Acknowledgments

A study of this scope requires the commitment and hard work of many people and organizations. First and foremost, we want to express our appreciation to the leaders of high quality programs throughout the United States who committed the time and effort to complete and return our survey. The agencies that participated in this study and agreed to be acknowledged are listed on the following page. Hopefully, the results of their efforts will lead to greater visibility and support for the work of community-based organizations that serve older adults.

Within The National Council on the Aging (NCOA), many staff members made important contributions to this effort, including Alixe McNeill, Constance Todd, Diane Webb, Binod Suwal, Janette Hoisington and Lynn Beattie. In addition, the NCOA Board and leaders of our constituent units were especially helpful in nominating programs to participate in the study and pretesting early drafts of the survey. The leadership of the National Institute of Senior Centers worked very closely with NCOA staff on this study.

The National Association of State Units on Aging (NASUA) helped solicit nominations, and they prepared the special supplement to this report on statewide initiatives in health and supportive services. We recognized early in this effort that our mail survey would not be able to capture the details of statewide initiatives. NASUA agreed to identify innovative health and supportive services initiatives at the state level, interview key informants and prepare the attached report. Special thanks to Greg Case, Theresa Lambert and Dan Quirk for their support.

The National Association of Area Agencies on Aging (N4A) was especially helpful in soliciting nominations of area agencies on aging, recruiting participants for the four focus groups and designing the survey. Janice Jackson and Adrienne Dern at N4A and board members Robert Logan and Pam Piering shared their years of experience and knowledge of local service networks with this project.

The Seniors Research Group, Inc. in Livonia, Michigan provided research design and analysis support throughout the project. Additionally, they managed the entire mail survey process. Their efforts exceeded expectations and reflected their longtime commitment to strengthening community services and improving the quality of life of older adults.

Several consultants, each with many years of experience in the aging network and innovative programming, contributed their expertise and insights to this effort. We want to acknowledge the contributions of Susan Lutz, John Krout, Ph.D., Rick Fortinsky, Ph.D., and Laura Wilson, Ph.D.

Without the support of The Robert Wood Johnson Foundation, this study would not have been possible. Beyond the grant funding, Robin Mockenhaupt, Ph.D. and Jane Lowe offered their support and guidance throughout the project. Their commitment to the aging network and to improving the quality of life of older Americans led to their support of this project and to the development of major new initiatives at the Foundation.

Nancy Whitelaw, Ph.D.
Project Director
The National Council on the Aging
Agencies Participating in Survey

55 Kip Center
55 Plus Center
55 Plus Center of Aegopos Housing Opportunities & Management Enterprises Inc.)
Adams Co. Senior Services
ADDSP at Area Agency for Developmental Services, Inc.
Adult Day Services of Orleans Co.
Aging & Adult Care of Central WA
Aging & Disability Resource Center of Marathon Co.
Aging & Independence Services
AL Dept. of Public Health, Arthritis Prevention Branch
Allen Co. Council on Aging
Alliance for Aging, Inc.
Alzheimer’s Assoc. – Upstate S.C. Chapter
Alzheimer’s Assoc. - Southeastern WI Chapter
Alzheimer’s Assoc. - Mid-Willamette Chapter
Alzheimer’s Assoc. - Central MD Chapter
Alzheimer’s Community Care Assoc. of Palm Beach and Martin Counties, Inc.
Anderson Senior Center
Ann M. Healy
Area Agency on Aging - South AL Regional Planning Commission
Area Agency on Aging for Luz/Wyo Counties
Area Agency on Aging for North FL, Inc.
Area Agency on Aging for Northeastern VT
Area Agency on Aging of Broward Co. Area Agency of Aging of Central FL, Inc.
Area Agency on Aging of Northwest MI
Area Agency on Aging of Pasco - Pinellas, Inc.
Area Agency on Aging of Texoma Area Agency on Aging of the Concho Valley
Arlington Area Agency on Aging
Arlington Co. Dept. of Human Services Nursing Case Management Unit
Arlington Co., Dept. of Parks, Recreation Community Resources, Office of Senior Adult Program
Arlington Heights Senior Center Art Therapy Inspirational Art for Seniors, Inc.
Arthritis Foundation
Arts & Aging Program / Ages on Stages Program
ASI
Augustana Care Corporation
Avenidas
Baltimore City:AAA
Baltimore Co. Dept. of Aging
Banta Activity Center
Barrington Area Council on Aging
Bay Area Agency on Aging
Bay Ridge Center
Bayshore Manor Beardall Senior Center
Berthoud Golden Links, Inc.
Bethany Homes
Bethany Village Apartments
Beverly Council on Aging
Blaine Co. Senior Council, Inc.
Bloomington Senior Program
Boone Co. Council on Aging
Boulder Community Hospital
Boulder Co. Aging Services Division
Boulder Senior Services
Bourne Council on Aging
Bozeman Senior Center
Brighton Senior Center
Bureau of Geriatric Psychiatry AL Dept. of Mental Health and Mental Retardation
Butler Senior Center
Calvert Co. Office on Aging
Canton Senior Adult Program
Cardinal Ritter Institute Caring Hands Volunteer Caregivers Program
CASA (Care Assurance System for the Aging & Homebound) of Madison Co.
Catawba Area Agency on Aging
Catholic Charities
Catholic Charities Elderly Services
Catholic Charities Northern Catholic Charities of Santa Clara Co.
Catholic Charities of the Archdiocese of Chicago
Catholic Charities of the Archdiocese of St Paul MN
Catholic Charities / St. Martin de Porres Family Center
Catholic Charities, Archdiocese of Milwaukee
Catholic Charities, Archdiocese of NY
Catholic Family Service Inc.
Cenla Area Agency on Aging, Inc.
Cenla Area Agency on Aging - Westside Senior Center Central MO Area Agency on Aging - Tipton Nutrition Center
Chapel Hill Senior Center
Charles Co. Dept. of Community Services
Charles Walker Senior Center
Charlotte Mecklenburg Senior Centers, Inc.
Chester Co. Dept. of Aging Services
Chicopee Council on Aging
Child and Family Service
Children of Aging Parents
Choctaw Nation of OK
Christian Communities Group Homes
CICOA The Access Network
City of Avondale Social Services
City of Bowie, Senior Citizen Services
City of Foster City
City of Houston
City of Longmont Senior Services
City of Phoenix Human Services Dept.
Senior Services Division
City of Phoenix Police Dept., Squaw Peak Senior Center City of San Angelo - Senior Services
City of Sunrise Senior Center
City of Warwick, Dept. of Human Services, Division of Senior Services
Clifton Heights Senior Center
Clinton Township Senior Center
Coastline Elderly Services, Inc.
Colonial Club Senior Activity Center
Columbia - Montour Area Agency on Aging
Commission on Aging and Retirement Education, Balt. City
Community and Economic Development Assoc. of Cook Co., Inc.
Community Health Ministry St Peter Villa Rehabilitation Center
Community Resource Center
Copperas Cove Parks and Recreation
COPSA Day Program
Council for Jewish Elderly
Council of Senior Tyler Countians, Inc.
Council of Spanish Speaking Organizations of the Lehigh Valley, Inc.
Council on Aging of Elkhart Co.
Country Neighbor Program Inc.
CP Sutton Community Center for Seniors of Edgur Co.
Cranston Dept. of Senior Services
Cuba Senior Center
Culpeper Dept. of Social Services - Adult Service Program
Culver City Senior Center
Daily Living Centers, Inc.
Darts
Davidson Co. Dept. of Senior Services
Daviess Co. Senior Services
District III Area Agency on Aging Division of Aging & Adult Services (AK)
Dominican Sisters Family Health Service, Inc.
Dorot, Inc.
Denver Regional Council of Governments Area Agency on Aging
East Brunswick Dept. on Aging
East Lansing Seniors Program
Eastern Area Adult Services
Eau Claire Co. Dept. on Aging
Elder Services of Merrimack Valley
Elders in Action
Emmanos Services for the Aging
Enoch D. Davis Center
Episcopal Senior Ministries
Introduction

With the findings of the National Survey of Health and Supportive Services in the Aging Network, The National Council on the Aging is pleased to contribute to the growing body of evidence that community-based organizations are empowering and assisting thousands of older people in communities throughout the country to achieve vital aging.

This study documents the work of many leading community organizations in the aging services network including senior centers, area agencies on aging, multi-service and faith-based organizations and housing facilities. It describes the impact of these organizations in improving health outcomes and supporting older people in their own homes and shows the vitality and diversity of agencies and services in the aging network.

This network, built with the strength and foresight of community, state and national leaders over the last 50 years, helps older people age with vitality and, with their families, respond to life’s challenges. The agencies provide such services as: evidence-based physical activity programs operating in senior centers; visiting and in-home support by volunteers; as well as education and respite for caregivers.

