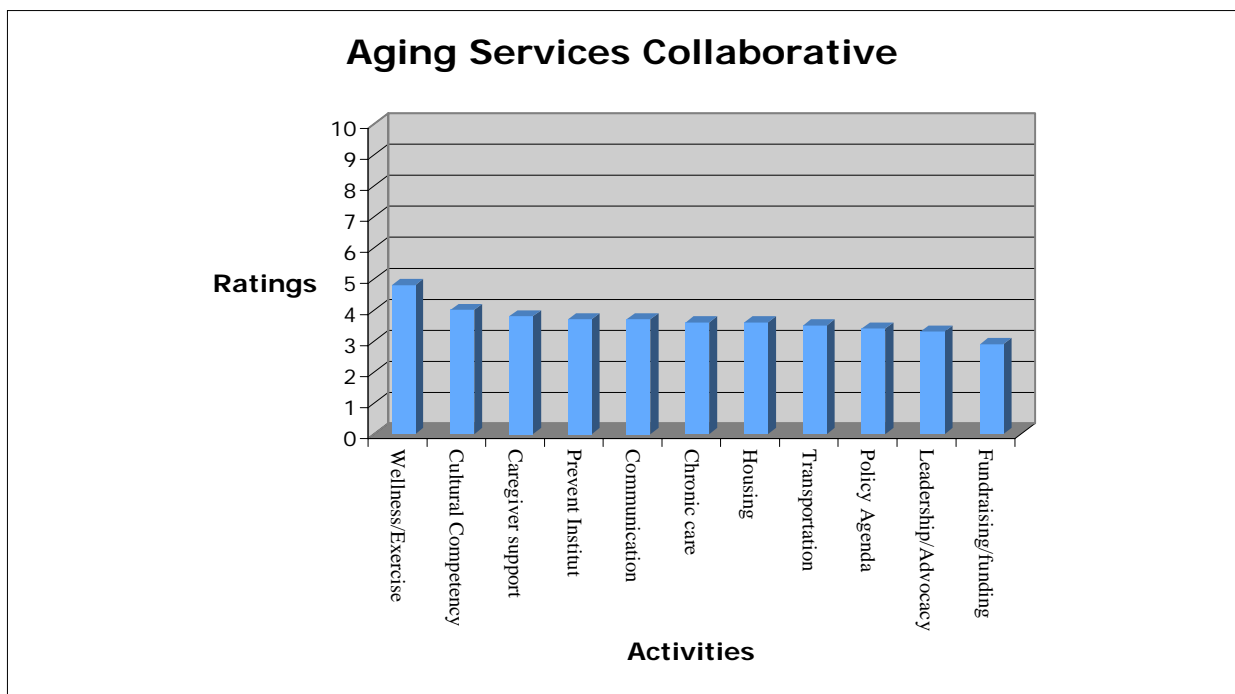


# AGING SERVICES COLLABORATIVE

## FINAL REPORT: MISSION, TAKING STOCK, AND PLANNING FOR THE FUTURE



**SPONSOR**  
**THE HEALTH TRUST**

**FACILITATOR**

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## INTRODUCTION

Healthy aging is a social and cultural imperative. Senior Americans make up one of the fastest growing segments of our population. Efforts to provide healthy environments and effective support systems for our community members as they age not only increases the quality of life for individuals and their families, but strengthens our society overall. The Aging Services Collaborative is a promising venture designed to improve the well-being of seniors in Santa Clara County.

This report highlights the Aging Services Collaborative's efforts to identify high priority needs, prioritize these needs and concerns, develop its leadership, create governance structures, coordinate its efforts and initiatives, and create a sustainable funding stream to support its efforts in the future.

The Collaborative has adopted an empowerment evaluation approach to help guide its efforts in each of these areas. This report summarizes the Collaborative's initial work after completing an empowerment evaluation exercise on October 29, 2007 and November 13, 2007. The report concludes with the Collaborative's strategic plan for the future.

## BACKGROUND

The Aging Services Collaborative was formed in June 2007. It is composed of over 50 government agencies and community organizations. The purpose of the collaborative is to focus on the needs of older adults in Santa Clara County.

