: Moving for Better Balance" picks up where "Stepping On" left off, offering instruction on improving strength, balance and mobility.<sup>23</sup>

Older adults' needs vary greatly depending on factors like their age, health needs, connection to existing services and social capital. In considering a new program, determine if it would meet an outstanding need and whether fits with existing services. Creating a continuum of opportunities that complement one another and work symbiotically, as is the case in Cañon City, allows seniors with a range of needs to thrive in the community.

#### *Lessons from the Field: Evolution of the Old North End Neighborhood (ONEN) Village*

A few years ago, Innovations in Aging, a collaboration of leaders in aging, set out to bring the Village model to Colorado Springs. Villages – also known as iVillages or iHubs – engage the younger generation to provide discounted services and supports, such as snow removal or grocery delivery, to older adults in a specific neighborhood through intergenerational partnerships and collaboration.<sup>24</sup>

Advocates wanted to adopt the best of existing Villages while tailoring the model to meet the needs and preferences of seniors in the Old North End Neighborhood (ONEN). Modeling after existing programs is often the most efficient approach, but what works in one community may not be as successful in another.

Eventually, the Colorado Springs aging advocates realized they had been so set on customizing the ONEN program that they had begun to reinvent the wheel. So they changed course. They discovered that the Village in Denver, called “A Little Help,”<sup>25</sup> was closely aligned with the goals for the Old North End, so they decided to use the Denver model.<sup>26</sup>

### *Critical Success Factors*

- Evaluate assets, such as existing resources and programs that can be modified, leveraged or expanded to meet emerging or evolving needs.
- Ensure that key players in the community — particularly older adults, their families and caregivers who are potential users of the program — are invited to contribute to the program selection process.
- Choose the program based on what was learned from the community needs assessment in step 1 of the framework.
- During the program selection phase, consider each program’s contextual fit for those who will be implementing, supporting and receiving the intervention.
- There are benefits and drawbacks to both EBPs and emerging programs. Consider both and select the one that is the best fit for that community.

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Partnering with existing programs, community leaders and organizations serving older adults will help a new initiative get off the ground and stay there. Organizations and individuals with a long history in a community or strong ties to a target population can help a new initiative expand its reach. Without the support of partners, implementation is an uphill battle.

Several key informants said that engaging partners early on lays a foundation for collaboration, while hearing about a new initiative secondhand can be off-putting. It’s equally important to reach out to organizations other than the usual suspects; they may provide a valuable connection or perspective. Feedback from partners can help refine a program’s approach, reach isolated populations and result in a more effective effort.<sup>27, 28, 29</sup>

Relationship-building should be viewed as a dynamic process rather than a checkbox on a things-to-do list. Successful organizations keep lines of communication open long after a program begins. Older adults should be involved in the planning process to keep goals and strategies aligned with their needs and interests. Recruiting familiar faces and “lay leaders” to get the word out about a new program can promote buy-in among potential users.

A powerful strategy for engaging community leaders is to share local data that demonstrates needs among senior residents. One AAA director described her organization’s successful process for reaching vulnerable individuals.<sup>30</sup> First, data is used to identify an underserved community. Then staff members reach out to on-the ground sources. A national survey of 44 senior centers showed that police and fire departments, social service agencies, faith-based organizations and senior housing complexes are all good places to make those connections. Representatives of these institutions can provide insights into the community and identify leaders to assist the agency in outreach, according to the National Council on Aging (NCOA).<sup>31</sup>

Outreach and education strategies will differ from one community to another. In the same survey of senior centers, respondents said flyers and newspapers are effective in reaching older adults.<sup>32</sup> But not all seniors rely on old media. In Douglas County, for example, surveys and focus groups showed that older residents prefer to get information on the internet or through social media.<sup>33</sup>

Knowing how a target audience consumes information helps organizations to tailor their outreach strategies. Douglas County’s Senior Initiative Project did just that. After learning that local seniors preferred web-based resources, the Senior Initiative Project created a web page with a unique URL that contains information about available services for older adults in the county.<sup>34, 35</sup>

Communities also can plan for the future needs of seniors by reaching out to their children. In many cases, younger adults serve as informal caregivers for their parents, so educating them about available resources will facilitate healthy aging down the road.

