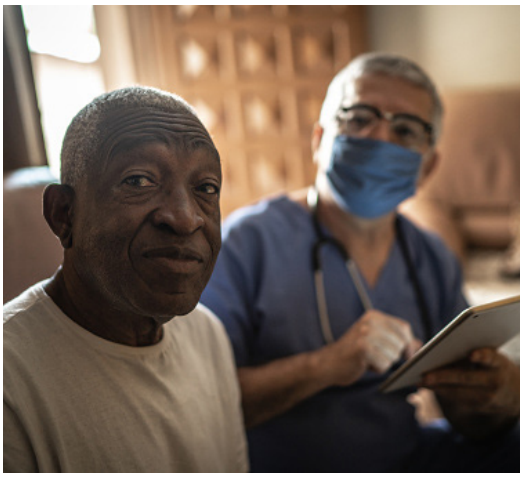
NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING





AGING Innovations & Achievement AWARDS

n4a

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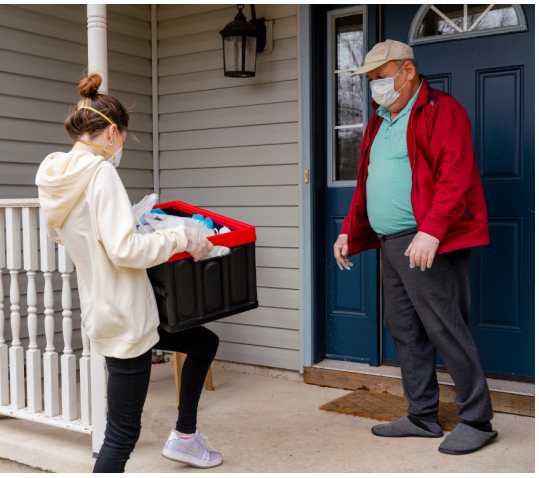

2020

advocacy | action | answers on aging

About n4a

The National Association of Area Agencies on Aging (n4a) is a 501(c)(3) membership association representing America's national network of 622 Area Agencies on Aging (AAAs) and providing a voice in the nation's capital for the more than 250 Title VI Native American aging programs. n4a's primary mission is to build the capacity of our members so they can help older adults and people with disabilities live with dignity and choices in their homes and communities for as long as possible.

For more information about n4a, AAAs or Title VI programs, visit www.n4a.org.

n4a's Aging Innovations and Achievement Awards staff:

Sandy Markwood, Chief Executive Officer

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Rebecca Levine, Senior Manager, Membership

Additional editing by Joellen Leavelle, Director, Communications.

CENTENE® Corporation

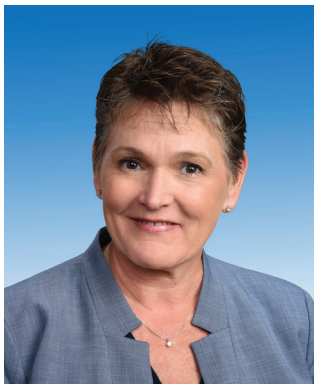
About Centene

Centene Corporation is a leading multi-national healthcare enterprise committed to supporting older adults and persons with disabilities. Centene takes a local approach to provide high-quality services through government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. We have a whole-person approach to meet our members' needs, including addressing the social determinants of health. We partner closely with advocacy groups and providers, such as Area Agencies on Aging, to implement innovative programs and improve the overall quality of care for our members. For example, we are currently collaborating with AAAs across six states to provide food and essential services during the COVID-19 pandemic. Through our ongoing collaboration with AAAs, we are improving quality of life and health outcomes.

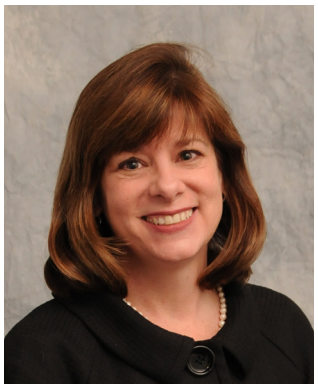
Centene Leadership:

Mark Henry, Director, Contracting & Network Development

The bottom right cover photo and middle photo on page seven are both National Aging and Disability Transportation Center photo contest winners, and used here with permission. www.nadtc.org.



Deborah Stone-Walls
n4a President



Sandy Markwood
n4a CEO

Every year, the National Association of Area Agencies on Aging (n4a) proudly recognizes the innovative programs and best practices of our members through the *n4a Aging Innovations and Achievement (AIA) Awards* program. This publication is a comprehensive listing of the 44 programs earning awards in 2020.

It is thanks to our partnership with Centene that we have this opportunity to honor and showcase the initiatives of Area Agencies on Aging (AAAs) and Title VI Native American aging programs across the country.

We salute all those who have enhanced the prestige of this awards program by sharing their initiatives with their peers in the Aging Network. This sharing of cutting-edge concepts, best practices and innovative ideas helps inspire others, seed replication and ultimately, boost the capacity and success of all agencies.

The awards highlight leading-edge and successful programs that demonstrate sound management practices that are replicable by others in the Aging Network. They exemplify both traditional and new strategies in a range of categories including Advocacy, Agency Operations, Caregiving, Community Planning & Livable Communities, Diversity & Cultural Competency, Economic Security, Elder Abuse Prevention, Health-LTSS Integration, Healthy Aging, Home & Community-Based Services, Housing, Information & Referral/Access to Services, Intergenerational Programs, Nutrition, Social Engagement, Technology, Transportation & Mobility and Workforce Development.

Aging Innovations Awards honor the most innovative programs among all nominations received and **Aging Achievement Awards** recognize the most contemporary, effective and replicable programs.

Annually, the awards are presented during the n4a Conference & Tradeshow. This year during the n4a Virtual Conference & Tradeshow, 17 programs were honored with engraved Aging Innovations Awards and 27 received Aging Achievement Awards with a certificate of recognition. In addition, through the generous support of Centene, the top three highest-ranking recipients received monetary awards.

To qualify for an award, programs must have been in operation between one and five years, receive minimal assistance from outside experts and demonstrate effective approaches in either offering new services or improving existing services. Awards criteria include demonstration of measurable results, e.g., cost savings, improved client service and enhanced staff productivity. The AIA Awards are open to n4a members only.

Given the criteria that a program must have been in operation for at least a year to qualify for an award in 2020, all programs included in this publication were implemented prior to the start of the COVID-19 pandemic. The program summaries for the Aging Innovations Awards contain, where possible, details on how each program has adapted or adjusted in response to COVID. We believe that the tremendous innovations and adaptations developed by the Aging Network this year in response to the pandemic will likely generate future AIA-winning programs and seed other game-changing programs and practices.

Highlights of all past Aging Innovations Award recipients are available in the n4a members-only clearinghouse of best practices at **www.n4a.org/bestpractices.**

We hope that these award-winning programs will inspire your efforts as you address current challenges, seize opportunities and implement solutions in your community. And remember, plan to share your innovations with us next year!

n4a Aging Innovations Award Winners

n4a Aging Achievement Award Winners

HEALTHY AGING

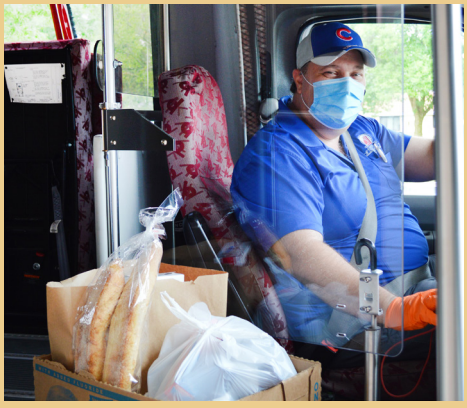
HOUSING

NUTRITION

SOCIAL ENGAGEMENT

TRANSPORTATION & MOBILITY

advocacy | action | answers on aging



2020

Aging INNOVATIONS Awards

ADVOCACY

Boston's Senior Civic Academy

Age Strong Commission

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Boston's Senior Civic Academy is a six-week, 30-hour program that educates and empowers adults age 50 and older to advocate for themselves and their peers about issues related to aging in Boston. Now in its third year, the Academy focuses on advocacy at the city, state and federal levels, and engages participants in developing public-speaking, information-gathering and networking skills.

Age Strong Commission, Boston's Area Agency on Aging, developed the curriculum for the Academy through a partnership with the UMass Boston Gerontology Institute. The Academy provides participants with information about local government, skill-building activities and networking opportunities with elected officials. An outreach plan ensures participants are recruited from different neighborhoods and diverse backgrounds, and participants are surveyed about topics of interest to ensure the program includes relevant information. During a graduation ceremony, participants make a two-minute advocacy "pitch" for the policy issue of their choice.

COVID-19 Update

Age Strong Commission postponed the spring 2020 in-person program in response to the pandemic. Staff are currently exploring the possibility of adapting the Academy to a virtual platform.

Budget:

The only program cost is for participant supplies (less than $200). Existing staff run the program and coordinate with government departments and officials to provide content. Lunch and meeting space are donated.

Accomplishments:

Evaluation results indicate participants gained familiarity with and confidence in advocating at various levels of government. After completing the six-week program, all 50 graduates continue to be civically engaged, with many advocating for a village model in the community and for a variety of bills at the State House.

Replicability:

Develop partnerships with government departments and nonprofit and advocacy organizations to support content and curriculum creation. Invite residents age 50 and older to apply, and review applications to identify individuals who have a passion for and commitment to improving the community.

Building the AAA's Value in the Business Community

Council on Aging of Southwestern Ohio

Local business leaders often do not realize that the Council on Aging of Southwestern Ohio (COA) supports a population that extends beyond older adults. To address this issue, COA developed an advocacy campaign to help area businesses and organizations such as the Chamber of Commerce recognize the impact family caregiving has on the regional workforce and how Area Agencies on Aging help family caregivers stay in the workforce.

The campaign includes Care Census, a company-specific research project to help businesses understand the time and resource demands their employees face. An extensive social media and email campaign centers on the economic, personal and professional impact of caregiving on the workforce. Nine "working caregiver" videos incorporate the stories of real working caregivers to further convey the impact of caregiving on the workforce and how COA can support area business employees who are also caregivers.