The study illuminates the range of innovative services offered to older adults in diverse settings and geographic areas. For example, they operate in clinics, churches, community centers and in residences of the homebound in inner cities, urban, suburban and rural areas. It also identifies the resourcefulness of agencies in recruiting and employing certified professionals and engaging well-trained volunteers. The study then reports their success in measuring program outcomes seen in positive changes in health status, health practices and quality of life.

The high quality programs in this study make extensive use of partnerships to leverage funding and meet client needs. More than 50% have partnerships with health systems. Others partner with universities, public agencies and local businesses. Cost sharing is used extensively with 67% reporting fees and donations as important funding sources.

This study has identified hundreds of exemplary programs. NCOA will be analyzing some of the programs in further detail to offer best practices to community organizations ready to replicate these approaches. Furthermore, a special addition in this report was prepared by the National Association of State Units on Aging to describe replicable statewide initiatives targeted at disease self-management or caregiving.

On behalf of NCOA, I thank NCOA Director of Health and Aging Services Research, Nancy Whitelaw, Ph.D., for directing this study and The Robert Wood Johnson Foundation for funding it. I also want to acknowledge the work of our partners, the National Association of State Units on Aging, the National Association of Area Agencies on Aging and the Seniors Research Group. This important work will strengthen public policy, societal attitudes and business practices that promote vital aging. It goes a long way toward helping community organizations to enhance the lives of older adults through innovative programs. It certainly complements our organization’s mission and goals.

James Firman, Ed.D.
President & CEO
The National Council on the Aging
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I. Report on Health and Supportive Services in the Aging Network

Background and Methods

In 2000-2001, The National Council on the Aging conducted a study of health and supportive services programs in community organizations around the country. The Robert Wood Johnson Foundation provided support for this work. Collaborators on the study included the National Association of State Units on Aging, the National Association of Area Agencies on Aging and the National Institute of Senior Centers. Focus groups and the mail survey that were a part of this study were administered by the Seniors Research Group of Livonia, Michigan.

The purpose of the study was to gather evidence about innovative community programs and to learn about barriers to service expansion. Specific programs of interest are:
- social support (e.g. in-home services, case management, companionship)
- caregiving (e.g. caregiver education, resources and support, respite)
- chronic disease self-management/health promotion (e.g. information, classes, support groups to improve health, manage chronic diseases and reduce risk of disability)
- physical activity (e.g. exercise and other activities to improve fitness)

Furthermore, the study was designed to identify the essential features of successful community-based programs regarding such topics as: recruitment, referral, and retention of clients; accessibility; strategies for improving the quality of life of clients; staffing, volunteer roles and training; funding; partnering; and program management and measures of performance.

In the summer of 2000, we asked national experts to nominate health and supportive services programs with a reputation for innovation and/or quality. Nomination forms were distributed to 253 experts identified by the National Council on the Aging, the National Association of State Units on Aging and the National Association of Area Agencies on Aging. Included among these experts were the leaders of every state office on aging. These experts nominated the 1198 programs that were sent a mail survey in late 2000. Completed surveys were returned by 628 program leaders.

Though this was not a random sample, the organizations that participated are representative of many agencies in aging network. Among the programs studied, 174 were in senior centers, 118 in area agencies on aging, 202 in multi-purpose social service organizations, and 105 in other organizations such as adult day care, faith-based, health care and others. Surveys were received from 47 states and the District of Columbia.

The survey was designed by researchers at The National Council on the Aging working with our collaborating associations, academic consultants, and the Seniors Research Group. Four focus groups were held in the summer of 2000 to learn from program leaders key features of quality programming and topics that should be addressed in the survey. The survey was pretested by agency leaders around the country who provided valuable feedback on how to bring greater focus to the questions. The final survey was 12 pages in length and included mostly closed-ended questions.
Overview of Health and Supportive Service Programs

In preparing this report, our main goal is to describe these 628 programs and to highlight differences, when they occur, across the four types of programming – social support, caregiving, disease self-management and physical activity. Thus, these data provide a broad descriptive overview of health and supportive services programming that can help us understand current and potential capacity in the aging network and suggest ways in which the aging network can further enhance its impact on the quality of life of older Americans.

The first page of the survey asked agency leaders to select ONE high quality health or supportive services program within their agency. Most of the survey asked questions about this one program. The following data are about this single program—not the total agency. Of the 628 programs studied, 59% are social support, 16% are caregiving, 11% are disease self-management and 14% are physical activity. (See Chart 1.) The fact that over half the agencies selected a social support program is not surprising, given the attention to in-home supportive services within the aging network.

These four types of programming cover a broad array of services and supports. Most programs in the aging network are developed locally to meet local need and to coordinate with other local agencies so as to provide comprehensive but non-duplicative services throughout the community. Therefore, it is difficult to provide a single description of each of our four program types. Below, we provide a general overview of each program type and more detailed information on the programs studied.

Social support programs generally serve frail or vulnerable older adults, often in the home but also in an adult day center or other facility. They may offer or coordinate many types of services and often include assessments, case management, referral and care coordination. For the social support programs in this study (see Charts 2-4), the most common services offered are information and referral, transportation, friendly visiting, case management and congregate meals. On average, these social support programs offer seven to eight different services from the list of nineteen in the survey.

Nearly three out of four programs include the active engagement of the family as a standard feature of their social support programming. Just over one-third include door-to-door outreach as a standard way to identify clients in need. Phrases commonly used by respondents to describe their social support programs include “one stop shopping,” “comprehensive,” “personal,” and “allows older adults to remain in their own homes.”

Caregiving programs are targeted toward a family member or other “informal” caregiver, and may also include supplementary services for the frail older adult. Many caregiver programs address the specific needs of caring for an older adult with dementia. In this study, (see Charts 5-7), frequently mentioned supports for caregivers include training in the care of frail elderly, operating a resource center, formal assessments of caregiver needs and caregiver support groups.
The most common services for older adults and/or the caregiver are respite, case management, social stimulation, personal care, and adult day services. Certified or licensed paid caregivers are available through 64% of these programs; one-third of programs offer services 24 hours/day and 7 days/week. Descriptive phrases used by survey respondents with caregiving programs include “family-centered,” “client-directed,” and “flexible, individualized relief for caregivers.”

*Chronic disease self-management and/or health promotion programs* work with older adults to promote healthy lifestyles and self-care skills, and to slow possible progression of functional decline or disability. Often these programs are run as health education classes, workshops or support groups, but they may also include health fairs, immunization drives, health screenings, and individualized health assessments among other formats. For the programs in this study (see Charts 8-10), the most common diseases being addressed are diabetes, hypertension, heart disease, arthritis and osteoporosis. On average, these programs address seven to eight of the fifteen diseases/conditions listed in the survey.

Most frequently, the educational content in these programs includes nutrition/diet, physical activity, appropriate use of medications, and health literacy. Two-thirds of programs have paid or contract staff available with certified expertise in specific diseases or health problems. Health care providers frequently partner with community organizations to operate these programs. Phrases used by leaders to describe these programs include “holistic,” “empowering,” and “preventive and wellness focus.”

*Physical activity programs* offer mixtures of exercise and health education targeted at improving balance, flexibility, strength and/or endurance, as well as overall health. Most are delivered through group classes, but in some cases participation is individualized. These programs are not just for healthy, active seniors. Many involve older adults who are frail, disabled or homebound. For the physical activity programs in this study (see Charts 11-13), walking, aerobics, weight training and dancing are the most common forms of exercise. From the survey’s list of ten types of physical activity, the average program offers four to five.

Nearly all programs include educational content on the importance of physical activity and how to engage in physical activity safely. Eight in ten programs have paid or contract staff available with certified expertise in physical activity for older adults. Phrases used to describe these programs include “diverse options,” “fitness-focused,” “fun, social,” and “educational.”

For all types of programs, our study wanted to identify which ones are based on a well-recognized model and which models are commonly used. (See Charts 4, 7, 10, 13.) Among our respondents, about 35% are using a well-recognized model. Examples of such models include: Brookdale National Group Respite Program, Interfaith Volunteer Caregivers, Social Model of Adult Day Center, Senior Companion Program, Arthritis Foundation Programs, Body Recall, Strong Living Program and the YMCA Active Older Adult Program. Those that are using models such as these report very little difficulty in
fitting the model program to their agency. The use of a well-recognized model is most
common in caregiving programs and least common among physical activity programs.

Descriptive Findings

The programs studied vary widely in the numbers of clients reached. (See Chart 14.)
Some of these programs involve one-on-one services, others are for small groups and yet
others, such as health fairs, reach large numbers. Across all programs, two in ten reached
more than 2000 clients in 1999 while two in ten reached fewer than 100 clients. The
average is approximately 1200 clients annually; however the median is about 500. This
indicates that a few very large programs are raising the overall average. In general, social
support and disease self-management programs reach larger numbers of clients than
caregiving and physical activity programs. This may be due, in part, to differences in the
size and types of funding available to these four types of program.