#### *Lessons from the Field: ElderWatch Leveraging Partnerships for Effective and Efficient Outreach*

In 1999, the office of then-Attorney General Ken Salazar was flooded with reports of financial abuse schemes targeting Colorado’s older adults. Salazar convened stakeholders, who decided to fight back by creating ElderWatch, a program of the AARP Foundation.

ElderWatch helps older adults avoid being victims of scam artists. Amy Nofziger, director of Regional Operations at AARP, said a key to the program’s success is its approach to reaching its target audience. Whenever possible, ElderWatch works with organizations that already serve older adults. “I can’t think of the last time we sponsored an event without a partner,” she said.

ElderWatch also engages organizations with a stake in the fight against financial fraud — delivery services like the U.S. Post Office, UPS and FedEx; banks and money transfer companies; and home health agencies whose workers are often the first to notice suspicious mailings or voicemails. Potential victims are referred to ElderWatch or the AARP Foundation for guidance.<sup>36</sup>

#### *Critical Success Factors*

- Consider organizing a task force of organizations and stakeholders to contribute to the planning, selection and implementation of a new aging initiative.
- Allow adequate time to identify and engage key players in the community. One strategy is to collaborate with local partners to create a resource map that identifies existing organizations

and programs and shows supporters of a new initiative how to find to movers and shakers in the community.

- Formalize partnerships with other community organizations and demonstrate the value of those relationships by tracking service or program referrals across organizations and programs.

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Measuring the impact of community-based aging programs begins on day one.

It's important to strike a balance between accurately tracking and measuring what matters with what is feasible given budgets and staffing. Consider leveraging existing data collection efforts whenever possible. Data collected early on for the needs assessment can contribute to the baseline evaluation for a new program.

In addition to the community-level measures collected during the assessment phase, new programs can benefit from collecting baseline metrics among program participants prior to implementation.<sup>37</sup> A set of core metrics, preferably measures that abide by the SMART criteria — Specific, Measurable, Achievable, Realistic and Time-bound — will help to assess impact and highlight needed course corrections.<sup>38</sup>

While developing an evaluation framework, consider both process and outcome measures. Indicators that measure processes look at the effectiveness of service delivery, such as number of meals delivered to seniors. Such measures can provide early insights into the efficacy of a program and alert implementers to potential problems. Outcome measures, such as proportion of seniors living in hunger, look at the long-term effects of a program on the target population.<sup>39</sup>

Rigorous evaluation is also important for a program's financial health. Long-term funding is typically contingent upon a program's ability to demonstrate its value. Funding sources may specify an evaluation approach or criteria, such as demonstrating cost effectiveness or return on investment. These are important considerations and should be evaluated in addition to — not in place of — process and outcomes measures that reflect the goals of the program.

It is also prudent to recruit community partners and potential clients to help develop the evaluation tool. Once an evaluation is done, disseminate findings to partners — and celebrate successes along the way.<sup>40</sup>

Several evaluation frameworks guide community-based organizations through this process. The RE-AIM (Reach, Efficacy, Adoption, Implementation and Maintenance) framework enhances the quality and impact of public health programs by translating research into practice.<sup>41</sup> It is a widely used tool that can be used throughout implementation as an assessment and quality improvement tool. The National Council on Aging and U.S. Administration on Aging have recognized RE-AIM as a useful tool for community-based aging programs.<sup>42</sup> Strong evaluation metrics can inform future implementation efforts, providing justification for scaling a program up or down, replicating, or terminating a program.

#### *Lessons from the Field: The Value of Qualitative Data*

Qualitative and anecdotal information can complement hard data. ElderWatch learned this firsthand.

Besides collecting how many complaints were received, the number of scams in the works and other data, staff members also listened to stories shared by victims of fraud and financial abuse. The ElderWatch staff saw patterns in the reports that came in. The stories suggested a strong connection between financial abuse and health and life changes.

Victims were often in a poor physical or mental health when they were approached or were undergoing a transition, such as leaving the hospital. Some were grieving for a loved one who recently died or planning a move to another home. ElderWatch hopes to share these findings and information about its programs with discharge nurses, social workers and other professionals on the front lines.<sup>43</sup>

#### *Critical Success Factors*

- An evaluation framework, like RE-AIM, can inform the evaluation metrics used for program evaluation. Identifying a framework early in the planning process can help ensure that the necessary metrics are being collected.
- Use evaluation metrics that reflect programmatic goals and participant experiences.
- Look to community partners for input on and support with data collection and evaluation.
- Qualitative metrics can be equally important as quantitative data for making mid-course corrections and measuring success. This is particularly true for programs still building an evidence basis.
- Use the findings to refine the program, expand it or scale it back.