Budget:

COA partnered with a local marketing firm to build and implement the advocacy campaign, including the Care Census ($33,500), the "working caregiver" videos and broadcast and social media advertising ($52,000), monthly email outreach and LinkedIn sponsored content ($155,450). Additional costs included internal staff time spent on project management, travel and outreach events.

Accomplishments:

The 164,500-plus views of caregiver videos and 1,000 responses to the Care Census indicate that the campaign is helping businesses understand how caregiving impacts their workforces. COA has held 16 employer-based education events and has sent 77,000 executive emails with a 22 percent open rate and 20,700 LinkedIn InMails with a 48 percent open rate.

Replicability:

This project is easily replicable by drawing on organizational board and advisory council connections. Project staff will need access to a variety of inexpensive, easy-to-use online survey and email marketing tools and free social media accounts.

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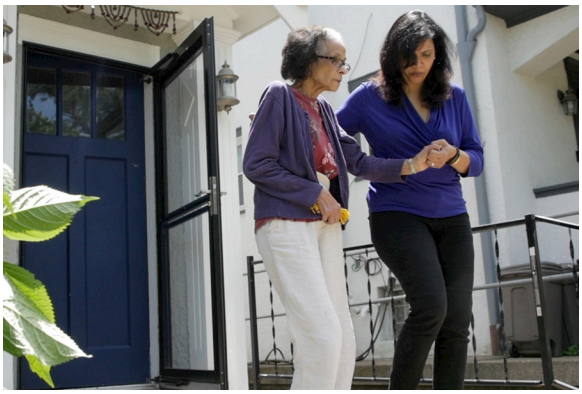

COVID-19 Update

Using the momentum of the 2020 Census, COA was set to launch a second wave of the Care Census with area employers, but the pandemic shifted priorities. With many caregivers working remotely and under social distancing orders that may prevent them from visiting older loved ones, working caregivers are facing new challenges. The Care Census is as relevant as ever and remains part of COA's strategic priorities.

ADVOCACY

Reframing Aging San Francisco

San Francisco Department of Disability and Aging Services

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The Reframing Aging San Francisco (SF) initiative seeks to raise awareness of ageism and its cost to communities, disrupt negative stereotypes about aging and connect older residents with supportive services. Leaders from advocacy and service organizations, a private foundation, and the San Francisco Department of Disability and Aging Services (DAS) joined together to develop this cohesive strategy to address ageism in San Francisco.

After a series of educational sessions with the Frameworks Institute (a nonprofit that specializes in using evidence-based techniques to communicate about social issues), working sessions with agencies serving diverse populations, and local research to understand perspectives on aging and ageism, DAS developed a vivid public messaging campaign that integrates traditional and social media strategies. The campaign showcases how characteristics like creativity and courage never get old. Local older adults' stories are shared on the campaign website.

Budget:

Reframing Aging SF is funded by government and philanthropic resources. Developing and implementing the public messaging campaign cost $200,000. Other components, such as educational workshops, had much lower one-time fees. In-kind donations offset many costs.

COVID-19 Update

The pandemic has only highlighted how difficult ageism and isolation are to overcome. During the pandemic, Reframing Aging SF has continued its efforts by providing guidance to prevention efforts emphasizing COVID-19 as an intergenerational problem for people with underlying health conditions, not just a problem for older adults; working with the community to help bridge the digital divide; and working with the California Department of Aging on a statewide virtual town hall to combat ageism.

Accomplishments:

The public campaign resulted in 8,500 clicks on paid social media posts, 5,000 visits to the initiative's website and more than 3,800 people sharing the anti-ageism pledge online. As a result of the campaign, providers have reframed the way they talk and write about aging, a critical first step in changing perceptions. These efforts have been highlighted in news media and celebrated by leading aging advocates.

Replicability:

Collaboration with a diverse community network that understands local culture is critical for success. Buy-in and participation from local partners significantly extends the audience and impact of public messaging efforts. Develop a shared toolkit of resources that partners can leverage in their own contexts.

AGENCY OPERATIONS

FIRST: Boosting Dementia Capability Through Cognitive Screening

County of San Diego Health and Human Services Agency, Aging & Independence Services

To increase dementia service capability and assist older adults who may be living with dementia, the County of San Diego Health and Human Services Agency, Aging & Independence Services (AIS) has implemented new cognitive screening protocols. The FIRST cognitive screening program is conducted with clients who meet specific criteria (over age 65 with deficiencies in two or more activities of daily living or over age 85). Those whose score places them in the at-risk category are encouraged to follow up with their doctors.

This new practice is embedded into agency procedures, and an online training is provided for incoming staff. The new screening protocols require Adult Protective Services staff, In-Home Supportive Services intake social workers and Older Americans Act Title III B case management staff to provide cognitive assessments using one of two cognitive screening tools (Mini-Cog or AD8).

Budget:

Approximately $10,000 of in-kind staff time was spent to develop policies, procedures, training and materials to implement systematic cognitive screening. Annual printing costs for materials are less than $100. Existing staff integrate the brief training intervention into their existing workflow.

Accomplishments:

Through 2019, 289 clients across agency programs were screened, with 184 clients (64 percent) scoring at-risk. Of those who scored at-risk, 113 (61 percent) consented to sharing their results with health care providers.

Replicability:

The screening portion of the program can be replicated with minimal staff time by adapting the AIS protocol and materials. AIS created a 30-minute online training to provide guidance on when and how to conduct screening and which assessment to use based on the context. Screening is conducted using publicly available tools that have no licensing fees.

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COVID-19 Update

In response to the pandemic, AIS began conducting the AD8 screening via phone calls when home visits are not possible. Some programs have temporarily suspended screening activities, while others have been able to continue, including the FIRST case management program. The training on how to use the protocol and make physician referrals was designed to be conducted virtually with a video, so that component has continued unabated during the pandemic.

CAREGIVING

Older Relative Caregivers: Back to School

Alamo Area Council of Governments Area Agency on Aging

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Through community partnerships, employee donations and Older Relative Caregiver (ORC) funding, the Back to School program provides backpacks, school supplies and clothing/school uniforms to children being raised by grandparents or relative caregivers who are age 55 or older.

Local partnerships enabled the program, which initially provided backpacks to a handful of families in need, to grow in recent years. In December 2018, the Alamo Area Council of Governments Area Agency on Aging developed a partnership with San Antonio Threads, a local nonprofit. The AAA provides funding and children's sizes and ages to San Antonio Threads, which gathers appropriately sized clothing and shoes so that families can "shop."

Budget:

Funding comes from the National Family Caregiver Support Program (Older Americans Act Title III E). As the program has grown, more of the ORC portion has been dedicated to the Back to School program. In 2019, total funding of $62,294 included direct support ($45,428) and personnel/overhead ($16,866). Budgeted funding for 2020 is $66,548 to serve an estimated 350 children from 145 ORC families.

COVID-19 Update

While the in-person back-to-school voucher distribution and resource fair was not possible this year due to COVID-19 restrictions, AAA staff worked with the vendor to send all needed referrals. Flyers and brochures on community resources, special appointment cards and a letter of explanation were mailed to all registered Older Relative Caregiver families, noting the families were responsible for scheduling appointments for clothing shopping with the vendors, where social distancing protocols and safety measures were implemented. Staff also worked with the school districts to get backpacks delivered to the families.

Accomplishments:

The number of ORC families served increases each year as funding increases. In 2019, a total of 297 children from 122 ORC families were served. Of those responding to client satisfaction surveys, 100 percent reported that the program has had a positive impact and 90 percent felt services provided resolved problems they were having.

Replicability:

Partnerships are key to success and will look different in every community. AAAs can use OAA Title III E funding for the program and start small. Word of mouth will help partnerships and support grow.

HEALTH-LTSS INTEGRATION

Mobile Integrated Healthcare Partnership

Aging & Disability Services, City of Seattle Human Services Department, Seattle-King County Area Agency on Aging

Health One is a mobile integrated health program that helps reduce the burden of non-emergency 911 calls on the Seattle Fire Department (SFD) and connects vulnerable older adults with the services and supports they need for stability. A dedicated vehicle with two firefighters/medics and a Seattle Human Services Department Aging and Disability Services (ADS) case manager responds to non-emergency calls.

The Health One Program expands a four-year partnership between ADS and SFD through two programs: Low Acuity Alarm (follow-up with 911 callers whose complaints do not present immediate danger) and Vulnerable Adult (identification of adults at risk for abuse and self-neglect). An ADS case manager and SFD personnel also provide training and resources for high-utilizing locations, such as shelters and assisted living communities.

Budget:
The annual cost for two full-time case managers is $250,000, with one funded by the City of Seattle and the other funded by ADS. In 2019, SFD received $475,000 in city funds to launch the Health One team, which covered additional hiring, training, repurposing of a Chevy Suburban, protective clothing, and food and hydration for clients.

Accomplishments:
In its first three months of operation, Health One responded to 220 emergency calls. The median client age was 52. The three-person staffing model is highly effective, allowing for safety, the development of a rapport with clients and the ability to document activities. The Mayor of Seattle plans to add another vehicle soon.

Replicability:
This model can be replicated in any community where mobile vehicles can respond to 911 calls more easily than fire trucks. The City of Seattle can share data on the service's effectiveness.

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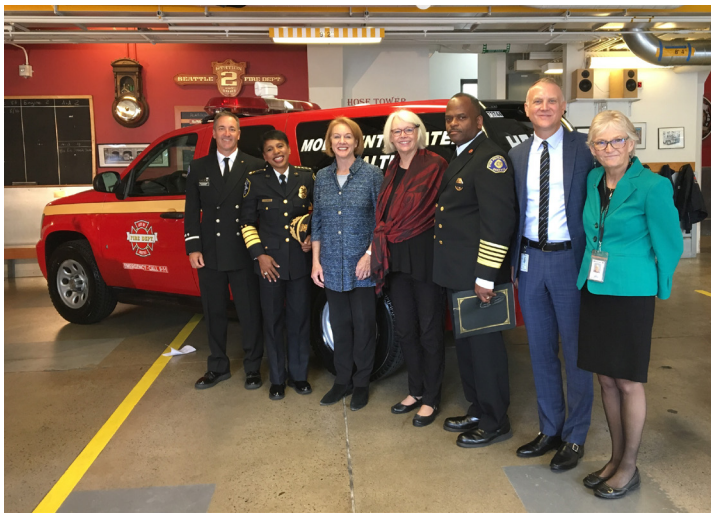

COVID-19 Update

At the start of the pandemic, the Mobile Integrated Healthcare Partnership adapted its protocols with ADS case managers helping remotely, either at SFD headquarters or from telecommuting sites and service expanded to the entire City of Seattle. After adequate safety protocols were established, ADS case managers returned to riding with firefighters in mid-May.