Programs of all types appear to be serving older adults with the greatest needs. (See
Chart 15.) In over half the programs, at least 60% of clients are low income and/or over
age 75. In at least one-fourth of the programs, 35% of clients are members of a minority
group. And in one-fourth of the programs, 70% of clients live in rural areas. In
approximately two-thirds of these programs, clients receive services for at least one year,
suggesting that these programs have success in maintaining continuity in the relationship
with the older person.

The survey asked agency leaders to rate the quality of many aspects of their programming
as “compared to similar programs with which you are familiar.” A 7-point rating scale
was used anchored by 7=Excellent and 1=Poor, with a Not Applicable option. For
reporting purposes, this scale has been collapsed and labeled as: Excellent=7, Good=6,5
and Needs Improvement=4,3,2,1.

How programs help older adults access their own services, and other community services,
is an important aspect of health and supportive services programming. (See Charts 16-
20.) Survey respondents most frequently rate their programs as ‘excellent” in linking
clients to various other services and “good” at various access items related to their own
program (e.g., meeting transportation needs, adapting schedules to meet client
preferences, motivating hard to reach elders to participate, and marketing through mass
media). Programming is offered in a variety of locations including the agency, the
client’s home and other community organizations.

Agency leaders were also asked various questions designed to tell us how their program
seeks to improve the quality of life of clients. (See Charts 21-25.) We were specifically
interested in learning if programs are trying to improve self care and/or communication
skills, and enhance self-efficacy. In general, respondents rate their programs as “good”
on improving skills for communicating with family or physicians. About 25%-35% of
respondents indicate that addressing one or more of these skills is not applicable to their
programs. Most respondents rate themselves as “good” on self-efficacy items such as
teaching clients to develop their own service/improvement plan and incorporating peer-to-peer support in programming.

The survey included questions on staffing, use of volunteers, funding, partnering and overall program management. These are key components of any community-based program. Based upon our data, high quality programming does not necessarily require large numbers of staff or funding, however, there are sizable differences across the program types. (See Charts 26-30.) Social support programs require the most staff and volunteers, whereas physical activity programs often operate with 1 or no paid staff and few volunteers. Similarly, nearly two-thirds of physical activity programs had budgets under $50,000 in 1999 compared to only 16% of social support programs. In fact, one-fourth of social support programs had budgets in excess of $750,000. Across all programs studied, 60% started with grant funding.

Though many start with grant funding, most of these health and supportive services programs sustained themselves over the long term, with 60% operating at least 10 years. (See Chart 31.) Disease self-management programs are newer; nearly half are less than five years old. One factor that contributes to program survival is partnering with other local organizations. Such partnerships are fundamental to the aging services network. Not surprisingly, the most common partner is the area agency on aging. (See Charts 32-34.) However, other common partners are health care organizations, other aging agencies and municipal agencies. The most important functions of these partnerships are to provide funding and to refer clients, but partners also assist with program evaluation, training and/or strategic planning. About 25%-35% of respondents rate their partnering efforts as “excellent.”

Pulling all the pieces of quality programming together takes strong program management. One aspect of management that we are especially interested in is performance and outcome measurement. (See Charts 35-37.) Forty to forty-five percent of respondents rate their programs as excellent in tracking actual vs. expected revenues and/or clients served. Somewhat fewer (30%-35%) give excellent ratings to indicators of “continuous quality improvement,” such as using performance data to revise and improve the program and using written objectives to focus on desired outcomes.

Outcome measurement is challenging, even for these high quality programs. About one in four respondents rate their programs as excellent in various categories of outcome measurement (changes in quality of life, health status, health behavior and/or health care use). Disease self-management programs are much more likely to give themselves excellent ratings for measuring changes in client health status, and caregiving programs are more likely to be excellent in measuring changes in the quality of life of clients/caregivers.

Given that these programs were nominated for their quality, we wanted to learn what barriers stand in the way of program expansion. (See Chart 38.) Not surprisingly, the leading barrier is difficulties in securing funding. However, at least 40% of respondents cited each of the following as a medium or high barrier: shortages of volunteers, rules and
regulations of funding agencies, shortages of in-home personal care workers and/or shortages of staff with appropriate certification or training.

Finally, our survey covered some basic descriptive information about the entire agency, even though the focus of this study is a specific health or supportive services program within the agency. We gathered data on the agencies to better understand the organizational setting in which these programs operate. (See Charts 39-41.) Among the programs studied, 174 were in senior centers, 118 in area agencies on aging, 202 in multi-purpose social service organizations and 105 in other types of organizations. Typical of the aging network, the data indicate that these are solid, stable agencies that have been a part of their communities for several decades.

Over 70% of these organizations were established at least 20 years ago; over half have annual budgets exceeding $1,000,000. Half are independent agencies and half are part of a larger organization—most often a city, county or regional authority. Frequently, those with smaller budgets are a part of a much larger agency. Over half employ more than 20 staff and have over 100 volunteers. Approximately 40% serve more than 4000 seniors annually; nearly two-thirds reach at least 2000 seniors.

Conclusions

Overall, these data document the valuable work being done by agencies in the aging services network to improve the health and quality of life of older adults. The programs described include social support, caregiving, disease self-management, and physical activity. Within these broad program areas, there is great variety in number and types of specific services and educational content provided to older adults throughout the country.

The wide variation in program size (budget, staffing, clients served) is indicative of the success of these programs in adapting to local needs and resources. There is no “one size fits all.” Even programs based upon a well-recognized model must fit the model to the local situation. Though target populations vary by program type and geographic location, in general these programs reach those in greatest need – minorities, persons of low income, those over age 75, and/or those in rural areas.

The collaborators on this project see this survey as a way to identify areas to target for future initiatives, technical assistance, training, and best practice studies. Drawing upon the survey data, we have identified some specific services and/or program features that we believe are likely to become increasingly important in the years ahead. Special initiative funding from foundations or the public sector could help community agencies expand programming.

An area of specific interest was the extent to which the programs studied are built off of well-recognized models. We learned that one-third of the programs are based on such models. Some of the models named were not designed from strong evidence or documented outcomes. The number of intervention studies with documented positive outcomes for older adults is growing, but too rarely these studies are translated into “real
world,” effective programs that could reach millions of older adults through community agencies. Despite considerable recognition of the importance of translating research evidence into programs, there has been very little leadership or funding for such work. Recently, The John A. Hartford Foundation has stepped forward to provide funding to The National Council on the Aging to bring more evidence-based model programs to the aging network.

The study also indicates that whether or not these programs are based on well-recognized models, many appear to have a long and successful history of addressing critical needs of older people. This study provides an excellent platform for identifying best practices around the country that are suitable for replication. While the survey offers a broad overview of programs, it needs to be supplemented with in-depth, on-site studies of how best to bring together all the components (e.g. funding, partnering, staffing, management, services and supports) to run high quality, sustainable, client-centered programs. The 628 programs participating in this study have provided a wealth of information that can be used to identify best practices. They have valuable lessons to share with the aging network—whose members are eager for best practice information. Such best practice material can also serve as the basis for training and technical assistance, and the design and implementation of relevant outcomes measures. Through such efforts, tens of thousands of older adults nationwide could reap the benefits of stronger programming.

We looked at services and features offered by each of the programs to identify areas that may need expansion. For each of the topics listed below, fewer than 40% of respondents indicated that their program is currently including this service or feature. The National Family Caregiver Support Act will expand some of these services, but more resources are needed.

- Social Support – adult day services, elder abuse services, door-to-door outreach
- Caregiving – special assistance to long distance caregivers, internet support groups, services available 24/7
- Disease Self-Management and Health Promotion – attention to alcohol-related problems and pain management
- Physical Activity – tools for client goal setting and monitoring progress, replication of an evidence-based program

Though our data indicate that some of these services are not widely available, this may not always be the case. Our data were gathered on specific programs within larger agencies – agencies that are part of a community network working to provide comprehensive services to older adults. Services not offered in the specific program may be offered elsewhere in the agency or in a local partnering agency. For example, one-third of these programs have caregiver support services available every hour of every day. However, this round-the-clock service may be provided by some other local agency, or may not be in great demand in some communities. A study that maps the services available in an entire community, and how those services are or are not linked for clients, would provide an excellent complement to these data.
We also looked at the quality ratings to identify the topics that respondents are less likely to rate as "excellent." Such areas may be targeted for developing and delivering best practice information, and training and technical assistance to community-based agencies. Listed below are selected topics for which fewer than 25% of respondents rate their programs as "excellent."

- Accessibility – motivating hard to reach elders to participate, marketing through the mass media
- Self-care – improving clients’ skills in self-care
- Staffing – training on cultural competence, using computer-based training tools
- Funding – engaging broader community to meet funding needs
- Outcomes – measuring changes in health status and/or health behaviors

In addition to these quality ratings, the most frequently mentioned barriers to expansion also provide opportunities for new initiatives, including training and technical assistance. Clearly, identifying new funding sources or expanding existing ones is key to reaching more older adults. Fostering consistency across regulatory agencies and eliminating unnecessary rules and regulations would also lead to service expansion. A first step could be to document the most problematic regulations at the state and federal levels, and the negative impact that these regulations have on getting needed services to older adults.