The Aging Services Collaborative is guided by a 10-year strategic plan for enhancing the well-being of seniors. The plan was developed by the County of Santa Clara and the City of San Jose and is presented in the **Community for a Lifetime** report.<sup>i</sup> It includes both the results of a countywide needs assessment and strategies to address needs identified in the report, including transportation, housing, in-home care, health care, caregiver support, senior center programs, and access to relevant information.

The Collaborative has a Policy Team and an Action Team. They are charged with the goal of improving services (including the coordination of services) for seniors. The Policy Team is comprised of elected officials, as well as community agency leaders in the public and private sectors. The Action Team is primarily composed of service providers and advocates. They prioritize service gaps, initiate and implement projects to fill those gaps, and network to coordinate services.<sup>ii</sup>

The Health Trust retained Fetterman & Associates to help facilitate the Collaborative's efforts, as well as efforts guided by the list of needs identified by the Collaborative<sup>1</sup>.

## EVALUATION

Evaluation is considered a driving force in this effort. The Health Trust and the Aging Services Collaborative selected an empowerment evaluation approach to guide the overall initiative and the participants' work, specifically because this approach is designed to help programs accomplish their objectives and remain accountable. It is also used to improve program performance. This approach involves a three-step process: 1) Establishing a mission, 2) Taking stock, and 3) Planning for the future.

The first evaluation workshop was held on October 29, 2007. A total of 49 members of affiliated organizations under the umbrella of the Aging Services Collaborative attended the workshop. Dr. Fetterman facilitated the workshop with the assistance of his associates, Dr. Davidson and Ms. Berry.

They developed a mission that they hold in common. In addition, they established a list of critical activities needed to accomplish their mission. The Collaborative took the next step, taking stock, by assessing how well the community was doing concerning each of these activities. Members of the Collaborative took stock of their current activities, rating each activity from high (10) to low (1). Aging Services Collaborative members discussed their ratings and provided evidence for their assessment of the activities they rated.

On November 13, 2007, they engaged in the last step of this initial exercise. At that time they built on the first two steps of the empowerment evaluation, 1) mission and 2) taking stock, by moving onto the final step of planning for the future: specifying goals, strategies, and ideas of documenting that progress has been made.

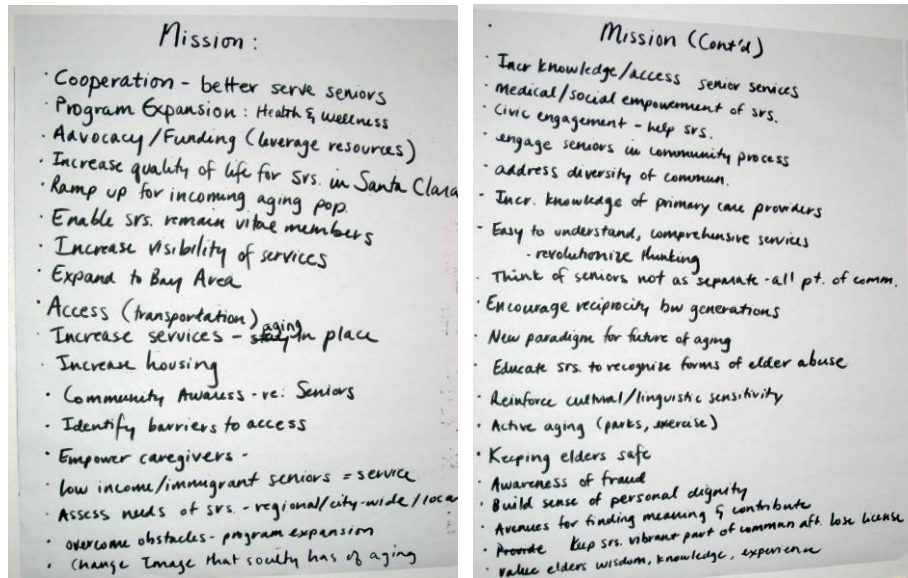
This reports summarizes these efforts: Step 1: Establishing a mission, Step 2: Taking stock, and Step 3: Planning for the future.