HEALTH-LTSS INTEGRATION

Take Charge

Elder Options

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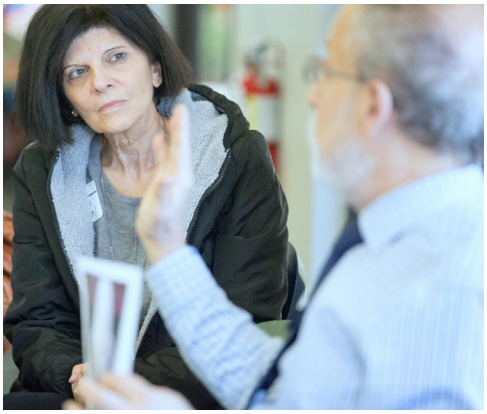

COVID-19 Update

With permission from the developers at the University of Washington, Elder Options has been providing the PEARLS program virtually. To allow coaches to work remotely, all coaches have been equipped with cell phones, as well as "soft phone" interfaces that allow them to conduct visits over the internet. If clients do not have a computer and/or Wi-Fi, 15 tablets are available for clients to check out. Elder Options has seen an increase in referrals to the overall Take Charge program since the start of the COVID-19 pandemic.

Since 2015, the Elder Options Take Charge program has contracted with University of Florida Health (UF Health) to provide a care coordination intervention to patients identified by the hospital as super utilizers—individuals who use the health care system with extraordinary frequency and have high health care costs. Take Charge staff regularly noted that many of their clients experienced depressive symptoms in addition to having a chronic disease. To address the issue, Elder Options integrated Program to Encourage Active and Rewarding Lives (PEARLS), an evidence-based depression management program targeted to adults 60 and older and their caregivers, into Take Charge in 2018. The result is a significant reduction in hospital admission rates and emergency room visits.

The Patient Health Questionnaire-9 (PHQ-9), a depression screening instrument, now is incorporated into the overall "Take Charge Healthy Living Program Assessment" and administered to all Take Charge clients. Clients scoring high on the PHQ-9 are referred for PEARLS services so their social and psychological needs can be addressed alongside physical issues.

Budget:

The annual program cost for PEARLS is $99,800, which covers two full-time employees (salaries and fringe benefits) and their travel reimbursement. The PEARLS program was initially funded by the Weinberg Foundation and Florida Health Networks, which is part of the Health Foundation of South Florida. As of August 1, 2020, the PEARLS program is funded by an U.S. Administration for Community Living Chronic Disease Self-Management Education Programs grant.

Accomplishments:

Based on data collected by UF Health, in 2018, hospital admissions for patients receiving PEARLS services decreased by 32 percent and emergency room visits decreased by 11 percent. PEARLS services have provided a measurable health benefit for Take Charge patients and have resulted in reduced medical costs for UF Health and insurers.

Replicability:

Data collected by UF Health on the positive benefits of introducing PEARLS services to patients being released from the hospital can help persuade local health care facilities of its effectiveness. When approaching hospital administrators about testing a Care Transitions intervention with a PEARLS component, emphasize the potential cost savings.

HEALTHY AGING

Care Transitions: A Model of Acuity and Activation

Region VII Area Agency on Aging

The Region VII Area Agency on Aging Community Care Transitions Initiative (CCTI) integrates an unskilled care transitions model with skilled medical care in the home to improve transitions of Medicare beneficiaries from inpatient hospital stays back to their homes. Region VII AAA Community Health Workers (CHWs) stationed in the hospital meet clients at their bedsides before discharge to arrange home visits, creating a smoother transition for clients. Having a knowledgeable, community-based point person within the hospital system is particularly beneficial to rural patients who live more than 60 miles from the hospital.

During the home visit, the CHW connects with a AAA-employed pharmacist for a medication reconciliation via video-conference software. Following each visit, the pharmacist sends a detailed letter summarizing the medication reconciliation to the client's health care providers and the client.

Budget:

Total operating costs for FY 2019 were $239,000, and included employing a pharmacist and three CHWs and purchasing software and laptops with secure Wi-Fi. Other costs include reimbursement for driving to rural areas. Grant funding covered startup costs. Now a hospital contract fully funds the program.

Accomplishments:

Of the 500 clients served, 80 percent were seen by a provider within seven days of discharge. Combined with the pharmacist's medication reconciliation, this reduced clients' readmission rate to three percent, compared to 18 percent for all hospital patients. The University of Michigan College of Pharmacy is documenting the positive outcomes for a journal article.

Replicability:

Appropriate staffing is needed to ensure the program can arrange meetings with clients that take place in a timely manner. A collaboration with a local health care organization helps ensure capacity-building, program sustainability and long-term funding.

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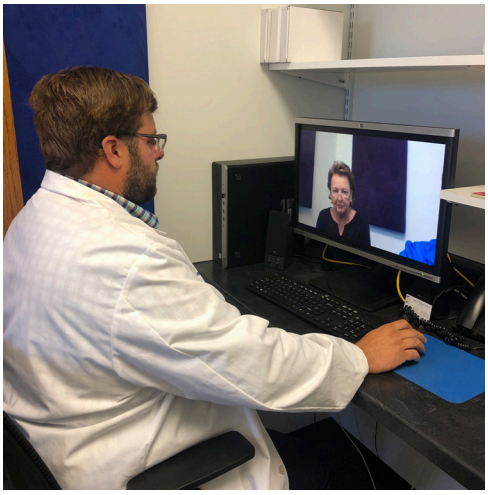

COVID-19 Update

The Region VII AAA transitioned its CHWs to a mobile workforce with the CHWs conducting visits using video conferencing software or by making phone calls to continue to meet the needs of those discharged in its community. The pharmacist still reviews all medications with the client to ensure any issues and errors are addressed. Referrals to the program have continued to come in during the pandemic and the impact on client care remains evident.

HEALTHY AGING

Community Impact Through Private/Public Collaboration

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The Valley Area Agency on Aging (VAAA) collaborated with Tivity Health, through Tivity Health's SilverSneakers health and fitness program, to provide additional opportunities for SilverSneakers' members to get out of their homes, socialize and move more, and for VAAA to reach more older adults, improve health outcomes among older adults and diversify its funding stream.

As part of the pilot program, VAAA reviewed evidence-based programs that made the most impact in its community, such as A Matter of Balance and arthritis exercise programs, then submitted those programs to Tivity Health for approval as SilverSneakers FLEX classes. In addition, the AAA began offering SilverSneakers Stability classes within the community. To expand access to the exercise and wellness classes and reach more older adults, VAAA offered SilverSneakers classes at senior centers, senior housing apartments, assisted living facilities, community centers, churches and more. VAAA and Tivity Health also worked together to develop a pre and post-test tool to measure outcomes.

COVID-19 Update

Following the start of the pandemic, VAAA partnered with Tivity Health to provide extra meals for homebound older adults to keep them safe, lessen outside contact and ensure they have nutritious meals, thus supplementing the AAA's usual offerings. VAAA now also offers virtual and outdoor SilverSneakers classes that have been extremely successful.

Budget:

VAAA used funds from the Older Americans Act and other funding sources to support the program. Operating costs include exercise equipment, mileage reimbursement and a percentage of each program coordinator's salary. VAAA was reimbursed by Tivity Health at a per member per class rate, with the revenue used to increase access to wellness classes for all older adults.

Accomplishments:

VAAA's class participation rate increased approximately 62 percent from 2017 to 2019. Tivity Health reported a 71 percent increase in participation among those SilverSneakers members who had not previously taken a class in the past year and an 88 percent increase in participation among those members who had never taken a class. Surveyed participants reported increases in strength and flexibility, improved health and reductions in depression, anxiety, stress, anger, isolation and loneliness.

Replicability:

To replicate, Area Agencies on Aging must register with Tivity Health to provide SilverSneakers classes and take additional online training. AAAs get reimbursed for SilverSneaker members. Marketing is key, with news interviews, mailings and social media helping to spread the word.

Opioids: Safe Use, Safe Storage, A Healthier You

Region IV Area Agency on Aging

To address the opioid public health crisis in Michigan, Region IV Area Agency on Aging pioneered a trailblazing regional partnership with health officials and housing authorities to develop and launch "Opioids: Safe Use, Safe Storage, A Healthier You," an opioid education and medication management program for older adults residing in senior housing complexes.

The project deploys Certified Addiction Prevention Specialists and focuses on providing training and education to combat older adult opioid use disorder; preventing opioid theft; and connecting older adults to alternative pain management options, addiction treatment and other supportive services. The programming is held in senior housing complexes.

Budget:

Program development costs in FY 2019 were $1,000. Operating costs for FY 2020 include $7,350 for staff ($350 per education session, provided by a health department in-kind match); $5,000 for events; and $57,000 for a prevention specialist, materials and supplies ($3,000 per site).

Accomplishments:

Programming was delivered at 12 senior housing complexes in FY 2019. Survey results show an increase in residents' understanding of what an opioid is (90 percent) and the potential harms/risks associated with them (93 percent); increased knowledge and understanding of alternative ways to treat pain (93 percent); and increased awareness of actions to prevent medication theft, properly store medications and properly dispose of unused or expired medications (93 percent). Due to project success, senior centers in the community have requested programming at their sites in 2020.

Replicability:

The program curriculum is available and easy to replicate in partnership with local health departments and housing authorities. To launch, use Older Americans Act funds or tap into local nonprofit health systems' community benefits or United Way health impact funds.