Despite considerable attention to the problem of shortages of volunteers and in-home personal care workers, these shortages continue to pose serious barriers to program expansion. One way to address some of these shortages is to support new initiatives that recruit and train older workers for employment in personal care. Greater investment in finding solutions to the shortage of volunteers and staff is crucial if older adults are to receive the services they need and deserve.

The fact that 59% of respondents selected a social support program to describe in the survey is not surprising, given the long history of development of in-home support services. However, we know that caregiving, disease self-management/health promotion and physical activity programming is also necessary and needs to be expanded. Two new initiatives should help expand these programming areas: The National Family Caregiver Support Program and the planned RWJF initiative to promote physical activity among older adults. Additionally, the RWJF Initiative on Community Partnerships for Older Adults will strengthen the comprehensiveness and integration of supportive services programs.

We hope that this study will be used by leaders across the country to document the value and capacity of existing programs for older adults and to identify ways to expand and improve services. In fact, it has already increased visibility and support to expanding and improving services in the aging network. The Robert Wood Johnson Foundation used these findings to develop their recent initiatives on community partnerships and physical activity. The National Council on the Aging has drawn upon this study to conduct two best practices studies – one on caregiving and one on health promotion – that will be published soon. NCOA also drew upon these findings in gaining support from The John
A. Hartford Foundation to strengthen model programs in health and supportive services and foster teamwork between local agencies and healthcare providers.
II. Chartbook of Findings

A Note on the Charts

The following charts provide detailed findings from the study. The notes below will help you to read and interpret these charts.

- The survey was comprehensive, with over 100 questions. For this report, many of the results are summarized and the items of most interest are displayed in charts.
- In general, the results are reported for the total respondents to the question. When there are important differences across the four types of program (Social Support, Caregiving, Disease Self-Management, and Physical Activity), these differences are summarized in a bullet note or a chart.
- Specific items may have fewer than 628 respondents. The number of respondents is indicated by (N=) following the chart title.
- Some questions in the survey asked respondents to rate the quality of their own program (on a specified topic) “compared to similar programs with which you are familiar.” A 7-point rating scale was used, anchored by 7=Excellent and 1=Poor with a “Not Applicable” option. For reporting purposes, this scale has been collapsed and labeled as: Excellent=7, Good=6,5, and Needs Improvement=4,3,2,1.

Sample Chart: Training Staff to Foster Client Self-Efficacy (N = 611)
1. The Four Types of Program Studied

- Overall, 628 programs are included in the study. For these analyses, each program falls into one, and only one, of the following types: Social Support (N=370), Caregiving (N=101), Disease Self-Management and/or Health Promotion (N=69), or Physical Activity (N=88). Respondents selected the type that best fit their program.
- The majority of respondents are from Social Support programs. The other respondents are relatively evenly distributed across the other three program types.
- The next few pages provide details on the services and features specific to each type of program, followed by more general descriptions of all the programs.

![Program Type Pie Chart]

2. Social Support Programs: Services Offered

- On average, the 370 Social Support programs offer seven to eight different services.
- The most common service is information and referral. Over half the programs provide transportation, friendly visiting, case management, and/or congregate meal services.

![Services Offered Bar Chart]

Services included in the questionnaire, but with less than 20% response include: assistive devices, home safety checks, housing, protective services, spiritual services and discounted pharmacy services.
3. Features of Social Support Programs

- Respondents were given a list of four program features and asked to indicate which ones are standard in their social support program. Active engagement of family is the feature most frequently mentioned by Social Support programs. Only about one-third of programs are doing door-to-door outreach.

**Standard Features (check all that apply)**

- Active engagement of family: 71%
- Professional counseling: 45%
- Client choice of a specific volunteer or service worker: 44%
- Door-to-door outreach: 37%

4. Social Support Models

- A third of the Social Support programs are based on a “well recognized model.” Among those using a well-recognized model, most found it not difficult to fit it to their agency.
- Models mentioned by some of the respondents include: Brookdale National Group Respite Program, Interfaith Volunteer Caregivers, Gatekeepers, Social Model of Adult Day Center, Shepherd’s Center, and Senior Companion Program.

**Is this program based on a well-recognized model? (N = 335)**

- Yes: 33%
- No: 67%

**If yes, how difficult was it to fit this model to your agency? (N = 98)**

- Not Difficult: 78%
- Neutral: 15%
- Difficult: 7%
5. Caregiving Programs: Services and Supports

The survey listed many different types of services and supports. Respondents were asked to check all that are included in their program. Most of the 101 Caregiving programs offer several different services. On average, the programs studied offered:

- Five to six different services to clients and/or caregivers.
- Three to four supports specifically for caregivers.

### Services Offered to Elderly Clients and/or Caregivers (check all that apply)

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite care</td>
<td>76%</td>
</tr>
<tr>
<td>Case management</td>
<td>71%</td>
</tr>
<tr>
<td>Social stimulation</td>
<td>68%</td>
</tr>
<tr>
<td>Personal care</td>
<td>66%</td>
</tr>
<tr>
<td>Adult day services</td>
<td>54%</td>
</tr>
<tr>
<td>Homemaker service</td>
<td>32%</td>
</tr>
<tr>
<td>Cognitive stimulation</td>
<td>37%</td>
</tr>
<tr>
<td>Assistive devices</td>
<td>36%</td>
</tr>
<tr>
<td>Home health care</td>
<td>30%</td>
</tr>
<tr>
<td>Legal assistance</td>
<td>22%</td>
</tr>
<tr>
<td>Spiritual services</td>
<td>25%</td>
</tr>
</tbody>
</table>

### Support Offered Specifically to Caregivers (check all that apply)

<table>
<thead>
<tr>
<th>Support Offered</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training in care of frail elder</td>
<td>44%</td>
</tr>
<tr>
<td>Caregiver resource center</td>
<td>42%</td>
</tr>
<tr>
<td>Staff complete assessments of caregiver needs</td>
<td>34%</td>
</tr>
<tr>
<td>Face-to-face caregiver support groups</td>
<td>37%</td>
</tr>
<tr>
<td>Training in stress management</td>
<td>49%</td>
</tr>
<tr>
<td>Caregivers complete assessments of their own needs</td>
<td>40%</td>
</tr>
<tr>
<td>Special assistance for long distance caregivers</td>
<td>35%</td>
</tr>
<tr>
<td>Depression screening</td>
<td>26%</td>
</tr>
<tr>
<td>Organizing caregiver associations</td>
<td>7%</td>
</tr>
<tr>
<td>Internet-based caregiver support groups</td>
<td>33%</td>
</tr>
</tbody>
</table>

6. Features of Caregiving Programs

Respondents were given a list of program features and asked to indicate which ones are standard in their Caregiving program.

- Having available certified or licensed paid caregivers is the feature most frequently mentioned.

### Standard Features

<table>
<thead>
<tr>
<th>Feature</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified or licensed paid caregivers available</td>
<td>44%</td>
</tr>
<tr>
<td>Health professional on staff or contract</td>
<td>39%</td>
</tr>
<tr>
<td>Training and certifying staff or paid caregivers</td>
<td>52%</td>
</tr>
<tr>
<td>Certified or licensed volunteer caregivers available</td>
<td>49%</td>
</tr>
<tr>
<td>Services available 24 hours/day 7 days/wk</td>
<td>33%</td>
</tr>
</tbody>
</table>
7. Caregiving Program Models

- Four in ten Caregiving programs are based on a well recognized model. Most did not have difficulty fitting the model to their agency.
- Models mentioned by some of the respondents include: Social Model of Adult Day Center, Brookdale National Group Respite Program, Senior Companion Program, and Interfaith Caregivers Alliance.

8. Disease Self-Management and/or Health Promotion Programs

- On average, the 69 Disease Self-Management and/or Health Promotion programs studied address seven to eight different diseases.
- The diseases most commonly addressed include diabetes, hypertension, heart disease, arthritis, osteoporosis and depression. These diseases are among the leading causes of disability and mortality among older adults.
9. Features of Disease Self-Management Programs

- Respondents were given a list of different types of program features and educational content and asked to indicate which ones are incorporated into their program.
  - On average three to four different standard features are included in programming. Most common is having available paid or contract staff with certified expertise.
  - On average, five to six different topics are covered in educational programming. The most frequently covered topics are nutrition, exercise and medication use.