### **Mission**

Members of the Aging Services Collaborative developed a mission that is held in common across diverse individual organizations. This process was important because it established a foundation of common understandings across organizations. The process of establishing a mission was simple. The evaluation coach requested ideas and the members of the Collaborative provided specific value statements. The mission-related phrases were consolidated into a brief paragraph. The list of mission concepts and ideas was photographically documented (Figure 1) and reproduced below (see Figure 2) along with a paragraph summarizing the sentiment of the group (Figure 3).

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**FIGURE 1. POSTERS USED TO RECORD COLLABORATIVE MEMBERS CONTRIBUTIONS TO THE MISSION**



**MISSION DISCUSSION**

## **Mission Concepts and Ideas**

Cooperation to serve seniors  
Program expansion to serve seniors  
Advocacy  
Leverage resources  
Increase quality of life for seniors  
Prepare for needs of increasing aging population  
Access  
Services that allow seniors to age in place  
Increase community awareness for seniors  
Increase housing  
Identify barriers to access  
Empower caregivers to help mentally, emotionally, and financially  
Address both city and region-wide needs  
Improve image that society has towards aging  
Increase knowledge of and access to available services  
Inclusivity  
Low income and ethnic access  
Empower patients' access to social, emotional, or medical services  
Incorporate civic engagement for seniors  
Facilitate involvement of seniors in community processes  
Address multicultural diversity in seniors  
Increase Knowledge of primary care providers to better help seniors  
Revolutionize  
Eliminate fragmentation  
Seniors are part of the whole community  
Foster social responsibility between and among generations  
Look into the future  
Educate seniors to recognize elder abuse  
Encourage healthy aging  
Active aging  
Keeping elders safe  
Personal dignity  
Community where seniors contribute to life and the community  
Vibrant part of the community  
Value wisdom  
Create climate of understanding  
See seniors in a larger context (family, neighborhood, and community)  
Empower seniors with language barriers  
Create opportunities  
Breakdown stereotypes of seniors and caregivers  
Differentiate aging needs  
Predict funding needs  
Shape policies  
Showcase contributions of seniors and elder



### **Mission Statement**

The mission of the Aging Services Collaborative is to increase the overall quality of life for seniors and their caregivers in the Santa Clara County. The mission is nothing less than a commitment to foster an environment where seniors of all ages and ethnicities are vibrant members of their community.

Our aim is to increase knowledge and access to a well-coordinated system of medical, emotional, and social services that meet the needs of an aging population. Our goals include breaking down stereotypes, encouraging healthy aging, and fostering social responsibility across all generations. Our aim is to create a community where all seniors feel safe, knowledgeable, valued, respected and dignified.

Our efforts are directed at shaping policies, identifying funding needs, improving transportation systems, developing access to better housing, showcasing contributions of seniors, and creating opportunities for seniors to contribute to the community at large. Through our efforts we include diverse populations, including seniors experiencing language barriers, at different stages of aging, and at various abilities.


**Figure 3. Mission Statement (draft)**

### **Taking Stock**

The group built on this value or mission statement by taking stock of their current efforts. Using a brainstorming technique, the group generated a list of the critical activities required to accomplish the group's mission. It is not feasible or desirable to evaluate every aspect of the activities. Therefore, the group prioritized their list of activities by voting for the most important

activities to evaluate as a group over time. They made a list of the activities on poster paper. Then they placed sticky dots by the activity they thought the group should assess and monitor. This process enabled the group to prioritize the list of activities in a short period of time (less than 15 minutes).

The prioritized list of activities is provided below (Figure 4).

- 
- Taking Stock I** (prioritization)
1. Transportation
  2. Caregiver support
  3. Fundraising/funding
  4. Chronic care
  5. Wellness/Exercise
  6. Leadership/Advocacy
  7. Preventing Institutionalization
  8. Cultural Competency
  9. Housing
  10. Policy Agenda
  11. Communication

The group rated each one of these prioritized activities from high (10) to low (1). This represents the group's view of their efforts to-date concerning each of these activities. It constitutes the groups' evaluation baseline. This baseline represents the first data point for the group. Groups are encouraged to undergo a second taking stock activity approximately 6 months later to represent a second data point. The two data points can be compared and used to demonstrate change over time. The comparison will demonstrate improvement in specific areas, encouraging the group to continue implementing effective strategies. The comparison can also highlight areas meriting improvement, encouraging the group to generate new strategies to replace ineffective ones. The baseline ratings are presented below (see Figure 5):