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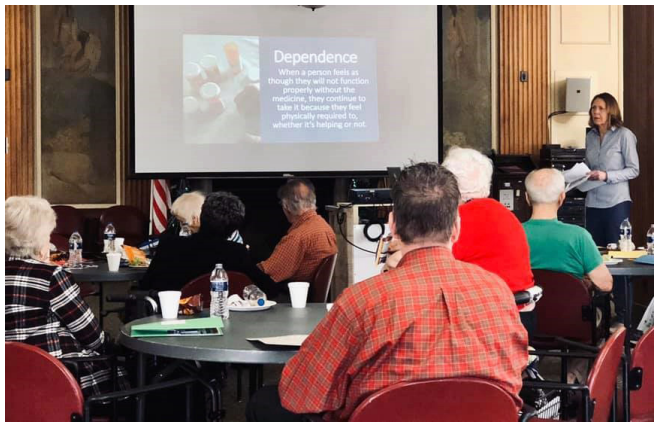

COVID-19 Update

In response to the pandemic, the program created a video recording of the education presentation and disseminated it to senior housing complexes and other residential facilities for residents to watch. The prevention specialist's contact information is provided in the video and as a part of the education packets, which include a Deterra drug-disposal packet, COVID-19 information, Lysol wipes and hand sanitizers, for one-on-one follow-up. In-person trainings are planned for fall 2020 at housing facilities and senior centers that have appropriate outdoor space to accommodate social distancing.

HOUSING

Bergen County Housing Navigator

Bergen County Division of Senior Services ADRC

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Bergen County Division of Senior Services ADRC

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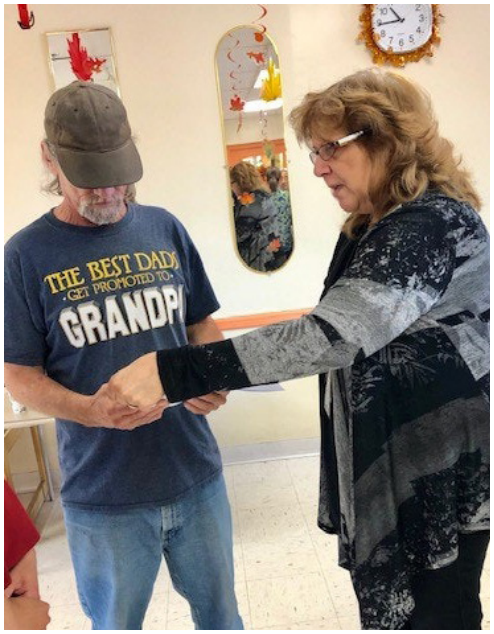

COVID-19 Update

The Housing Navigator program continues to operate at full capacity during the pandemic. The program has seen an increase in calls from older adults who are experiencing a financial impact from the pandemic and are worried about eviction or foreclosure, so staff have continued to help older adults understand their housing rights, provided timely updates on changes to state and federal eviction and foreclosure moratoriums, and directed older adults to local agencies who can help with their legal and financial needs.

In one of the most expensive counties in the nation, the Bergen County Housing Navigator program connects older adults, caregivers and people with disabilities to accessible, affordable housing. Based within the Information & Assistance Unit of the Bergen County Division of Senior Services (the AAA), the program creates a seamless link from the "front door" of their Aging and Disability Resource Center (ADRC) to accurate, timely information on housing.

The Navigator tracks subsidized housing listings, creates a "Navigator Notes" email newsletter with information on available housing options and articles on housing issues, and provides technical support to all providers within the ADRC network. Additionally, the Navigator serves as a liaison to the homeless services network, providing resources to at-risk older adults and assisting them as they transition from homelessness to permanent housing.

Budget:

The program was launched with Community Development Block Grant funding, which covered staffing costs in the first year. The total cost of the program (approximately $80,000 per year) is currently funded within the AAA budget as an Information & Assistance position. Costs include staffing, training and attendance at industry events.

Accomplishments:

Since the program began, the number of housing-related contacts has increased 60 percent and the Information & Assistance Unit has had more than 1,400 one-on-one interactions. Affordable housing property managers have requested the Navigator's assistance in conducting outreach to hard-to-reach populations.

Replicability:

This program is easily replicable within a AAA's Information & Referral/Assistance or equivalent program.

Elder Cottage Housing Opportunity (ECHO)

Clearfield County Area Agency on Aging, Inc.

The Elder Cottage Housing Opportunity (ECHO) enables older adults to live independently, age in place and maintain a higher quality of life by residing in manufactured cottages with affordable rent. The 600-square-foot accessible units can be placed on the property of a family member and include a large bedroom, a living/dining area and a wheelchair-accessible bathroom and kitchen. Elder cottages allow privacy for older adults to live in close proximity to their host family and give older adults a safe housing option.

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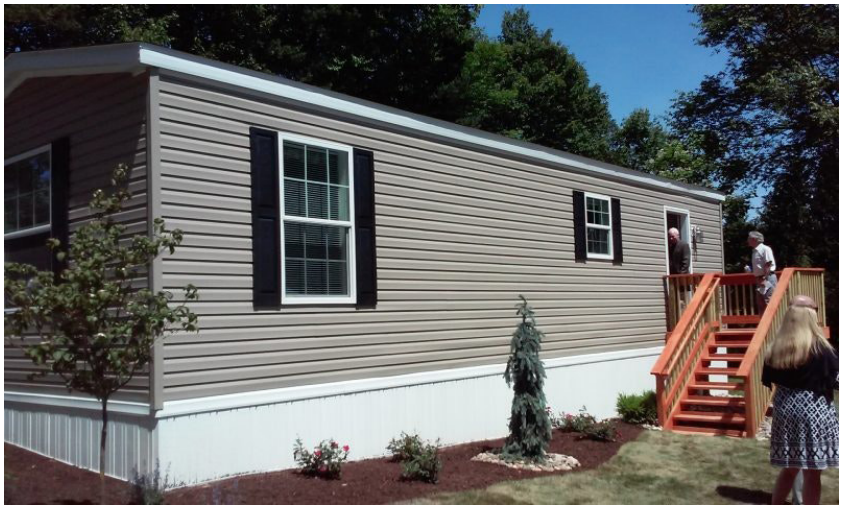
Mature Resources Foundation (MRF), a nonprofit affiliate of the Clearfield County Area Agency on Aging, owns and rents the cottages to older adults at a cost equivalent to 30 percent of their income. MRF is responsible for maintenance and upkeep and will relocate the cottage if the family or older adult no longer needs it.



Budget:

The first ECHO Cottage cost $100,433, which included all building-related costs. The second, more streamlined version of the project resulted in an ECHO Cottage cost of $49,974.

Accomplishments:

ECHO cottages provide safety and autonomy for older adults, reduce stress on family caregivers and preserve family cohesiveness. They are a more cost-effective and timely option than nursing home placement and can thus offer an alternative to premature institutionalization of older adults.

Replicability:

Replication requires partnering with a manufactured home company to design an appropriate, movable home; seeking grant funding to offset costs; and identifying eligible older adults with a target age and income level. Host families must agree to placement of the cottage on their property. Municipal guidelines such as zoning codes must be followed.

COVID-19 Update

The appeal of the ECHO program has only grown as older adults have experienced devastating outcomes while living in group settings, particularly nursing homes, as a result of the pandemic. The ECHO program has allowed older adults to age in place, experience better health outcomes and continue vital interaction with loved ones.

INTERGENERATIONAL PROGRAMS

Weaving Hearts Intergenerational Program

San Francisco Department of Disability and Aging Services

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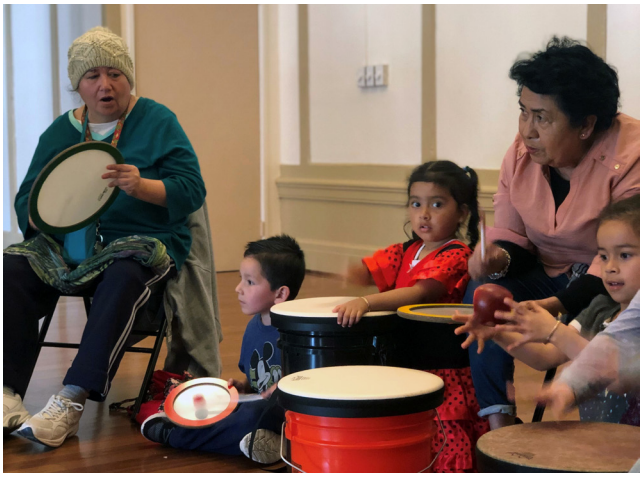

Weaving Hearts is an intergenerational program offered by the San Francisco Department of Disability and Aging Services (DAS) and Mission Neighborhood Centers, Inc. (a DAS provider) to celebrate Latino(x) culture and facilitate sharing of talents and resources between different generations. The program aims to empower older adults, reinforce feelings of being valued community members, mitigate feelings of loneliness and promote youth leadership.

Weaving Hearts includes three intergenerational activities. Each One Teach One is a percussion and singing intergenerational music class in which older adults learn songs and musical skills and share what they learn with preschool children and their parents. La Vida Comida brings together older adults with elementary and junior high school youth to make healthy, culturally significant meals, with recipes selected by the older adults. Tech-Pals is a monthly youth-led technology training for older adults that aims to bridge the digital divide for older adults and strengthen youth communication skills.

Budget:

The program budget of approximately $68,000 for 2019–2020 includes staffing ($28,000); operating costs and overhead ($22,000); subcontracting agreements for a music instructor, a technology consultant and a nutritionist ($17,000); and equipment costs ($1,000). Approximately .40 full-time equivalent staff time is shared among three employees.

Accomplishments:

In 2018–2019, 48 older adults participated in the program and 40 completed a follow-up evaluation survey. All survey respondents reported that the program helped them develop new relationships and that program participation reinforced their feelings of being valued members of the community.

Replicability:

Organizations first need to assess demand for intergenerational, culturally relevant programming and establish relationships with youth groups interested in participating. The amount of funding needed depends on the ability of organizations to leverage existing resources for operating costs and staffing.

COVID-19 Update

In response to the pandemic, Weaving Hearts began providing music, dancing and cooking classes via Zoom. To ensure older adults can participate in the online classes and virtual activities, program staff distributed tablets and hotspots and provided training to participants.

NUTRITION

Change of Condition Project

Minuteman Senior Services

The Change of Condition (COC) Project is expanding and standardizing safety checks for the thousands of homebound older adults served by the Minuteman Senior Services Meals on Wheels (MOW) program. Through this proactive approach, 700 MOW drivers use a smartphone software application to record potential health and safety concerns they observe during their deliveries. The app sends an immediate report to a designated specialist at Minuteman so staff can follow up the same day.