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Communities may develop programs in response to new funding opportunities. But in today's environment of uncertain support, programs for the aging must plan for financial stability from the start.

Developing a financially sustainable program requires a clear understanding of costs — not just for the actual services but for staffing and administration.<sup>44</sup> It's common for new programs to consider using volunteers to reduce costs. However, it's important to factor in expenses associated with operating and managing a volunteer program.<sup>45</sup>

Worker retention is one important factor to consider when planning for financial sustainability of a program. Cost-of-living increases and inflation are outpacing growth in income for many low-wage direct-care workers serving older adults in Colorado, such as those in the health care or transportation industries.<sup>46</sup> Competitive wages and benefits, comprehensive training, career advancement opportunities and culture are some key retention factors to consider.<sup>47, 48</sup> One study of certified nursing assistants showed that extrinsic rewards, such as higher wages and paid time off, were more closely linked to job tenure compared with office culture and other intrinsic factors.<sup>49</sup> In addition to financial disincentives, the high physical and emotional demands of providing direct service for high-need older adult populations also contribute to the high turnover rates.<sup>50</sup> These costs should be considered when implementing a new program that is financially sustainable.

Sometimes success comes at a cost. Word spreads fast when clients are pleased with services, especially when they are free or low cost. This serves as a built-in outreach mechanism for connecting with high-need individuals, but it also attracts other people who are not as needy. AAAs and other organizations are grappling with this phenomenon, sometimes referred to as service creep.<sup>51</sup>

One strategy for managing service creep is to charge a fee for certain services or for people above a certain income level. This can feel unfamiliar and uncomfortable for charitable organizations, but this approach recognizes that some older adults or their families are willing and able to pay for support.

Fortunately, new funding streams are becoming available. New health care financing and delivery options introduced in the Affordable Care Act incentivize providers to avoid hospital readmissions and keep costs in check by providing person-centered, coordinated health services. Community-based aging organizations, particularly those that address health care, personal wellness and home service needs, are well positioned to step in as partners in this effort. This could open up new pathways for additional funding if organizations serving older adults are able to measure the extent to which their programs save money by keeping older adults at home and out of hospitals or nursing homes.

#### *Lessons from the Field: Building Business Acumen in Community-Based Organizations*

A cohort of community-based aging organizations in Colorado is more than halfway through a two-year boot camp that promotes linkages between the health care sector — hospitals, providers and insurers — and long-term services and supports (LTSS) providers. The Colorado Linkage Lab, sponsored by the Colorado Health Foundation, provides participants training and technical assistance to grow their internal business capacity and to explore new funding partnerships.

✚ *Lessons from the Field: Community Paramedicine Taps into Insurance Market*

Community paramedicine is an emerging best practice in the emergency medicine field — especially when it comes to keeping older adults healthy and safe at home.

Community paramedics are emergency medical technicians and paramedics who make house calls. A 911 operator asks questions to determine what the caller needs. Callers with non-acute concerns will be offered a visit by community paramedics, who are trained and equipped to treat a variety of medical needs and run tests without an expensive trip to the hospital.

Eagle County Paramedics in Colorado launched the first rural community paramedic program in the U.S. in 2009. A 2013 study estimated that the program had saved \$500,000 in net health care costs during its first three years.<sup>52</sup> Dispatch Health, a community paramedic agency in the Denver metro area, estimated most of its visits cost one-sixth the price of a typical ambulance transport.<sup>53</sup>

One of the biggest challenges for community paramedic programs involves reimbursement for services. When these programs begin, they are typically funded by the ambulance service itself or through grants.<sup>54</sup> In the 2016 legislative session, state lawmakers demonstrated their support for this emerging model by passing SB 16-069, which establishes community paramedics as a regulated, licensed health profession.

*Critical Success Factors*

- When budgeting, consider the costs of employee training and adequate wage and benefit compensation in order to retain workers.
- New aging programs should consider setting up sliding-scale fees or accepting payments for services. This could become a reliable funding source supported by those who are able to pay.
- Building business acumen can help a community-based aging organization understand the value of its services and effectively market its programs to potential partners.