### Standard Features (check all that apply)
- Paid or contract staff with certified expertise in specific diseases or health problems: 45%
- Training for staff or volunteers in health and chronic disease management: 35%
- Volunteers with formal training/expertise in specific diseases or health problems: 32%
- Educating physicians and other health professionals on needs of older adults: 58%
- Giving vaccines or immunizations: 47%
- Disease-specific, written self-management protocols for clients: 45%
- Disease-specific self-management support groups: 45%

### Educational Content (check all that apply)
- Nutrition or diet: 87%
- Exercise/physical activity: 85%
- Appropriate use of medications: 82%
- Health literacy: 72%
- Symptom management: 67%
- Managing emotions or psychological response to illness: 63%
- Pain management: 40%
- Managing acute episodes and emergencies: 37%
- Smoking cessation: 34%

10. Disease Self-Management Program Models

- Almost four in ten of the Disease Self-Management programs are based on a well recognized model. Among those using a well recognized model, the vast majority find it easy to implement.
- Models mentioned by some of the respondents include: Arthritis Foundation Programs, Colorado Action for Healthy People, Orem’s Self-Care Model, and the Precede-Proceed Model.

Is this program based on a well-recognized model? (N = 61)
- Yes: 39%
- No: 61%

If yes, how difficult was it to fit this model to your agency? (N = 23)
- Not Difficult: 91%
- Neutral: 4%
- Difficult: 4%
11. Physical Activity Programs

- On average, the 88 Physical Activity programs studied offer four to five different types of activities. Most common are walking, aerobics, weight training, and dancing.
- Respondents indicate that their activities target key components of fitness, and many serve frail elders.

### Activities Offered (check all that apply)

- Walking: 88%
- Aerobics: 59%
- Weights: 59%
- Dancing: 55%
- Fitness equipment: 47%
- Tai Chi: 43%
- Yoga: 32%
- Swimming: 32%
- Sports leagues: 28%
- Wellness retreats: 10%

### Activities Targeted At: (check all that apply)

- Flexibility: 91%
- Strength: 85%
- Balance: 84%
- Endurance: 69%
- General fitness: 82%
- Frail elders: 78%

12. Features of Physical Activity Programs

- Most Physical Activity Programs include several types of educational content and standard features.
  - On average, four out of the five educational topics listed are covered.
  - On average, three to four different standard features are included in programming.

### Educational Content (check all that apply)

- Importance of physical activity: 98%
- Engaging in physical activity safely: 96%
- Fitness maintenance or adherence over time: 78%
- Advantages and disadvantages of types of physical activity: 64%
- Nutrition or diet: 61%

### Standard Features (check all that apply)

- Staff with certified expertise related to physical activity for older adults: 81%
- Linking clients to physical activity programs and services at other organizations: 61%
- Motivators for sedentary adults to participate: 61%
- Volunteers with certified expertise related to physical activity for older adults: 38%
- Clients setting goals, in writing, for health improvement/flexibility: 29%
- Replication of an evidence-based program: 27%
- Facilitating access to assistive technology: 24%
13. Physical Activity Models

- Less than a quarter of the Physical Activity programs are based on a well recognized model. Among those that use a model, most found it easy to fit the model to their agency.
- Some of the models mentioned by respondents include: Body Recall, California State University, Fullerton Balance and Mobility Program, National Wellness Institute Program, Tufts University Strong Living Program, YMCA’s Active Older Adult Program, and Arthritis Foundation Programs.

14. Program Specific Numbers of Clients Reached

- There is great variability in the number of clients reached by these programs. About 20% of programs reached fewer than 100 older adults in 1999, and a similar number reached more that 2000. Four in ten programs reached between 100 and 750 clients in 1999.
  - Caregiving programs are more likely to be smaller, with 41% reaching less than 100 clients.
  - Nearly one-fourth of Social Support and Disease Self-Management programs are reaching 2000 or more clients.

Unduplicated Number of Clients Reached by Program in 1999 (N = 576)
15. Client Population

- The survey asked respondents to describe their client populations in terms of the percent of clients who have various characteristics. Some programs do not have these data. The results below represent answers from 70%-80% of the 628 programs surveyed.
- Not surprisingly, most clients are women, over age 75 and low income. For half of the programs studied:
  - at least 75% of clients were women.
  - at least 65% of clients were age 75+.
  - at least 60% of clients were “low income”.
- This survey also reached programs serving minority and rural elders. For one-fourth of the programs studied:
  - at least 35% of clients were African-American, Hispanic or a member of another minority group.
  - at least 70% of clients live in rural areas.
- A higher percent of Caregiving programs reach clients who are low income and/or 75 years of age and older.

16. Recruiting and Retaining Clients

- A key part of any successful program is the ability to recruit and retain clients. Respondents were asked several questions about recruitment and retention. Each of these questions included a 7 point rating scale that has been collapsed into three categories: excellent, good and needs improvement. Respondents also had the option of indicating that this question was “Not Applicable” to their program.
- In general, the programs studied rate themselves highest at retaining clients and engaging the health and medical community for referrals. One third of programs rated themselves as “needing improvement” in marketing through the media, motivating hard-to-reach elders and meeting the needs of non-English speaking clients.
17. Program Specific Waiting Lists and Length of Participation

- On average, only 23% of programs have a waiting list. Once in a program, most people participate at least nine months.
  - Waiting lists are more common for Caregiving and Social Support programs where services tend to be more intense and for longer periods of time. Not surprisingly, Caregiving and Social Support programs tend to have longer periods of participation.

**Average Length of Participation in Program (N = 341)**

- **Social Support**:
  - 32% 1 year or more
  - 35% 9 months to a year
  - 19% 3-9 months
  - 14% 3 months or less

- **Caregiving**:
  - 43% 1 year or more
  - 28% 9 months to a year
  - 16% 3-9 months
  - 14% 3 months or less

- **Disease Self-Management**:
  - 54% 1 year or more
  - 19% 9 months to a year
  - 19% 3-9 months
  - 17% 3 months or less

- **Physical Activity**:
  - 13% 1 year or more
  - 51% 9 months to a year
  - 35% 3-9 months
  - 28% 3 months or less

- **Total**:
  - 27% 1 year or more
  - 38% 9 months to a year
  - 28% 3-9 months
  - 13% 3 months or less

18. Program Locations

- Most programs provide services in their own facility, particularly Social Support and Physical Activity programs, although a wide variety of settings are used. Many programs take place in more than one type of setting (e.g. agency facility, home, recreation center).
  - Not surprisingly, Social Support and Caregiving programs frequently provide in-home services. Disease Self-Management programs use many different types of settings.

**Types of Location (check all that apply)**

- **Social Support**:
  - 78% Our facility
  - 75% Client’s home
  - 69% Recreation, fitness, school
  - 58% Health center or clinic
  - 34% Other (service, faith, housing)

- **Caregiving**:
  - 53% Our facility
  - 49% Client’s home
  - 24% Recreation, fitness, school
  - 38% Health center or clinic
  - 27% Other (service, faith, housing)

- **Disease Self-Management**:
  - 71% Our facility
  - 71% Client’s home
  - 52% Recreation, fitness, school
  - 44% Health center or clinic
  - 35% Other (service, faith, housing)

- **Physical Activity**:
  - 71% Our facility
  - 66% Client’s home
  - 52% Recreation, fitness, school
  - 44% Health center or clinic
  - 35% Other (service, faith, housing)

- **Total**:
  - 66% Our facility
  - 64% Client’s home
  - 50% Recreation, fitness, school
  - 44% Health center or clinic
  - 36% Other (service, faith, housing)
19. Addressing Access Barriers

- A key quality issue for many programs is the ability to address access barriers and preferences of clients. In general, the programs studied rated themselves higher on adapting program schedules to meet client preferences than on addressing transportation needs or cultural competence.
  - Disease Self-Management programs are more likely than other programs to give themselves an excellent rating on adapting programs schedules.
  - Compared to the other programs, a higher percent (32%) of Physical Activity programs rate themselves as needing improvement on meeting transportation needs.

**Own Program Quality Compared to Similar Programs (N = 610+)**

- Adapting program schedules to meet preferences of clients
- Meeting program-related transportation needs of clients
- Assessing cultural competence of program

20. Linking Clients to Other Services

- A fundamental service of many programs for older adults is providing information and referral to community resources. Generally, the programs studied rate themselves highly on linking their clients to other services.
  - Physical Activity programs are more likely than other programs to rate themselves as needing improvement, or to indicate that these items are not applicable to their program.

**Own Program Quality Compared to Similar Programs (N = 619+)**
21. Improving Quality of Life and Self-Care Skills

- The main goal of many aging programs is to enhance well-being and quality of life for the older adult and/or caregiver. A more recent trend is to view improving self-care skills and self-efficacy as a key to improving quality of life. Respondents were asked to rate their program’s quality in terms of improving various self-care skills and overall quality of life.
  - Four in ten feel they are doing an excellent job at improving quality of life.
  - Fewer programs feel they are doing an excellent job at improving various self-care skills, and approximately one-fourth of programs report that improving these skills is “not applicable” to their program. Program specific results on self care skills are presented on the next pages.

Own Program Quality Compared to Similar Programs (N = 614+)

22. Program Specific Efforts to Improve Self-Care Skills

- The vast majority of Disease Self-Management programs say they are doing well at improving self-care skills on managing diseases and/or functional impairments. A higher percent of Social Support and Physical Activity programs see room for improvement or indicate that improving these skills does not apply to their programs.
- Disease Self-Management programs are more likely than other programs to give themselves an excellent rating on improving self-care skills on managing stress. A larger number of Social Support programs say this is not applicable.