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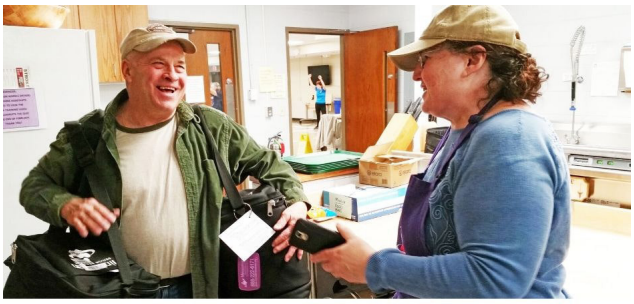
The smartphone app was developed in partnership with YPoint Analytics and is compatible with the statewide case management database that Minuteman and its fellow local aging agencies are required to use. Volunteer feedback, such as suggestions to minimize left turns in the app's route optimization function, have improved app functionality. The app also creates reports on meal delivery, change of condition, observable symptoms and care manager notes.



Budget:

The first year of program implementation cost $44,000, which included staff time, software development fees, smartphone purchase and monthly smartphone service fees. Currently, the smartphone service fees are the only ongoing expense.

Accomplishments:

As a result of the COC Project, homebound older adults receive faster follow-up care and have experienced a reduced decline and improved quality of life. In addition, COC will save Minuteman approximately 90 hours of staff time each year.

Replicability:

Implementing COC requires purchase of the smartphone app (via the Google app store) and purchase of smartphones on which to use the app. Organizations should plan for staff and volunteer training.

COVID-19 Update

When the pandemic arrived in March, nearly half of Minuteman Senior Services' 1,400 home-delivered meals consumers benefited from the expanded, standardized safety checks facilitated by the COC Project. While the continued rollout of the COC Project paused during the early stages of the pandemic, Minuteman Senior Services has used the time to train volunteers and anticipates resuming rollout across remaining dining areas in fall 2020.

NUTRITION

My Meal–My Way Senior Dining

Area Agency on Aging of Dane County

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Area Agency on Aging of Dane County

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Through the My Meal–My Way partnership, older adults participating in the Area Agency on Aging of Dane County congregate nutrition program have the opportunity to dine at seven different restaurants that offer a variety of menu options and dining times. My Meal–My Way was created to reverse the decline in attendance by reducing the stigma associated with dining at congregate meal locations and offering freshly prepared, appetizing meals at local restaurants.

Each restaurant offers a choice of six to 12 menu options during a two to four-hour window of time, allowing older adults to choose what, when, where and with whom they dine. Each site has a program manager who greets participants and handles paperwork, surveys and donation accounting. Transportation is provided to each site. The average site serves 50–70 meals per day, one time per week.

Budget:

The annual operating cost per site ranges from $28,240–$30,840. Annual costs include a nutrition site manager and data entry/supervision ($7,900 per site), food costs ($15,600–$18,200), 10 hours of dietitian time for menu creation and dietary analysis ($560), menu printing/signage ($500) and administrative costs ($3,680).

COVID-19 Update

At the start of the pandemic, My Meal–My Way began providing takeout meals to older adults at each location. When older adults pick up their meals, staff also provide safety and hyenine supplies and activity bags, including coloring supplies and craft kits. In May 2020 alone, more than 18,000 meals were provided through the program.

Accomplishments:

From 2015–2019, participation in the congregate meal program grew by 1,040 new diners (22 percent), congregate meals served increased by 15,624 (15 percent) and donations increased from $422,000 to $544,000.

Replicability:

Since its inception, this program has inspired nine other WI counties, as well as other states, to replicate the model. Replication generally takes six months. AAA of Dane County staff are available to provide technical assistance and marketing materials.

SOCIAL ENGAGEMENT

Technology and Connections at Home

San Francisco Department of Disability and Aging Services

Technology and Connections at Home enables older adults to manage their health and their well-being at home. During the one-year San Francisco Department of Disability and Aging Services (DAS) program, participants are loaned iPads, Fitbits and digital scales, participate in weekly technology classes, and receive access to health support and health coaching at Curry Senior Center, a local DAS provider.

At the end of the year, participants who meet specific eligibility criteria receive their own personal device and, if needed, financial assistance for one year of in-home internet access. Reflecting the community, the program is offered in English, Chinese and Russian. It supports older adults in making lifestyle changes, mitigates feelings of loneliness and provides a way for participants to connect with friends and family using technology.

Budget:

The FY 2019–2020 program budget of $339,300 covers staffing ($200,000), operating costs and overhead ($83,000), two subcontracting agreements for weekly classroom instruction and ongoing tech support ($39,500), and the cost of replacing and purchasing additional technology ($16,800). Staffing time for 2.5 full-time equivalents is shared across four employees. In the first year of the program, startup expenses for participant devices were $38,000.

Accomplishments:

In FY 2019–2020, two cohorts totaling 28 participants completed the program. After the program, 57 percent reported an increase in self-efficacy in managing their health, 77 percent of Fitbit users reported an increase in their daily movement and 73 percent who screened as lonely reported a decrease in loneliness. Participants reported an increase in confidence in using the internet (93 percent) and iPads (100 percent).

Replicability:

Start with a small pilot program. Funding required will vary by location. Organizations should research low-cost home internet options for participants. Reach out to local businesses who might be interested in underwriting technology costs.

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COVID-19 Update

The Technology and Connections at Home health coaching moved to phone calls and Zoom at the start of the pandemic, with curriculum taught by videos uploaded to a YouTube channel. The staff send weekly emails containing exercise options, ways to reduce stress and healthy eating tips to participants and also provide weekly Zoom hangouts to participants. If needed, in-person tech support is offered with staff and clients following social distancing guidelines.

SOCIAL ENGAGEMENT

Weber-Morgan Senior Art Gallery

Weber Human Services Area Agency on Aging

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Weber Human Services Area Agency on Aging

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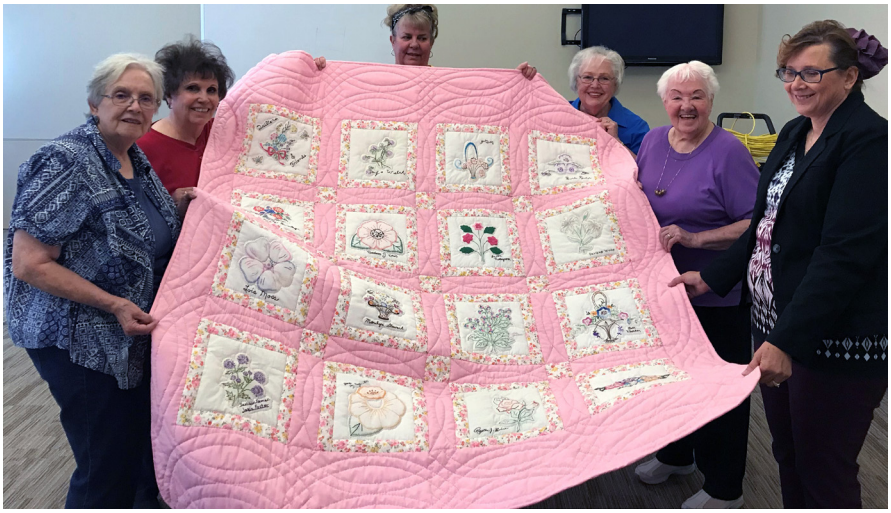
The Weber-Morgan Senior Art Gallery (www.wmseniorart.net) showcases the incredible talent of artists who produce artwork at senior center art classes in Weber and Morgan counties. The online gallery is a collaboration between Weber Human Services Area Agency on Aging, six local senior centers and five senior center art instructors. It connects artists to their community and world, motivates participating older adult artists and encourages more older adults to join art classes as a tool for social engagement.

Any older adult who participates in art classes at senior centers in Weber or Morgan counties is able to contribute their artwork to the site using their own name or a pseudonym. Images are uploaded to the site by the Weber Human Services AAA.



Budget:

Annual project costs of $146.06 include $128.57 for a website builder service and $17.49 for domain registration. All time and materials are donated.

Accomplishments:

Over a 13-month period, 73 older adult artists have created approximately 400 artworks shown on the Weber-Morgan Senior Art Gallery website. The gallery gets approximately 500 visitors per month, including families and friends of participating artists living in different states and countries. Two senior center oil painting classes are now at maximum capacity and have waiting lists. One center started a new watercolor class.

Replicability:

This project can be replicated easily and with minimal expense by working with local art instructors and senior center managers. Project staff or participating older adults must take photos of completed artwork for uploading. An artwork release form must be signed by participants before their artwork is uploaded to the gallery.

COVID-19 Update

Following the temporary closure of senior centers at the start of the pandemic, the Weber-Morgan Senior Art Gallery began displaying artwork created at home by the participating older adult artists to ensure artwork continued to be shared during the pandemic. The Weber-Morgan Senior Art Gallery partners are also working to restart art classes on a limited basis with social distancing protocols and safety measures in place.



2020

Aging ACHIEVEMENT Awards

ADVOCACY

Crisis Intervention: A Multi-System Wraparound for At-Risk Seniors

Direction Home of Eastern Ohio

Crisis Intervention is a community partnership that identifies and serves at-risk individuals living in Mahoning County, Ohio, through direct crisis coordination. The Crisis Coordinator serves as a single point of contact for identified cases, ensuring coordination of services, reducing service overlap, and creating customized plans of care during face-to-face home visits with individuals needing in-home services or suffering from mental health challenges or housing instability. The program succeeds through partnerships and coordination with local health departments, law enforcement, probate court and services related to mental health, housing and adult protection.

Budget:
The roughly $50,000 program cost covers a .50 to .75 full-time equivalent employee, including benefits, travel and other fringe expenses.

Accomplishments:
Since September 2018, the Crisis Intervention program has assisted more than 100 older adults by making service referrals, assisting clients in securing housing, facilitating hoarding cleanout and counseling, and directing mental health and substance abuse intervention.

Replicability:
Any areas with similar social service and government agencies willing to share the expense of the Crisis Coordinator have the potential to build this program and see immediate results.