## **Opportunities for the Strategic Action Planning Group on Aging**

While the framework is targeted to communities, there are several opportunities at the state level for supporting local implementation of aging programs. The SAPGA can consider some of those opportunities, outlined below, as it develops recommendations. The opportunities for the SAPGA have been grouped into four categories. Item 4 in the Appendix summarizes this section in a succinct table.

### **Support Data Collection**

- Colorado lacks an ongoing, consistent data resource that measures older adults' needs and experiences. The CASOA is valuable, but the 2011 findings are dated and there is no indication that the state survey will be updated in the near future (though some communities have fielded it more recently). The SAPGA could consider recommending ongoing investment in standard and consistent data collection at the state and local levels. Alternatively, it could work with local

communities and AAAs to identify opportunities for leveraging data that is already being collected and ensuring the information is publicly available and easily accessible.

- Measuring impact is critical for effective program implementation, but community-based aging organizations may not have the expertise or software to interpret and analyze data. The SAPGA could consider recommending creation of a specialized technical assistance resource to support aging groups. The technical assistance resource could be provided through a state agency or partnerships with private funders or other community partners.
- Investigating community needs and forging meaningful partnerships takes time and resources. Both may be in short supply for communities or aging organizations. The SAPGA could consider recommending planning grants for community-based aging initiatives.

### **Leverage Existing Resources and Expertise**

- Many Colorado communities have years of experience developing and implementing programs for seniors living in the community. For others, this is unfamiliar territory. Sharing best practices and disseminating lessons learned across communities could be a powerful way to ignite innovative ideas, create opportunities for collaboration and help to ensure that new programs are being set up for success. The SAPGA could consider recommending that Colorado offer a statewide conference or smaller-scale convening that allows for collaboration and sharing. Alternative options for engagement such as livestreaming, webchat or Zoom video conferencing could improve participation, especially among rural communities.
- The AARP's Network of Age-Friendly Communities initiative can be a great resource for Colorado communities to enhance their aging services and promote independent living. The network "helps participating communities become great places for all ages by adopting such features as safe, walkable streets; better housing and transportation options; access to key services; and opportunities for residents to participate in community activities."<sup>55</sup> The SAPGA could explore ways to promote this initiative and encourage more Colorado communities to join the network.

### **Identify Systemic Strategies for Supporting Implementation**

- State policymakers can play a role in building age-friendly communities by establishing standards or guidelines to ensure that new programs and service providers meet certain baseline criteria. Incorporating standards into contracts between state agencies and community provider organizations is one way to create quality assurance safeguards that promote efficient use of resources and effective service delivery.<sup>56</sup>
- Many opportunities identified in the framework are closely aligned with the work underway to establish a No Wrong Door system in Colorado. For example, a comprehensive database of community-based services for older adults, something proposed in the No Wrong Door plan, would be an invaluable tool for communities as they evaluate assets and needs, identify partners and measure the impact of new programs. Such a database could require a large time and financial commitment. Because the No Wrong Door pilot program is still in a nascent stage and long-term funding is not certain, the SAPGA may choose to support this work through its recommendations.

**Consider Older Adults' Needs in All Policies and Programs**

- Including older adults in planning and evaluation will help ensure that program goals meet the needs of older adults. The SAPGA could consider recommending that state agencies prioritize funding for programs that demonstrate meaningful participation by the people they are aiming to serve.
- Creating an age-friendly environment is about more than just developing senior programming. It's about creating a community that supports residents of all ages. The SAPGA can identify policies and programs where there are opportunities to better integrate older adults' perspectives and needs.

**Conclusion**

Colorado's senior population is projected to increase by nearly 70 percent by 2030. And most older adults will want to age in place. Local leaders and organizations will play an important role in meeting the growing demand for community-based aging programs.

This report can serve as a guide for communities looking to strengthen their network of services for older adults. It synthesizes insights from state experts, representatives of local programs, national leaders and other sources on aging and service delivery. The five-part framework identifies components of successful program implementation and highlights common decisions and considerations organizations face as they undergo this process.

While this research is focused on the programmatic and community level, there are many steps that state policymakers can take to support communities in their efforts. CHI researched potential policy levers and funding opportunities and included those findings in the report.