Improving self-care skills on managing diseases/functional impairments (N = 614)

Improving self-care skills on managing stress (N = 615)
23. Program Specific Efforts to Improve Client Communication Skills

- Disease Self-Management programs are more likely to give themselves an excellent rating on improving client skills in communicating with their physicians. Four in ten Physical Activity programs do not see this as applicable to their programs.
- About one in four Caregiving programs rate themselves excellent at improving client skills in communicating with family members.

![Improving client skills in communicating with physicians (N = 618)](chart1)

![Improving client skills in communicating with family members (N = 615)](chart2)

24. Offering Support for Improvement and Self-Efficacy

- Most strategies to improve self-care skills and build self-efficacy include specific supports for change. Several questions on the survey dealt with different ways of providing support.
- Nearly forty percent of programs rated themselves as excellent in formal assessments. The next page describes program specific differences in support strategies.

![Own Program Quality Compared to Similar Programs (N = 610+)](chart3)
25. Program Specific Support for Improvement

- Caregiving and Disease Self-Management programs rate themselves highest at conducting formal assessments on each client. Physical Activity programs are more likely to report that there is room for improvement or that formal assessments do not apply to their program.
- In general, programs do not believe that efforts to teach clients to develop their own plans are as strong as the formal assessment process.

26. Program Specific Numbers of Staff and Volunteers

- More than half the programs operate with three or fewer full-time equivalent (FTE) employees.
  - Higher percentages of Physical Activity and Disease Self-Management programs operate with one or no full-time employees assigned to the program.
  - In contrast, Social Support and Caregiving programs are more likely to have ten or more full-time employees assigned to the program.
- On average, just over half of the programs operate with 25 or more volunteers.
  - Physical Activity, Caregiving and Disease Self-Management programs rely on fewer volunteers than Social Support programs.
  - Survey respondents were asked to rate the quality of their program in using the services of older volunteers. Nearly half (47%) say “excellent.”

Number of FTEs Assigned to Program (N = 488)

Number of Volunteers Serving Program (N = 569)
27. Training Staff and Volunteers

- Keys to strong programming are the skills and knowledge of staff and volunteers. Less than one-fourth of these programs rate themselves as “excellent” on these training questions.
- Many programs indicate that the types of training listed in the survey are not applicable to their program. The next chart compares the different types of programs on training.

![Chart showing Own Program Quality Compared to Similar Programs (N = 611+)]

28. Program Specific Features of Training and Staffing

- Physical Activity programs are the least likely to train staff and volunteers to foster self-efficacy and self-care skills of clients. More than a third of these programs indicate that this does not apply to their program.
- More than half the Social Support programs rate themselves as doing a good or excellent job on training and employing older workers. Approximately six in ten Disease Self-Management programs feel that training and employing older workers does not apply to their program.

![Chart showing Training staff and volunteers to foster self-efficacy and self-care skills of clients (N = 611)]

![Chart showing Training and employing older workers (N = 614)]
29. 1999 Program Funding

- Annual program funding levels vary widely.
  - Most Physical Activity programs operated on less than $50,000 in 1999, whereas one quarter of the Social Support and Caregiving programs had budgets of in excess of $750,000.
- Grant funding was available to start 60% of these programs. However, only 34% of Physical Activity programs were started with a grant.
- When asked to compare the cost-effectiveness of this program to other programs operated by their agencies, more than half (55%) of respondents rate this program as excellent. Physical Activity programs are more likely than the other three types of program to rate cost effectiveness as excellent (73%).

![1999 Program Funding Level (N = 549)](chart)

30. Sources of Program Funding

- These programs rely upon multiple sources of funding. Most get some funding from fees or donations, particularly the Social Support (73%), Caregiving (67%) and Physical Activity (64%) programs. Disease Self-Management programs rely on fees and donations to a lesser extent (44%), and are more likely to have funding from hospitals, clinics or managed care.
- Local public funding supports nearly half of these programs, demonstrating the commitment of these communities to programs and services for older adults.
- Public funding is particularly important for Social Support programs.
- Ninety percent of respondents report that there is an excellent chance that funding for this program will continue in the next year.

![Sources of Funding](chart)
31. Program Age and Sustainability

- These programs have demonstrated sustainability. About 60% are at least 10 years old.
- Many of the Caregiving and Social Support programs were started in the 1970s or earlier.
- Nearly one fourth of all programs were established within the past 5 years.
- Disease Self-Management programs are likely to be more recently established, indicating growing attention to the importance of community agencies in promoting healthy aging.

Age of Program (N = 585)

32. Partnering: Types of Organizational Partners

- Partnering with other community organizations to leverage resources and address client needs is fundamental to the work of the aging services network. On average, the programs studied have partnerships with four different types of organization. Not surprisingly, Area Agencies on Aging (AAAs) are the most common partner mentioned but other frequent partners include health care organizations, public agencies and faith-based groups.
- Most Social Support programs partner with AAAs, whereas Caregiving programs partner almost equally with AAAs, health organizations and other community aging organizations. Disease Self-Management programs are more likely than the other three types to partner with Universities.
- Programs were asked to indicate which type of organization is the single most important partner. One-third say the AAA and approximately 10% say a health care organization or public agency.

Types of Organizational Partners (check all that apply)
33. Partnering: Nature of the Most Important Partnership

- Programs were asked about the nature of the single most important organizational partnership. Over half indicate that this partnership involves receiving funds and/or clients.
- Social support programs are more likely to indicate that this “most important” partner provides funding (73%) and technical assistance/training (91%). Caregiving programs are more likely to have this partner refer clients (70%). Disease Self-Management and Physical Activity programs are more likely to have this partner provide staff, interns, and/or volunteers (55%).

![Nature of the Most Important Partnership](chart)

34. Quality of Partnering Efforts

- Programs rated themselves on several aspects of partnering or linking with other organizations. Programs give themselves highest ratings on engaging the broader community to meet the needs of their clients.

![Own Program Quality Compared to Similar Programs](chart)
35. Program Management: Tracking Performance

- The survey included several questions about program management - especially setting objectives, tracking performance and using data for program improvement. Most programs rate themselves well on items dealing with program management.
  - A higher percent of Disease Self-Management programs (46%) give themselves excellent ratings on using written objectives to focus on desired outcomes.
  - Tracking actual vs. expected revenues is not applicable to approximately three in ten Disease Self-Management and Physical Activity programs.
  - A higher percent of Physical Activity programs (26%) feel they could be doing a better job of using performance data to revise and improve their programs.

<table>
<thead>
<tr>
<th>Own Program Quality Compared to Similar Programs (N = 612+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracking actual revenues against expected revenues</td>
</tr>
<tr>
<td>18% 7% 29% 45%</td>
</tr>
<tr>
<td>Tracking actual vs. expected number of individuals served</td>
</tr>
<tr>
<td>12% 15% 34% 41%</td>
</tr>
<tr>
<td>Using performance data to revise and improve the program</td>
</tr>
<tr>
<td>8% 13% 45% 34%</td>
</tr>
<tr>
<td>Using written objectives to focus on desired outcomes</td>
</tr>
<tr>
<td>13% 18% 30% 30%</td>
</tr>
</tbody>
</table>

36. Program Management: Measuring Outcomes

- One of the most challenging tasks of management is to define client improvement outcomes that can be monitored and measured. Less than one-third of programs give themselves an “excellent” rating on outcome measurement.
  - Measuring client satisfaction has the largest percentage of excellent ratings and the lowest of “not applicable.”
  - Between 25% and 50% of programs think that measuring outcomes related to health behaviors, health status and/or health use is “not applicable.”

<table>
<thead>
<tr>
<th>Own Program Quality Compared to Similar Programs (N = 611+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measuring changes in client satisfaction with services</td>
</tr>
<tr>
<td>14% 13% 43% 30%</td>
</tr>
<tr>
<td>Measuring changes in client health status</td>
</tr>
<tr>
<td>20% 14% 34% 23%</td>
</tr>
<tr>
<td>Measuring changes in client or caregiver quality of life</td>
</tr>
<tr>
<td>25% 17% 38% 20%</td>
</tr>
<tr>
<td>Measuring changes in client health behaviors/practices</td>
</tr>
<tr>
<td>31% 18% 34% 17%</td>
</tr>
<tr>
<td>Measuring changes in unnecessary health care use</td>
</tr>
<tr>
<td>58% 24% 18% 7%</td>
</tr>
</tbody>
</table>
37. Program Specific Outcome Measures

- Disease Self-Management programs are more likely than other programs to rate as “excellent” their outcome measures on health status.

  More than three in ten Physical Activity and Social Support programs report that this measure does not apply to their program.

- Not surprisingly, Caregiver programs are the most likely to rate themselves as “excellent” on measuring changes in client or caregiver quality of life.