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AGENCY OPERATIONS

Empowering Your Strategic Plan: Dashboard & Scorecard System

Senior Services of Southeastern Virginia

Senior Services of Southeastern Virginia (SSSEVA) has developed an innovative dashboard and scorecard system that provides ongoing feedback and facilitates the organization's strategic goals. The scorecard concisely conveys progress across the entire agency, enabling team directors/managers to tie the agency's strategic plan to day-to-day operations. The dashboard synthesizes the data and metrics from the scorecard into charts and graphs for the agency's board of directors.

Budget:
The only cost to implement the dashboard and scorecard system was the time invested by the CEO to create the system, with input from the board of directors and agency directors, managers and staff.

Accomplishments:
Since system implementation, SSSEVA has seen measurable progress toward strategic plan goals across all agency operations, including a reduction in 30-day hospital readmission rates among Care Transitions Intervention participants from 19 percent to six percent and an increase in rides provided to older adults in the Western Tidewater region.

Replicability:
The dashboard and scorecard system requires input and buy-in from stakeholders, dashboard training and ongoing analysis. SSSEVA welcomes questions and can share templates.

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CAREGIVING

Brain Health Club

South Carolina Appalachian Council of Governments Area Agency on Aging

The South Carolina Appalachian Council of Governments Area Agency on Aging converted a senior center that had been closed into a facility that now houses its Brain Health Club, a dementia program in which trained university students facilitate cognitive and social engagement activities for people living with early to mid-stage Alzheimer's Disease and Related Disorders (ADRD). Congregate meals and exercise classes for local older adults and an after-school program for children also are housed in the center, which is a joint effort of South Carolina Appalachian Council of Governments Area Agency on Aging and Dr. Cheryl Dye of the Clemson University Institute for Engaged Aging.

Budget:
Renovation ($42,500) was funded by a Permanent Improvement Project (PIP) grant from the state unit on aging and matching local funds. Brain Health Club operations are supported by Department on Aging Alzheimer's Resources Coordinating Center funds ($20,000 in the first year and $10,000 in the second). Group respite vouchers from the Alzheimer's Association cover the director's salary ($10,000 per year).

Accomplishments:
The Brain Health Club serves approximately 10 people with ADRD twice weekly. Participants enjoy an enhanced quality of life, family caregivers have a respite from caregiving and university students gain valuable experience.

Replicability:
Replicate the Brain Health Club by using caregiver respite funding and/or Alzheimer's resources funds from the state unit on aging.

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COMMUNITY PLANNING & LIVABLE COMMUNITIES

AAAs and First Responders: Responding to the Call of Aging Together

Middle Alabama Area Agency on Aging

Middle Alabama Area Agency on Aging (M4A) received a grant in 2017 to develop the Dementia Friendly Training Toolkit and Training Program for law enforcement officers and first responders in a five-county region. The training curriculum features three sections: How to Become Dementia Knowledgeable, How to Become Dementia Sensitive and How to Become Dementia Responsive. First responders also complete an aging simulation exercise and gain knowledge on AAA programs, resources and services. Upon completion of the training, local departments are designated as "dementia friendly" and receive framed certificates, laminated posters and stickers, and media coverage.

Budget:
M4A has secured small grants and funding to cover the annual cost of the Dementia Friendly Training program (approximately $6,000). This includes two staff trainers' time, travel and materials. Local sponsors offset costs of other joint initiatives.

Accomplishments:
To date, more than 1,700 first responders have completed the training, with their local police and fire departments receiving an official designation as "dementia friendly."

Replicability:
M4A has extensive training program materials available for AAAs and organizations interested in replication.

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COMMUNITY PLANNING & LIVABLE COMMUNITIES

Purposeful Aging LA: An Age-Friendly Initiative of the City and County of Los Angeles

City of Los Angeles Department of Aging

In 2016, the City and County of Los Angeles collaborated to launch Purposeful Aging Los Angeles (PALA): An Age-Friendly Initiative. PALA seeks to prepare the Los Angeles region for a rapidly aging population through an innovative combination of public and private leadership, resources, ideas and strategies. After holding events, surveying older adults and coordinating efforts among 78 public agencies and 88 cities, PALA has secured $3.5 million in grants to implement its action plan.

Budget:
Implementation costs ($250,000) cover two dedicated staff. Small grants have funded special projects, such as a $50,000 grant to translate a needs assessment survey into eight languages and to print the action plan report.

Accomplishments:
Sponsored events have reached more than 3,000 older adults. Three universities joined the Network of Age-Friendly Universities. More than 150 stakeholders participated in eight Livability Domain Working Groups.

Replicability:
Replication of the World Health Organization Age-Friendly process is highly recommended for AAAs across the nation. This well-established approach allows communities to adopt those aspects that best suit local needs.

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Silos to Circles Rural Aging Well Initiative

Central Minnesota Council on Aging and Dancing Sky Area Agency on Aging

The Silos to Circles Rural Aging Well Initiative is piloting ways to improve the aging experience in four rural MN communities by building awareness of resources and holding events for older adults and caregivers. The Central Minnesota Council on Aging and Dancing Sky Area Agency on Aging collaborated on the initiative. The foundation of the model is the Age Well Resource Hub, a multifaceted connector with in-person and virtual assistance.

Budget:
A grant from the LeadingAge Minnesota Foundation provided $150,000 per pilot. Costs included project management ($46,000), travel ($6,540), community education and training ($6,107), supplies/materials ($34,343), professional services ($29,000), development and web hosting ($6,000), and administrative expenses ($6,000).

Accomplishments:
The pilot projects resulted in the formation of a community coalition with 179 network partners. Outreach events and community forums were attended by 6,029 people. A total of 11,578 paper resource guides were distributed.

Replicability:
A new digital toolkit, "Silos to Circles Community Guide to Starting a Healthy Aging Initiative" (www.stcmnguide.org), shares videos and tools from four healthy aging initiatives in rural Minnesota. The website features step-by-step recommendations.

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Central Minnesota Council on Aging

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DIVERSITY & CULTURAL COMPETENCY

Breaking Barriers for CDSME

Alliance for Aging, Inc.

The Haitian American older adult population in Miami-Dade County is a particularly vulnerable segment of the community that has been hard to reach because of language and cultural barriers. Foundation funding and a partnership with Sant La Haitian Community Center enabled Alliance for Aging, Inc. to train and certify four bilingual Community Health Workers (CHWs) as leaders and hire a part-time program coordinator at Sant La to schedule and recruit participants for five Chronic Disease Self-Management Education (CDSME) workshops taught in Haitian Creole.

Budget:
Program costs ($40,000) included Alliance for Aging and Sant La staffing, administrative costs, training for four Sant La CHWs, and materials and supplies, including translated Healthy Living Manuals, culturally appropriate participant incentives and snacks, and handouts.

Accomplishments:
The trained and certified CHWs hosted evidence-based CDSME workshops attended by 80 participants. After the workshops, 84 percent of participants were "very satisfied with the program" and 16 percent were "satisfied."

Replicability:
To ensure cultural and linguistic appropriateness, agencies should work with community partners. The leader manual for the CDSME workshops is available in Haitian Creole.

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Sexual Orientation and Gender Identity Data Collection Training Program

San Francisco Department of Disability and Aging Services

When San Francisco and the state of California passed laws mandating collection of sexual orientation and gender identity (SOGI) data, San Francisco's Department of Disability and Aging Services (DAS) took the lead on implementation, developing a two-hour program for DAS staff, community partners and representatives from 15 California counties. The training program provided background on SOGI data collection needs, historical and personal perspectives, implementation practices for social workers and staff, and an overview of the continuum of sexual orientation and gender identity.

Budget:
Estimated annual costs of $5,225 vary depending on number of the training sessions and presenter rates. Expenses include staff salaries (offset by donated and volunteered time) and copying of materials.

Accomplishments:
The training led to a significant increase in data collection, resulting in better services for the LGBTQ+ population. Prior to SOGI training in spring 2017, 40 percent of data on sexual orientation was missing. After the training, the missing data dropped to 10 percent in FY 2017–2018 and seven percent in FY 2018–2019.

Replicability:
Openhouse, a community partner, provides train-the-trainer opportunities. DAS is open to sharing training documents and information.

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ECONOMIC SECURITY

DFTA Bill Paying Partnership

New York City Department for the Aging

A partnership between SilverBills, a New York-based fintech startup, and the New York City Department for the Aging (DFTA) has resulted in safe, paperless bill management services for vulnerable New York City residents age 60 and older. The partnership broadens the reach of DFTA's in-home volunteer service option, Bill Payer Program (BPP), which had been limited in part by availability of volunteers to serve some neighborhoods, as well as some clients' preference to not have a volunteer enter their home. Difficulties also arose when clients were hospitalized and volunteers could not access the incoming bills. With the addition of a technology component to the program to provide services virtually, DFTA can offer SilverBills to clients who were previously ineligible.

Budget:
The program is free for clients currently being served by DFTA-funded case management agencies and DFTA-funded Naturally Occurring Retirement Communities (NORCs). SilverBills charges DFTA a monthly fee of $67 per client. DFTA has made $150,000 available over three years for the pilot program.

Accomplishments:
SilverBills' tech-enabled services catch errors in household bill management in real time, allowing clients to avoid overdrafts and reducing fraud. Clients also avoid stress caused by unopened mail, concerns about their finances or the need to learn new technology. DFTA has a more equitable solution for clients in all neighborhoods and is able to serve and reach more clients than before.

Replicability:
SilverBills is willing to work with other AAAs, anywhere in the United States. AAAs can fully subsidize the cost or develop a sliding-scale community model based on income.

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ELDER ABUSE PREVENTION

ART: Alzheimer's Response Team

County of San Diego Health and Human Services Agency, Aging & Independence Services

The Alzheimer's Response Team (ART) provides intensive case management, education and support for people living with Alzheimer's Disease and Related Dementias (ADRD) and their caregivers. The service model includes a four-step crisis response approach and crisis prevention education. The San Diego AAA's Adult Protective Services unit operates the ART project.

Budget:
A Phase One budget ($142,579) established the administrative infrastructure, including two full-time equivalent (FTE) employees and first responder training. Phase Two ($1,146,381) covered eight FTE employees. Phase Three ($69,425) included data analysis, a comprehensive evaluation report and one FTE employee.