The SAPGA can contact Natalie Triedman with any questions about this research. She can be reached at [triedmann@coloradohealthinstitute.org](mailto:triedmann@coloradohealthinstitute.org) or 720-382-7077.

## APPENDIX

### Item 1. Health Care Needs

The research question evolved throughout the research process due to the interests of the SAPGA. A key element of the initial research was to identify some of the most prominent needs of older adults in Colorado. Those findings are included below.

CHI identified four categories of needs among Colorado's older adults seeking to age in place: health care, personal wellness, financial wellness, and home services and community engagement. Housing, transportation and informal caregiving also surfaced as recurring needs but were excluded due to overlap with other research projects for the SAPGA.

Health Care: The ability to access to health care is essential for seniors who want to age in the community of their choice. Seniors who face barriers to health care may end up moving to nursing facilities where 24-hour skilled care is available.

- Nearly 60 percent of adults ages 60 and older in Colorado said they have had recent problems with their physical health and about one of four reported problems getting health care.<sup>57</sup> Among the 156,000 older adults who said they went to an emergency department in the past year, 30 percent said it was for a condition that could have been treated by a regular doctor.<sup>58</sup>
- Access to affordable and quality mental health care also surfaces as a priority need, with only 40 percent of older adults in Colorado reporting good or excellent access to those services and 37 percent experiencing depression.<sup>59</sup>
- When it comes to oral health, 41 percent of older adults said they have tooth or mouth problems and more than one third said they were not able to get needed dental care.<sup>60</sup> About 15 percent cited cost as the reason.<sup>61</sup>

Personal Wellness: Staying physically active and eating nutritious food promote healthy aging. But many older adults have trouble eating right and finding opportunities for exercise.

- More than half of Colorado seniors (57 percent) said they have problems staying physically fit<sup>62</sup> and only three of four participated in any physical activity in the past month.<sup>63</sup> Forty percent had trouble finding interesting recreational or cultural activities.<sup>64</sup>
- One of three older adults in the state said they do not have good access to affordable, quality food and 10 percent reported problems obtaining enough to eat.<sup>65</sup>

Financial Wellness: Financial wellness is a critical factor that can help or hurt a person's ability to age in place. A financial plan provides security for older adults and peace of mind for their families and caregivers.

- More than one of three older Coloradans said they struggle to pay their daily expenses. A similar percentage do not have good access to financial or legal planning services.<sup>66</sup>

- When it comes to paying for health care, nearly one of five Colorado older adults (18.4 percent) does not feel financially well-protected. More than 10 percent had trouble paying their medical bills in the past year. Among them, more than half (59,000 people) saved less or took funds out of savings, 42 percent (49,000 people) took on credit card debt, 27 percent (31,000 people) cut back on basic necessities like food, heat or rent and 5 percent declared bankruptcy (6,000 people).<sup>67</sup>
- More than one of seven older adults in Colorado, 15 percent, said they have been the victim of fraud or a scam in the past year.<sup>68</sup> According to a representative from AARP Foundation’s ElderWatch program, financial exploitation of seniors is often treated as a blame-the-victim crime, which discourages seniors to report issues.<sup>69</sup>

Home Services and Community Engagement: Home services such as electrical repairs or mowing the lawn can quickly become formidable barriers to older adults’ ability to remain in their homes.

## **Item 2. Evidence-based and Emerging Aging Programs**

CHI reviewed the Community Assessment Survey for Older Adults (CASOA) as well as various reports from state commissions focused on aging. Based on this research, CHI identified four categories of need:<sup>1</sup>

- Health Care
- Personal Wellness
- Home Services and Community Engagement
- Financial Wellness

In preparation to respond to the initial research question, which charged CHI with highlighting specific community-based aging programs, CHI compiled a list of programs for consideration. The research question changed significantly, but this preliminary list of programs may be useful for the SAPGA in other ways.