Measuring changes in client health status (N = 615)

```
<table>
<thead>
<tr>
<th></th>
<th>Social Support</th>
<th>Caregiving</th>
<th>Disease Self-Management</th>
<th>Physical Activity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>16%</td>
<td>15%</td>
<td>25%</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>Good</td>
<td>36%</td>
<td>35%</td>
<td>48%</td>
<td>53%</td>
<td>51%</td>
</tr>
<tr>
<td>Needs Improvement</td>
<td>27%</td>
<td>29%</td>
<td>15%</td>
<td>18%</td>
<td>16%</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>20%</td>
<td>25%</td>
<td>10%</td>
<td>8%</td>
<td>10%</td>
</tr>
</tbody>
</table>
```

Measuring Changes in Client or Caregiver Quality of Life (N = 610)

```
<table>
<thead>
<tr>
<th></th>
<th>Social Support</th>
<th>Caregiving</th>
<th>Disease Self-Management</th>
<th>Physical Activity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>17%</td>
<td>19%</td>
<td>30%</td>
<td>32%</td>
<td>30%</td>
</tr>
<tr>
<td>Good</td>
<td>41%</td>
<td>41%</td>
<td>47%</td>
<td>46%</td>
<td>46%</td>
</tr>
<tr>
<td>Needs Improvement</td>
<td>19%</td>
<td>18%</td>
<td>18%</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>24%</td>
<td>35%</td>
<td>23%</td>
<td>21%</td>
<td>23%</td>
</tr>
</tbody>
</table>
```

38. Barriers to Expansion

- Given that these programs were nominated for their programming quality, it was important to learn what barriers restrict their growth and possible replication. Respondents were asked to rate several different barriers.

- Not surprisingly, by far the greatest barrier facing programs is difficulty in securing funding for program expansion.

- However, other barriers were also important. Nearly one in four consider shortages of in-home personal care workers as a high barrier. Other pressing obstacles include shortages of staff with appropriate certification or training, rules and regulations of funding agencies, and difficulties finding affordable sites. Nearly half of programs rate shortages of volunteers as a high or medium barrier.

Program Barriers (check all that apply)

```
<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulties in securing funding for program expansion</td>
<td>71%</td>
<td>15%</td>
<td>3%</td>
</tr>
<tr>
<td>Shortages of in-home personal care workers</td>
<td>26%</td>
<td>35%</td>
<td>39%</td>
</tr>
<tr>
<td>Shortages of staff with appropriate certification or training</td>
<td>23%</td>
<td>19%</td>
<td>44%</td>
</tr>
<tr>
<td>Rules and regulations of funding agencies</td>
<td>17%</td>
<td>15%</td>
<td>68%</td>
</tr>
<tr>
<td>Difficulties in finding affordable sites</td>
<td>13%</td>
<td>28%</td>
<td>6%</td>
</tr>
<tr>
<td>Shortages of volunteers</td>
<td>14%</td>
<td>44%</td>
<td>42%</td>
</tr>
<tr>
<td>Difficulties in finding convenient sites and facilities</td>
<td>18%</td>
<td>21%</td>
<td>61%</td>
</tr>
<tr>
<td>Lacking of parking at sites</td>
<td>10%</td>
<td>7%</td>
<td>83%</td>
</tr>
<tr>
<td>Inability to market to and reach appropriate client population</td>
<td>19%</td>
<td>24%</td>
<td>57%</td>
</tr>
<tr>
<td>Lack of data on client outcomes</td>
<td>17%</td>
<td>48%</td>
<td>35%</td>
</tr>
<tr>
<td>Increasing liability risks</td>
<td>17%</td>
<td>32%</td>
<td>50%</td>
</tr>
<tr>
<td>Lack of broad community support for the program</td>
<td>12%</td>
<td>44%</td>
<td>44%</td>
</tr>
<tr>
<td>Inability to accommodate client schedules, preferences</td>
<td>17%</td>
<td>24%</td>
<td>59%</td>
</tr>
</tbody>
</table>
```

Based on a 7-point scale, where 7=“To a great extent” and 1=“not at all.” In this chart, “High” = 7, “Medium” = 5,4 and “Low” =3, 2,1.
39. Overview of the Agencies

- Most of the survey was focused on a specific program, but some data were gathered on the agencies that house these programs. This brief agency overview provides a context for interpreting program data.
- The 628 programs studied are in many different kinds of agencies. By design, the majority are in a Multipurpose Social Service Organization, Senior Center or Area Agency on Aging. The “Other” category includes a mix of organizations, including housing and health care.
- Multipurpose and “Other” agencies are predominantly not-for-profit, whereas Senior Centers and AAAs are about equally split between not-for-profit and public.
- Most Multipurpose agencies are independent and most other types of agencies are part of a larger organization, such as local government, a faith-based group, health care or a national association.

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Number of Agencies</th>
<th>Not-for-profit</th>
<th>Public</th>
<th>For-profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multipurpose</td>
<td>202</td>
<td>38%</td>
<td>20%</td>
<td>42%</td>
</tr>
<tr>
<td>Senior Center</td>
<td>171</td>
<td>86%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>AAA</td>
<td>115</td>
<td>57%</td>
<td>56%</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>104</td>
<td>76%</td>
<td>21%</td>
<td>3%</td>
</tr>
</tbody>
</table>

40. Agency Age and Budget

- Most of the agencies are well-established, providing services to their communities for twenty or more years.
- The operating budgets of the agencies in this study vary widely, reflecting the diversity of agencies in the aging network.
  - Physical Activity programs are more likely than other programs to be in agencies with budgets of $200,000 or less (34%), whereas Caregiving programs are more likely to be in agencies with budgets in excess of $1,000,000 (38% are $1-5 million and 35% are $5,000,000+).
41. Agency Clients and Service Area

- Just as budget size varied widely, so does the number of clients served. In 1999, about one-third served fewer than 1000 clients and 17% served more than 10,000 older adults.
  - Agencies reporting on Disease Self-Management programs are comparatively large, with 68% serving more than 4000 seniors in 1999.
- For about one-fourth of the agencies, the number of seniors aged 60+ in their service area is under 10,000, indicating that the study includes rural agencies.
  - Thirty six percent of Physical Activity programs are in agencies with a service area of less than 10,000 seniors.

<table>
<thead>
<tr>
<th>Population 60+ in Service Area (N = 465)</th>
<th>Number of Clients 60+ Served in 1999 (N = 516)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100,000 or more</td>
<td>10,000 or more</td>
</tr>
<tr>
<td>50,000 to 99,999</td>
<td></td>
</tr>
<tr>
<td>10,000 to 49,999</td>
<td></td>
</tr>
<tr>
<td>1,000 to 3,999</td>
<td></td>
</tr>
<tr>
<td>Less than 1,000</td>
<td></td>
</tr>
</tbody>
</table>

(Population and clients served distributions are shown in pie charts.)
III. Statewide Initiatives in Health and Supportive Services
Prepared by the National Association of State Units on Aging (NASUA)

While the National Study of Health and Supportive Services in the Aging Network was designed to focus primarily on quality in community-based programming, it is important to recognize that a number of quality program initiatives have been established statewide. In this section of the report, several replicable statewide models are summarized in order to provide an understanding of how coordinating efforts on the state level can lead to quality cost-effective health and supportive services programming. Programs in the areas of chronic disease/health promotion/physical activity and caregiving/supportive services are described. Information on these statewide programs was obtained from telephone interviews conducted by NASUA and from printed materials. These statewide programs were not part of the mail survey described earlier in this report.

Disease Self-Mangement and/or Health Promotion

- Pennsylvania
The PrimeTime Health Program of the Pennsylvania Department of Aging focuses on health promotion and disease prevention activities for older Pennsylvanians. The overall goal of the PrimeTime Health Program is to promote optimum health and well being. Two of the most successful statewide Primetime programs are FRIENDS and PEPPI described below.

The Fall Reduction Initiative: Establishing New Directions for Safety (FRIENDS) program was developed in 1997 to help identify people with a high risk of falling and to help raise awareness of ways to reduce their risks. Operated through the area agencies on aging, fall risk screenings are offered on the local level through senior centers, senior housing facilities, hospitals, faith based groups and other community organizations. In FY 1999 approximately 3000 clients were served using $13,700 in state funding.

Participating organizations are given the materials and instructions for conducting the screening. The screening consists of three physical skills tests: a timed get up and go; functional reach; and the one leg stand. Participants also answer 10 questions concerning fall risk. Participants are given their results at the time of the screening and if rated at medium to high risk, they are given a copy to take to their physician as well as educational materials related to their particular risk factors. Other referrals, such as to the PEPPI program, are made as appropriate.