Accomplishments:
Hundreds of law enforcement and first responder personnel have been trained in the symptoms of ADRD, the new protocol for triage and the process of calling the dedicated ART line. At the end of the pilot, caregivers reported increased confidence in identifying and responding to ADRD-related behaviors and in caring for loved ones with support from ART.

Replicability:
ART may be replicated in organizations with Adult Protective Services and in partnership with community experts.

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HEALTH-LTSS INTEGRATION

Denver Regional Accountable Health Community

Denver Regional Council of Governments

The Denver Regional Accountable Health Community (AHC) is a network of clinical and community-based service providers working to create a continuum of care to better address Medicare and Medicaid beneficiaries' health-related social needs. Denver Regional Council of Governments Area Agency on Aging is the bridge organization, fostering collaboration among more than 20 clinical, community and other stakeholders. Clinical partners complete evidence-based screenings to identify individuals' housing, food, utility, transportation and safety needs and make referrals to community partners. Through work groups specific to each health-related social need, the AHC advisory board identifies and prioritizes service gaps, proposes solutions and improves access to community-based services.

Budget:
The AHC was funded with $4.51 million over five years from the Centers for Medicare & Medicaid Services as part of a competitive process to set up Accountable Health Communities. Annual costs for AAA program staff are $400,000–$500,000 per year.

Accomplishments:
As of February 2020, the Denver Regional AHC has screened more than 25,000 beneficiaries and helped 4,000 navigate community organizations to address health-related social needs.

Replicability:
Nationally, 29 organizations are currently participating in the AHC model, offering diverse strategies, evidence and best practices for future implementation.

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Iowa Return to Community

Connections Area Agency on Aging

The Iowa Department on Aging and Connections Area Agency on Aging (CAAA) have partnered with hospitals, nursing facilities and home and community-based services providers to offer long-term care support planning for individuals who are not eligible for Medicaid. The program helps individuals maintain their independence, prevents early entry into the Medicaid system, and reduces unnecessary facility placement and hospital readmissions. Program coaches assist individuals with accessing transportation to follow-up appointments, obtaining food, understanding discharge and prescription instructions, and more.

Budget:
CAAA received $200,000 to pilot the program, most of which was invested in technology. Annual costs for a similar program include personnel and overhead, computers and needed services.

Accomplishments:
In its first year, the program made 595 referrals, with 98 accepted and 74 able to successfully transition back to their homes.

Replicability:
This program can be replicated by any AAA or Title VI program that forms partnerships with skilled nursing rehab centers or individual hospitals. AAAs' regular line of service products can be used for the partnership's mutual consumers.

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HEALTH-LTSS INTEGRATION

Making the Link

Pierce County Aging & Disability Resources

Making the Link is an annual outreach and educational event for all types of front-line health care professionals that showcases the community's range of long-term care services and supports (LTSS) for older adults and individuals living with disabilities, so that these professionals understand how to help the older adults and caregivers they interact with to link to LTSS. The expo, a collaboration between Pierce County Aging & Disability Resources (ADR) and the nonprofit Health Care Providers Council of Pierce County, features more than 70 exhibitors.

Budget:
ADR spends $750 on a promotional mailing to all physicians and faith communities in Pierce County. The county communications department distributes an electronic news release to all area media and subscriber lists and via social media. Facility rental costs are offset by exhibitor fees, with income in excess of costs distributed annually to senior centers in the community.

Accomplishments:
Making the Link has successfully reached its target audiences of clinics, hospitals, social workers, care providers, faith communities and local volunteers. More than 300 people attended last year's drop-in educational event. Incoming calls and referrals to the Pierce County ADR's Aging and Disability Resource Center have steadily increased.

Replicability:
Many elements of this event are replicable with a minimal budget by relying on existing partnerships and business relationships.

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Partnering with Accountable Communities of Health to Deliver Whole Person Care Through the ADRC and Community Paramedicine

Area Agency on Aging & Disabilities of Southwest Washington

Area Agency on Aging & Disabilities of Southwest Washington (AAADSW) formed partnerships to integrate health care and long-term services and supports with two different Accountable Communities of Health in Washington state, Cascade Pacific Action Alliance (CPAA) and Southwest Washington Accountable Community of Health (SWACH). With CPAA, AAADSW operates the Community Paramedicine initiative, deploying a registered nurse to meet with high utilizers of Emergency Medical Services (EMS) to provide wraparound services that address social determinants of health, reducing non-emergent EMS calls. Through SWACH, Aging and Disability Resource Center (ADRC) specialists are embedded within primary and acute care settings to support delivery of whole-person care.

Budget:
In 2019, the total operating cost for the Community Paramedicine program of $68,425 included staff costs for program design, supervision and service delivery. For the embedded ADRC specialists effort, AAADSW braided funding and used 50 percent of a full-time equivalent employee, totaling $25,900 in 2019.

Accomplishments:
Through the Community Paramedicine program, a total of 160 EMS high utilizers have received personalized care. Health care partners on both projects report a reduction in non-emergent calls.

Replicability:
Organizations will need to spend six to 12 months on partnership cultivation, program development and implementation.

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HEALTHY AGING

Dine and Discover
Beaver County Office on Aging

Dine and Discover, an education and nutrition program developed by the Beaver County Office on Aging, helps meet the changing needs of today's older adults. The Beaver County Office on Aging holds the program's events at a local senior center multipurpose room with each event providing participants with education on healthy eating options, fact-based information on diet trends and recipes that older adults can make at home. The meal served at each event replicates the recipes attendees are given and occurs in the evenings—an intentional shift from the area's typical daytime senior center activities as a way to engage the greatest number of older adults of all ages. Finally, the program created an opportunity for the AAA to build a relationship with the Heritage Valley Hospital, which provides expertise and assistance to the program.

Budget:
Meals and presentation space at the senior center are funded through the AAA. Expenses ($485 total) include costs for meal delivery or special ingredients ($35), staffing ($400) and administrative overhead ($50). Volunteers or senior center staff assist with setup, serving meals and cleanup. Heritage Valley Hospital provides the dietician, recipe ideas, a reservation system and advertising at no cost.

Accomplishments:
Attendees express satisfaction in gaining useful knowledge of nutrition and food trends and appreciate the ability to socialize and enjoy a healthy meal.

Replicability:
Other AAAs could replicate this program by finding a large corporation or hospital sponsor. A successful program requires a dietitian/speaker, venue, decorations and food provider.

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Medication Safety for Older Arlingtonians
Arlington Agency on Aging

To raise awareness among older adults on how to safely discard medications, the Arlington Agency on Aging partnered with the Addiction and Recovery Initiative, a community stakeholders group that combats the opioid epidemic, to distribute drug deactivation kits and provide information on the risks of flushing or trashing medications to as many older adults as possible. Kits were distributed at an annual emergency preparedness event via the AAA's Virginia Insurance and Counseling Assistance Program (VICAP, a SHIP) during Medicare open enrollment and through providers making home-delivered meal deliveries.

Budget:
Costs, such as staff time and outreach materials, are minimal due to existing AAA programs and services and ongoing community partner collaborations.

Accomplishments:
Since the program began, 150 home-delivered meals participants received kits, more than 200 VICAP clients were engaged during Open Enrollment and nearly 75 individuals have attended the emergency preparedness event.

Replicability:
AAAs can engage community partners to identify events for drug deactivation kit distribution and review points of connection through existing programs and services for times that older adults and people with disabilities may share information about their current medications.

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HEALTHY AGING

Three Rivers Aging and Behavioral Health Collaborative

Three Rivers Area Agency on Aging

The Three Rivers Aging and Behavioral Health Collaborative is a quarterly meeting comprised of aging and behavioral health professionals interested in breaking down the "silos" of multiple agencies working with individuals who have co-occurring medical and behavioral health issues. The meeting focuses on staffing difficult case management issues, providing useful community resource information and offering social networking opportunities. The collaborative's training on aging and mental health issues helps direct-care providers better serve their clients.

Budget:
The program does not incur any operating or capital costs.

Accomplishments:
Recent successes include the certification of 20 Area Agency on Aging staff in Mental Health First Aid, training for two behavioral health community service boards on how to reduce prescription costs for their clients using a Medicare low-income subsidy, and placement of two individuals who had previously been unable to locate housing due to chronic mental health issues in personal care homes.

Replicability:
The collaborative can be replicated by connecting with local aging and behavioral health providers.

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Using the Adult Well-Being Assessment to Assess Quality of Life of Baltimore County's Older Adults

Baltimore County Department of Aging

The Baltimore County Department of Aging (BCDA) used the Adult Well-Being Assessment (AWA) to rate how senior center members felt about their quality of life, financial situation, physical health, mental health and more. The assessment also revealed inequities in access to programming and fitness facilities among low-income and African American older adults. BCDA used the assessment data to provide targeted, additional programming support and funding at senior centers in areas where the highest number of individuals reported that their physical health was "suffering." By using a data-driven approach, the AAA is assured that their resources are going to those most in need of services.

Budget:
BCDA staff collected and entered the assessments into their existing systems as part of the annual senior center membership registration process, and the National Council on Aging, which developed the AWA with the Institute for Healthcare Improvement, analyzed BCDA results and provided reports. There were costs to implement programs and amend facilities to resolve inequities and improve health outcomes.

Accomplishments:
BCDA provided additional programming support, funded the construction of a fitness center, expanded operating hours and lowered age eligibility to 50 years and older at the senior centers identified by the assessment. These efforts to improve physical health outcomes resulted in increases in "thriving" scores and decreases in "suffering" scores.

Replicability:
Municipalities can use the AWA and distribute it widely through their community. Local colleges or universities may be able to assist with data analysis.

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HOUSING

Developing Unique Partnerships to Address Critical Home Repair Needs

Central Plains Area Agency on Aging

Central Plains Area Agency on Aging (CPAAA) partnered with the Catholic Heart Work Camp to revitalize the homes of older adults living in Wichita, KS. For five days each summer from 2015–2018, approximately 250 volunteers ages 13 to 18 assisted individuals identified by CPAAA and provided a range of services, including extensive yard maintenance, painting, repairs and installation of ramps, handrails and smoke/carbon monoxide detectors.