The **health care** programs identified were:

- Coleman Care Transitions Intervention (CTI)<sup>70</sup>
- Program for the All-Inclusive Care for the Elderly (PACE)<sup>71</sup>
- Stanford’s Chronic Disease Self-Management program
- Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)<sup>72</sup>
- Healthy Identifying Depression, Empowering Activities for Seniors (IDEAS)<sup>73</sup>
- Virtual Dental Homes<sup>74</sup>
- Brief Intervention and Treatment for Elders (BRITE)<sup>75</sup>
- Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)<sup>76,77</sup>
- ElderSmile<sup>78</sup>
- Memory Café
- HealthSET<sup>79</sup>

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<sup>1</sup> Transportation and housing needs were also identified. These were not included since the SAPGA is already exploring best practices and policy options for transportation and housing as part of other research questions.

- Senior Reach<sup>80</sup>
- Community Paramedicine<sup>81</sup>
- Home MEds<sup>82,83</sup>

The **personal wellness** programs identified were:

- Matter of Balance<sup>84,85</sup>
- Stepping On<sup>86</sup>
- Healthy Moves for Aging Well<sup>87</sup>
- Silver Sneakers<sup>88</sup>
- EnhanceFitness<sup>89</sup>
- Chronic Disease Self-Management Programs<sup>90</sup>
- Congregate Nutrition Services<sup>91</sup>
- Meals on Wheels<sup>92,93</sup>
- Project Angel Heart<sup>94</sup>
- Project Lifesaver<sup>95</sup>
- Tai Chi (Tai Ji Quan): Moving for Better Balance<sup>96,97</sup>
- Active Choices<sup>98</sup>
- Active Living Every Day<sup>99</sup>
- Falls Talk and FallScope<sup>100</sup>
- Fit and Strong!<sup>101</sup>
- Geri-Fit<sup>102</sup>
- Stay Active and Independent for Life (SAIL)<sup>103,104</sup>
- Walk with Ease<sup>105</sup>
- Otago Exercise Program<sup>106</sup>

The **home services and community engagement** programs identified were:

- Village to Village<sup>107</sup>
- Naturally-Occurring Retirement Communities (NORCs)<sup>108</sup>

The **financial wellness** programs identified were:

- Savvy Saving Seniors<sup>109</sup>
- BenefitsCheckUp<sup>110</sup>
- ElderWatch<sup>111</sup>
- Senior \$afe<sup>112</sup>

While programs for informal caregivers were excluded from the research due to overlap with other SAPGA projects, the following evidence-based caregiver support programs were identified during this early phase of research.

- Powerful Tools for Caregivers<sup>113</sup>
- Resources for Enhancing Alzheimer's Caregiver Health II (REACH II)<sup>114</sup>
- Stress-Busting Program for Family Caregivers<sup>115</sup>
- Tailored Caregiver Assessment and Referral (TCARE)<sup>116</sup>
- NYU Caregiver Intervention<sup>117</sup>

**Item 3. Vulnerability Factors by County, Colorado**

County	Older Adults who are 80+ Years Old <sup>118</sup>	Older Adults who are a Minority <sup>119</sup>	Older Adults Living in Poverty <sup>120</sup>	Older Adults Living with a Disability <sup>121</sup>	Older Adults Living Alone <sup>122</sup>	County Designation <sup>123</sup>
Adams	23%	27%	9%	38%	35%	Urban
Alamosa	23%	37%	14%	44%	45%	Rural
Arapahoe	23%	17%	8%	32%	38%	Urban
Archuleta	18%	11%	7%	32%	31%	Rural
Baca	34%	5%	10%	51%	44%	Frontier
Bent	26%	24%	9%	52%	43%	Frontier
Boulder	22%	9%	6%	27%	39%	Urban
Broomfield	24%	10%	6%	32%	42%	Urban
Chaffee	24%	6%	4%	32%	36%	Rural
Cheyenne	30%	2%	5%	48%	39%	Frontier
Clear Creek	15%	4%	4%	28%	35%	Urban
Conejos	27%	58%	19%	55%	41%	Rural
Costilla	24%	63%	15%	54%	43%	Frontier
Crowley	24%	19%	26%	61%	46%	Rural
Custer	18%	3%	7%	36%	32%	Frontier
Delta	26%	6%	12%	38%	39%	Rural
Denver	25%	34%	12%	36%	50%	Urban
Dolores	24%	4%	8%	40%	40%	Frontier
Douglas	17%	8%	4%	25%	28%	Urban
Eagle	11%	11%	7%	17%	28%	Rural
Elbert	14%	5%	4%	35%	26%	Urban
El Paso	23%	15%	7%	34%	38%	Urban
Fremont	26%	7%	8%	39%	41%	Rural
Garfield	20%	8%	10%	34%	35%	Rural
Gilpin	12%	4%	8%	31%	29%	Urban
Grand	16%	3%	2%	23%	38%	Rural
Gunnison	16%	4%	11%	28%	41%	Frontier
Hinsdale	16%	1%	11%	22%	28%	Frontier
Huerfano	25%	30%	9%	38%	46%	Frontier
Jackson	26%	2%	3%	34%	40%	Frontier
Jefferson	23%	10%	5%	31%	38%	Urban
Kiowa	29%	1%	11%	35%	45%	Frontier
Kit Carson	28%	5%	11%	42%	43%	Frontier