<b>Activities</b>	<b>Average Ratings</b>
<b>Wellness/Exercise</b>	<b>4.8</b>
<b>Cultural Competency</b>	<b>4</b>
<b>Caregiver Support</b>	<b>3.8</b>
<b>Prevent Institutionalization</b>	<b>3.7</b>
<b>Communication</b>	<b>3.7</b>
<b>Chronic care</b>	<b>3.6</b>
<b>Housing</b>	<b>3.6</b>
<b>Transportation</b>	<b>3.6</b>
<b>Policy Agenda</b>	<b>3.4</b>
<b>Leadership/Advocacy</b>	<b>3.3</b>
<b>Fundraising/funding</b>	<b>2.9</b>

The ratings presented in Figures 5 and 6 represent the average of each participant’s ratings. The individual ratings ranged from 1 to 10 concerning these topics. However, only the overall averages are presented in this report. The average overall rating across activities was a **3.7 on a 10 point scale**.



**COLLABORATIVE ENGAGED IN RATING ACTIVITIES**

This is a reasonable and moderate appraisal of their efforts and is consistent with The Health Trust and Aging Services Collaborative documentation provided concerning current activities and assessments.

### **Specific Analysis of Activities**

Support for senior wellness, health and exercise was the most highly rated activity for the entire group, followed by cultural competency. In the area of cultural competency, there was a feeling that positive work was already being done to help integrate seniors and be sensitive to language

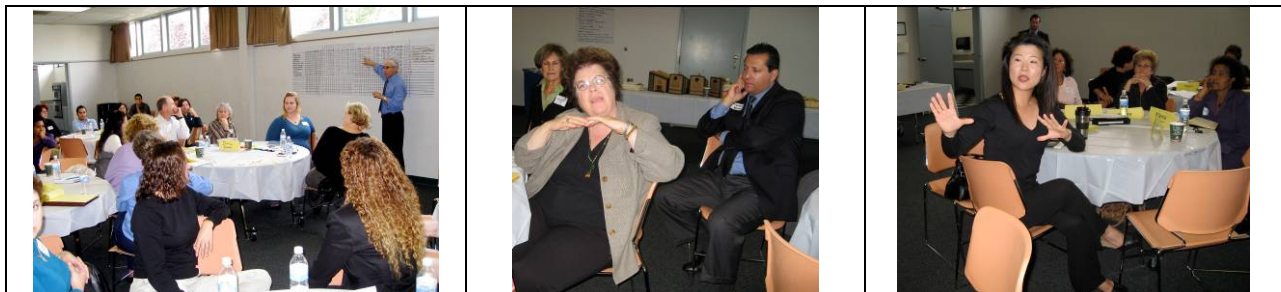
barriers and differences in cultures, and to help groups learn from one another. However, there is still a need for cultural brokering or navigations. Cultural translators can help seniors interface better with health care, and also with regard to housing needs.



**TAKING STOCK PART I (PRIORITIZATION) AND TAKING STOCK PART II (RATINGS)**

Caregiver support received the third highest rating. There is a sense that caregivers are doing good work, but that there are not enough caregivers available and that funding and supports for caregivers are inadequate. The group noted that both informal and formal caregivers play important roles in supporting the aging population, and that funding and supports must be targeted at both groups. Communication also earned comparatively high ratings. Participants said there have been good partnerships and liaisons formed across agencies. Their experiences communicating across agencies have generally been very positive, but could be even more proactive. Providing coordinated care for seniors involving good communication between doctors, therapists, insurance providers, caregivers and transportation services is a key concern.

Housing earned a rating of 3.6 and was identified as a key area of concern, but one for which there is a good degree of community awareness. Although programs do exist to assist seniors in homeowner repairs and accommodations that will allow them to stay in their homes, funding and outreach is limited. There are also efforts to coordinate nursing and transportation to ensure seniors can access medical care, but more work is needed. Housing needs dovetail with the issue of making sure that seniors are not prematurely institutionalized. One participant commented, “The environment seniors live in is very related to their health and wellness.”