Budget:
Total annual operating costs of $12,333 included CPAAA staff coordination ($7,333) and purchasing of building supplies ($5,000). Building supply expenses were covered through a combination of funds from the Older Americans Act, Kansas Senior Care Act and local Aging Mill Levy taxes. Dumpsters and paint were donated.

Accomplishments:
This project has resulted in repairs, maintenance and home or safety modifications for 272 clients, helping them to continue living in their homes. Repairs improved safety and/or accessibility for 100 percent of involved participants and helped 20 individuals with active code violations avoid or reduce court fees and fines.

Replicability:
To replicate, work with an organization that can provide volunteers with repair/renovation experience; develop relationships with local code enforcement, environmental resources and household hazardous waste agencies; and seek donations.

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NUTRITION

Frozen Meals for Homebound Seniors

Green River Area Development District

Green River Area Development District (GRADD) partnered with Morrison Healthcare to transform leftover food from a Morrison Healthcare–run cafeteria in a local hospital into frozen meals for homebound older adults. Approximately 75 homebound older adults receive two or three frozen meals per week in addition to their regular Monday through Friday home-delivered meals, providing them with a few extra meals for evenings and weekends. Volunteers at the Senior Community Center of Owensboro-Daviess County, one of GRADD's contracted providers, create and package meals from the leftover foods.

Budget:
All food is donated. Expenses include a sealer to package meals ($1,000), staff time for data entry and food delivery ($2,500 annually) and mileage ($720 annually). Hospital foundation grants covered special insulated delivery bags. A community volunteer donated a deep freezer.

Accomplishments:
Clients receiving the frozen meals report higher quality of life, additional financial resources and better nutrition. More than 10,000 meals have been donated at an estimated value of more than $75,000. Nutritional risk scores decreased by 50 percent for clients participating in the frozen meal program for six months or more.

Replicability:
AAAs can contact local hospitals or their contracted food providers to explore avenues for collaboration to reduce food waste and hunger.

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NUTRITION

Showing Those Who Serve the Gratitude They Deserve

Area Office on Aging of Northwestern Ohio, Inc.

After the Area Office on Aging of Northwestern Ohio worked with the U.S. Department of Veterans Affairs and other partners to build an apartment community with 75 units of permanent supportive housing for veterans who were homeless and disabled on the Area Office on Aging of Northwestern Ohio's campus, they realized many of the residents were going to a local gas station to purchase food for meals not provided by the senior center on campus. To reduce the reliance on low-quality gas-station food, the AAA held focus groups and ultimately developed a Saturday brunch meal program held at the housing facility to fill this nutritional gap.

Budget:

The only expense is the cost of the meals served. Lucas County Veterans Affairs covers the cost of meals for veterans under age 60 whose meals are not funded by the Older Americans Act.

Accomplishments:

More than 50 veterans reported reduced social isolation and increased nutrition status thanks to the Saturday brunch. They spend more time eating hot, nourishing meals designed by a licensed dietitian and gain access to information about other programs and services offered by the AAA and in the community.

Replicability:

This is a scalable solution for homelessness and food insecurity. Conducting a needs assessment ensures identification of specific community needs and formation of relevant local partnerships.

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SOCIAL ENGAGEMENT

AASC Senior Prom

Appalachian Agency for Senior Citizens

To combat social isolation in a rural area and bring together older adults from its different programs for physical activity and social engagement, Appalachian Agency for Senior Citizens (AASC) transformed the local police department into a beautiful prom setting for older adults living in the rural four-county area served by the agency. For the "Blue Moon Gala," older adults donned fine gowns or suits and had their makeup and hair done for an afternoon of music, dancing, food, photos and fun. A prom king and queen were crowned and driven back to the agency with a special police escort. For the second year of the prom, AASC partnered with a local high school to obtain prom decorations and held the event, with the theme "Strut Your Stuff," at the recreation park.

Budget:

The first year, staff prepared finger foods. Transportation costs were covered as a regular monthly outing and no additional staff costs were incurred. Food costs of $450 for the second year were paid by the AAA's nutrition funds. Facility access was donated.

Accomplishments:

Approximately 75 older adults participated in each prom. Participants displayed improvements in self-esteem due to the special attire and grooming and enjoyed physical activity and socialization.

Replicability:

Replication only depends on the ingenuity of Area Agency on Aging staff to customize a special event that meets the needs of the area's older adults, as well as drawing upon community partners to help lighten the workload.

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Living Connected: Key To Combating Social Isolation

Baltimore County Department of Aging

Baltimore County Department of Aging (BCDA) developed the Living Connected campaign to reduce loneliness among older adults. The yearlong program offered awareness education for all ages and engagement activities for older adults and caregivers. It included creation of promotional videos, local newspaper features highlighting resources, a professional conference, a Living Connected area at the BCDA Power of Age Expo, weekly social media posts, local Comcast television segments and a No Senior Eats Alone Day.

Budget:
Employee time was donated. A public service announcement cost $4,800 to produce and can be used for many years. The five-minute Living Connected television segment was made possible through a partnership with local media. No Senior Eats Alone Day meals were provided by community partners.

Accomplishments:
Living Connected reached more than 10,000 attendees at the BCDA Power of Age Expo, educated 325,000 viewers through television segments, hosted a conference for more than 200 professionals, and reached 10,000 newspaper subscribers. More than 60 community partners were involved in No Senior Eats Alone Day, which brought 276 new older adults to the BCDA senior center.

Replicability:
This initiative could be replicated by any Area Agency on Aging with strong public/private partnerships.

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PEARLS Connect

Area Agency on Aging of Tarrant County

The Program to Encourage Active and Rewarding Lives (PEARLS) is an evidence-based depression management program targeted to adults 60 and older and their caregivers. The Area Agency on Aging of Tarrant County (AAATC) worked with The Women's Center to launch PEARLS Connect, a peer-to-peer continued care model. Once AAATC clients complete their PEARLS sessions, they enroll in PEARLS Connect, which includes a monthly newsletter; opportunities to connect on social media; community service opportunities; and information on a series of older adult–focused events including classes on technology, mindfulness and holiday-themed gatherings.

Budget:
AAATC provided startup funding for staffing, PEARLS Training and some supplies/materials. PEARLS Connect is now a part of the overall PEARLS program delivery and does not have a separate budget.

Accomplishments:
Since PEARLS Connect launched in October 2018, 26 clients have enrolled and received 193 hours of service at events. The Patient Health Questionnaire-9 (PHQ-9), a depression screening tool, is administered at every PEARLS appointment and, as of October 2019, 83 percent of PEARLS Connect clients who attended two or more events maintained their improved PHQ-9 score three months after completing the PEARLS program.

Replicability:
For organizations with a PEARLS program, existing counselors can market PEARLS Connect, and a .50 full-time equivalent case manager can organize events, develop newsletters, manage the Facebook group and send reminders to participants.

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SOCIAL ENGAGEMENT

Senior Skip Day: Students Helping Seniors

AgeSmart Community Resources

AgeSmart Community Resources and Greenville University developed Senior Skip Day to raise awareness of social isolation and its impact on the health and well-being of older adults. Students in the university's Experience First program worked with AgeSmart and Bond County Senior Services to identify older adults at risk of loneliness then skipped a day of classes to visit them. The students offered to help with yard work, household tasks and technology troubleshooting. Students also held a celebration at the senior center and used their talents to provide music and games. A pen pal program is being developed to continue the relationships throughout the year.

Budget:
Students located community resources to offset program costs. The largest cost was meals at the senior center for students.

Accomplishments:
Senior Skip Day at Greenville University was a pilot that helped increase awareness of social isolation. Senior Skip Day is being replicated by other institutions in Illinois, and Greenville University will continue the event each spring.

Replicability:
AgeSmart created a toolkit for other AAAs, schools and universities to assist with replication.

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TRANSPORTATION & MOBILITY

CareRide

Elder Services of the Merrimack Valley and North Shore

CareRide is an on-demand transportation initiative that provides low-income older adults free or subsidized rides to non-emergency medical appointments. Working with Circulation Health, Elder Services of the Merrimack Valley and North Shore customized a digital platform originally created for Uber and Lyft that enables older adults to schedule rides when traditional providers (family, friends, public transit, taxis, aging services vans) are not available. Referrals from senior centers, AAA care managers and doctors' offices are processed by a bilingual transportation coordinator who contacts clients 24 hours prior to their appointments with a reminder.

Budget:
Annual program costs ($50,000) include staffing, maintaining the Care Ride/Circulation platform and subsidizing the cost of rides.

Accomplishments:
CareRide has provided an average of 90 rides per month since its inception, including an average of 12 accessible rides per month. Average consumer savings are at least $28 per ride. Without the rides, older adults may have missed an estimated 60 percent of scheduled appointments.

Replicability:
Any AAA or community-based organization can contract to use the Circulation Health platform. Partnerships with area hospitals can assist in successful replication.

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Senior Connections' Mobility Management

Senior Connections, the Capital Area Agency on Aging

Senior Connections is working to solve the public transportation challenges faced by older adults, their caregivers, people with disabilities and individuals with low incomes. Designated by the Richmond Regional Planning District Commission (PlanRVA) as the Human Services Transportation Coordination Entity (HSTCE), Senior Connections convened a transportation symposium for public, private, nonprofit and government transportation stakeholders to complete "A Framework for Action: A Self-Assessment Tool." The assessment results assisted in developing a coordinated human services transportation system.

Budget:
The HSTCE work is funded in part through a grant from the state transportation department as well as in-kind donations from community stakeholders. Contracts with a variety of transportation vendors ensure the most cost-effective options. Costs include one part-time ride counselor salary ($25,000), marketing/PR ($1,500) and ride costs not covered through grant funding ($21,000). Most staff costs are in-kind.

Accomplishments:
Collaboration between Senior Connections, PlanRVA and community stakeholders are ongoing to promote, facilitate, educate and coordinate regional transportation efforts that will provide older adults and people with disabilities with the knowledge of and access to transportation for medical and non-medical needs.

Replicability:
Maintaining relationships and local partnerships and streamlining onboarding processes for transportation providers are key. The work as the HSTCE only requires a dedicated staff person and connection to partner agencies, which many AAAs already have.

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