Lake	17%	22%	4%	16%	36%	Rural
La Plata	20%	11%	6%	31%	32%	Rural
Larimer	23%	6%	6%	32%	37%	Urban
Las Animas	25%	37%	12%	45%	44%	Frontier
Lincoln	33%	4%	7%	47%	46%	Frontier
Logan	30%	6%	8%	38%	41%	Rural
Mesa	27%	7%	9%	37%	39%	Urban
Mineral	18%	3%	4%	33%	41%	Frontier
Moffat	23%	6%	7%	45%	53%	Frontier
Montezuma	24%	11%	6%	38%	37%	Rural
Montrose	26%	7%	10%	35%	38%	Rural
Morgan	29%	14%	11%	40%	44%	Rural
Otero	30%	31%	13%	41%	40%	Rural
Ouray	14%	2%	4%	20%	23%	Rural
Park	12%	5%	8%	18%	28%	Urban
Phillips	36%	5%	12%	41%	41%	Rural
Pitkin	16%	3%	13%	18%	35%	Rural
Prowers	27%	18%	16%	47%	44%	Rural
Pueblo	27%	31%	11%	40%	41%	Urban
Rio Blanco	24%	5%	20%	37%	45%	Frontier
Rio Grande	25%	31%	18%	46%	36%	Rural
Routt	14%	3%	8%	17%	36%	Rural
Saguache	17%	29%	11%	42%	49%	Frontier
San Juan	12%	3%	7%	34%	56%	Frontier
San Miguel	10%	3%	7%	29%	42%	Frontier
Sedgwick	32%	9%	9%	40%	44%	Frontier
Summit	11%	3%	3%	10%	25%	Rural
Teller	14%	4%	4%	25%	32%	Urban
Washington	30%	2%	11%	36%	42%	Frontier
Weld	22%	17%	8%	38%	36%	Urban
Yuma	29%	4%	7%	33%	42%	Frontier

\*In this analysis, older adults were defined as individuals 65 and older.

**Item 4. Summary of Opportunities for the SAPGA**

This research yielded the following opportunities as having potential for supporting implementation of community-based aging programs. The Colorado Health Institute does not endorse these strategies or policies.

Support Data Collection
1. Support ongoing investments in standard and consistent data collection at the state and local levels, such as the CASOA.
2. Identify strategies for leveraging data that is already being collected, ensuring that it is publicly available and easily accessible.
3. Create a shared technical assistance resource to support aging groups with data collection, evaluation and quality assurance.
4. Identify existing funding streams that support program planning. Assess whether a recommendation for more resources like this are needed.

Leverage Existing Resources and Expertise
1. Support shared learning by creating a statewide conference or smaller convening for communities to share best practices and implementation challenges.
2. Promote AARP’s Network of Age-Friendly Communities by educating local leaders about resources available through this initiative and encouraging more Colorado communities to participate.

Identify Systemic Strategies for Supporting Implementation
1. Research whether other states use standards or guidelines to ensure that all community-based programs and service providers meet certain quality assurance criteria.
2. Depending on findings from the research above, consider incorporating standards into contracts between state agencies and community provider organizations to create quality assurance safeguards that promote efficiency and effective service delivery.
3. Identify opportunities to align the SAPGA recommendations with Colorado’s No Wrong Door Initiative.
4. Support work already underway to create a comprehensive database of community-based services for older adults.

Consider Older Adults’ Needs in All Policies and Programs
1. Prioritize funding for programs that demonstrate meaningful participation by the people they are aiming to serve.
2. Identify policies and programs where there are opportunities to better integrate older adults’ perspectives and needs.

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