**DR. FETTERMAN FACILITATING ACTIVE AND ENGAGED DIALOGUE AMONG COLLABORATIVE MEMBERS**

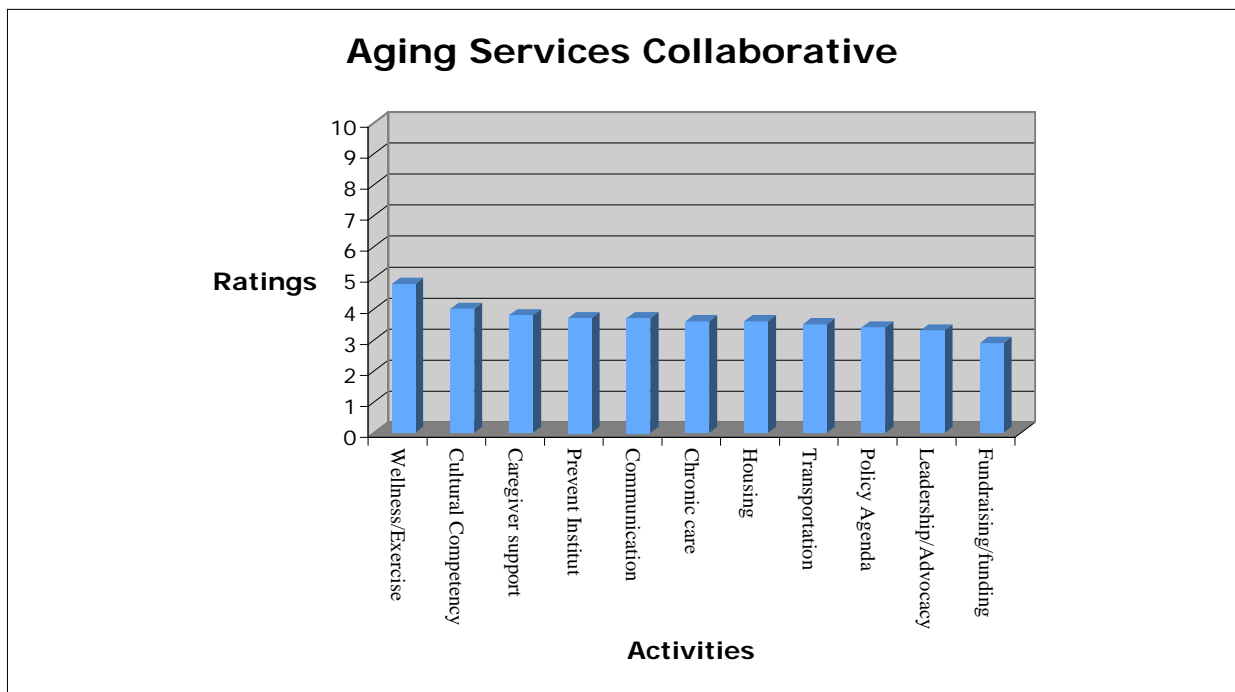
Fundraising and funding, leadership and advocacy, and influencing the policy agenda were activities that received the lowest ratings. The group agreed that these areas merit attention. However, the group did feel that simply coming together in this venue to meet was an excellent

first step in helping to identify resources available throughout the county, share contact information, make connections, and begin to establish a stronger sense of direction and leadership for the collaborative as a whole.

The group graphically represented the evaluation baseline below (Figure 6). The bar chart will facilitate comparisons over time, particular with a second data point.



**EXTENDED DIALOGUE BY COLLABORATIVE MEMBERS**



**Figure 6. Baseline Bar Chart**

The Collaborative participants are knowledgeable and engaged. This process is designed to bring additional focus to these efforts. These efforts will contribute to the implementation and evaluation of the Collaborative's healthy aging activities.

The next step in this process is the "planning for the future" exercise.

## Planning for the Future

The next logical step: 1) establishing a mission or foundation of shared values across programs and 2) taking stock of the collaborative participants' current critical activities, is to 3) plan for the future.