The Department of Aging contracts with the University of Pennsylvania for evaluation of the FRIENDS program. Three months after participating in the screening, each participant is sent a postcard which asks them to check off the follow-up steps they took after the screening: went to see a doctor; had their eyes checked; started an exercise program; saw a physical therapist and others. In addition, each FRIENDS site is annually given a composite report that details the results of their participants. These reports assist the site in planning educational programs for the next year.
Peer Exercise Program Promotes Independence (PEPPI), as with the FRIENDS program, partners the Pennsylvania Department of Aging with area agencies on aging to establish exercise programs at various community locations such as senior centers, senior housing, fitness centers and other locations. Older volunteers, committed to maintaining their independence and fitness, are trained to lead the exercise programs that include strength training, walking, and educational programming.

Through a consumer satisfaction survey, PEPPI program clients are tracked to measure improvements in their health status, behavior, and their knowledge of the benefits of good health practices including exercise. Performance data are used to revise and improve the program. Aging network support for the program is strong and marketing occurs largely at the local level. Incentive gifts and local recognition programs assist in the recruitment and retention of clients. In FY 1999, 3000 clients were served statewide for less than $30,000.

- Minnesota
  The Minnesota Board on Aging strives to increase consumer awareness and knowledge of health issues by annually focusing on a different acute or chronic disease. Each year they form a new partnership with state agencies and disease management organizations to pool resources, develop health promotion messages and implement an education campaign. In 1999, they partnered with the National and Minnesota Stroke Associations, the Minnesota Twins Baseball Team and others for the Strike Out Stroke campaign that won the Minnesota Association of Government Communication Award of Excellence. In 2000, they partnered with Minnesota’s Arthritis Foundation and Department of Health for the Arthritis Doesn’t Have to Slow You Down campaign. By focusing on a different topic each year, they not only educate consumers on a variety of issues, but also are able to develop lasting new partnerships, which continue on beyond the campaign. Upcoming campaigns will focus on Alzheimer’s disease, diabetes, and heart disease.

  The low cost programs ($12,000 in 1999) are conducted at senior nutrition sites and through the home delivered meals program. Promotional and educational materials are distributed providing consumers with basic information as well as resources for gaining additional knowledge. For example, the arthritis campaign materials instruct consumers on how to obtain additional written or on-line information and how to sign up for arthritis self-help courses.

  Each year, new program objectives are established and outcomes are measured to not only determine how well the objectives are met but to assist in planning for the next year’s campaign. An evaluation of the stroke campaign surveyed area agencies on aging and nutrition providers on quality and type of materials as well as feedback they received. Approximately 19% of the 342 sites responded to the survey. 65% of these rated the campaign materials as excellent or good. Respondents offered a number of useful suggestions for future campaigns. One participant reported that they had had a slight stroke and would not have known but for the campaign. For the arthritis campaign, the Health Department received CDC funds to conduct an on site evaluation of the program at select sites. The results are not yet available.
• New York
The New York State Office for the Aging conducts their Health Promotion and Disease Prevention program using a combination of Older Americans Act, state and private funding. Working in conjunction with the area agencies on aging, the New York Office for the Aging forms partnerships with a variety of public and private community organizations to conduct media campaigns, training and education programs for consumers and professionals and to develop resources related to health promotion and prevention.

A health and wellness web site (http://agingwell.state.ny.us), Aging Well: A Health and Wellness Village for Mature Adults, is one of the most visible products developed by the New York Office for the Aging effort to date. Funded by GlaxoWellcome and a number of health organizations, this site assists consumers and professionals in learning about nutrition, health and safety, specific diseases and disease prevention, and directs them to resources where additional information can be obtained.

In another effort, the New York Office for the Aging partnered with Pharmacia (formerly Upjohn) in an effort to educate older persons and their caregivers about urinary incontinence. This effort came about when Urinary Incontinence Centers funded through the National Institutes of Health noticed that they were not effectively reaching the older population. They produced a video training seminar called Good Bladder Health and distributed it through adult day care programs, caregiver support groups, and senior centers. Outcome measurements indicate that as a result of this training, visits to physicians for treatment of incontinence increased.

As a result of their work in the area of health promotion, they have gained new opportunities to educate physicians. Two Office for the Aging staff have been invited to sit on the Governing Board of the American Geriatrics Society. In this capacity, they have the opportunity, both for the American Geriatrics Society and their New York Affiliate, to review materials intended for physician training that relate to the field of aging.

Caregiving

• Oregon
The state of Oregon has developed a unique program in an attempt to reach caregivers during the early stages of their caregiving. Partnering with Oregon Public Broadcasting, area agencies on aging, faith based organizations, AARP and others, the Oregon Senior and Disabled Services Division (SDSD) took a multi-faceted approach which included a two hour television broadcast augmented with readily available information resources including a Web site (www.oregoncare.com), an 800# for caregivers, and written resource packets.

The two-hour broadcast aired twice in October 2000 and consisted of four documentary segments followed by an expert panel and studio audience discussion. Over 20,000
households viewed the program. Viewing “parties” sponsored by faith based organizations and other non-profits gave viewers an opportunity to watch the program with their peers. Plans for a second show are underway.

A caregiver web site was designed and launched with the show. The goal of the site is to help family caregivers access timely, low cost assistance which may help reduce or delay participation in public-funded services. Caregivers and other consumers were involved in the design of the site. Feedback on the television broadcast was sought through a survey posted on the web site. An additional web survey seeks input from consumers about their information and resource needs. Based on the results to date of this ongoing survey, new information on caregiving for younger people with disabilities will be added to the web site.

For more personalized assistance, or for those without web access, SDSD developed a toll free help line to provide caregivers with information, referral and consultation. Educational resource packets are distributed through the web site and an 800# is also handed out at the viewing parties. As ongoing activities, the web site and 800# are also marketed separately from the broadcast.

- **New Jersey**
  New Jersey’s statewide Respite Care Program was started in 1988. The New Jersey program operates at the county level and takes the approach that the caregiving family is the client. A formal assessment of caregiver needs is conducted and the client is involved in the design of her/his plan of care. The program is a partnership between the New Jersey Division of Senior Affairs, area agencies on aging, and local service providers. It is funded entirely through casino revenues. Each county level sponsor contracts with local agencies to provide the services.

A typical plan of care might include support groups or educational programming for the caregiver, as well as respite services through the provision of home health care, adult day care, temporary nursing facility placement, companion/sitter services and other supportive services for the elder family member.

The New Jersey Respite Care Program is well established and major program marketing is not required. Though the program was funded at $6 million for 2,500 client families in 1999, most counties maintain a waiting list for the program. Written program objectives guide the program; performance is measured; and the resulting data are used to revise and improve the program as necessary. The most recent program evaluation indicated that program flexibility is one of its greatest strengths. For example, when one family wanted to take their father with them on vacation to North Carolina, the respite program contracted with a North Carolina home health service agency to provide assistance during their vacation.

- **Wisconsin**
  The Wisconsin Bureau of Aging and Long Term Care Resources has been operating the Alzheimer’s Family and Caregiver Support Program since 1985. The program was
created by the Wisconsin legislature in response to the growing number of families trying to care for relatives with Alzheimer’s or related dementia at home. Designed with the entire family in mind, this program provides families with the funds necessary to obtain goods or services that allow the family to keep their loved one with Alzheimer’s in the community setting.

Over 900 Wisconsin families received services in 1999 using state funds totaling $1,877,000 with some client cost-sharing. The program is available in every county and counties may use the funds to develop or expand services, and to fund families directly.

The Wisconsin program provides caregiver training and support groups in addition to helping families obtain such services as respite care, adult day care, home care services, personal care, nutritional supplements, security systems, adaptive equipment and other needed supports. Case management services assist clients in determining their needs and setting up the appropriate plan of care.

- **Connecticut**
The Connecticut Elderly Services Division partners with the Alzheimer’s Association and area agencies on aging to offer a statewide Respite Care Program. Begun in 1998, this program served over 200 client families in 1999 with $500,000 in state appropriations.

In Connecticut, a comprehensive assessment assists caregivers in determining their needs. A plan of care is established with client input. Caregivers directly benefit from support groups, depression screening and case management. A Caregivers Resource Center is sponsored by the Alzheimers Association. The state additionally contracts with supportive services such as adult day care, personal care services, 24-hour respite services, home health and other programs to provide direct services. Depending on the care plan, a family can be funded up to $3,500 per year for securing services.

At the end of the program year, each family is given the opportunity to evaluate the program and offer suggestions for improvement. Most families report that the most important benefit of the program is stress reduction. The primary suggestion for improvement is an increase in funding.

**Summary**
There are a number of advantages to implementing health and supportive services programs on a regional or statewide basis. Some aspects of project administration can be centralized and thus more cost effective. Statewide programming allows the consumer to move from one area to another without loss of service. The involvement of a variety of agencies and organizations can stimulate creative thinking in program development and implementation. For these and other reasons, many states across the country seek to implement health and supportive services programs statewide. This report summarizes just a few of these efforts and is intended to give the reader a sense of the range and diversity of projects that have been developed. A number of good programs exist that have not been included in this report. Contact the appropriate state unit on aging for information on other statewide health and supportive services initiatives.