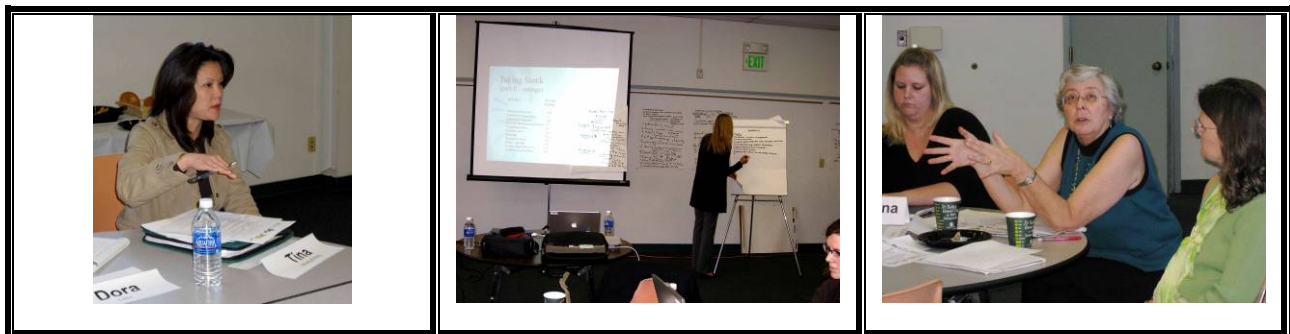
The group selected three activities to focus on at this stage in the development of the Collaborative. The three activities selected are: Wellness, Caregiver Support, and Housing. This represents a realistic plan. (The Collaborative will address the remaining activities at a later date as they deem appropriate and as time permits.)

The goals, strategies, and evidence for each activity are presented in the following Tables below:

ACTIVITIES	TABLES
Wellness	7 & 8
Caregiver Support	9 & 10
Housing	11 & 12



## COLLABORATIVE PARTICIPANTS ENGAGED IN THE DIALOGUE TO PLAN FOR THE FUTURE



## Health and Wellness

### Goals

- Improve overall quality of life for seniors
- Promote positive continuum of care
- Promote positive socialization opportunities

### Strategies

- Develop stronger peer to peer support through a senior work force (Senior Core)
  - Provide stipends
- Increase access to basic life education
  - Managing money, book keeping
  - Buying insurance
  - Housing decisions
  - Car decisions
  - Effective management of household help
- Increase access to public health education
  - Managing chronic illness
  - Public health issues
  - Fall prevention
- Use Media to promote education
  - Seniors educating each other on radio, TV, internet sites.
- Coordinate wrap around services and education that promote continuum of care
  - More case management to prevent accidents and hospitalization
  - Promote preventative services (i.e. screenings, flu shots)
  - Prevent and manage chronic diseases
  - Prevent hospitalization and illness
  - Promote resilience if hospitalized
  - Promote individualized discharge plans (IDP) with hospital care providers
  - Support positive reentry/transition into society after hospitalization
  - Services targeting wellness across generations (intergenerational)
  - Integrate physical activities
- Promote neighborhood advocacy
  - Form action groups in neighborhoods
  - Provide education on advocacy
  - Promote leadership developing in neighborhoods and senior councils
  - Promote socialization by connecting with youth
  - Promote story telling

**FIGURE 7: Goals and Strategies**

## Health and Wellness

### Evidence

- Track number of gyms available to seniors
- Track number of services that integrate physical activities
- Track clinics keeping records of services provided
- Increased networking of services
- Increased number of inter-agency collaborations
- Track and monitor individualized discharge plans (IDP)
  - Number and buy in from hospital providers
  - How long?
  - Realistic?
  - Who participates?
- Decrease county level behavioral risk factors
- Survey seniors for increase in quality of life
  - Someone they can confide in if feeling troubled
  - Feeling safe in their neighborhood to walk to parks
  - Life satisfaction
  - Increased social activities
  - Track overall activities
  - Activities where seniors have a sense of ownership
  - Track participation and leisure time exercise activities
  - Realist money management improves
  - Activities where seniors are utilizing their talents

**FIGURE 8: Evidence**

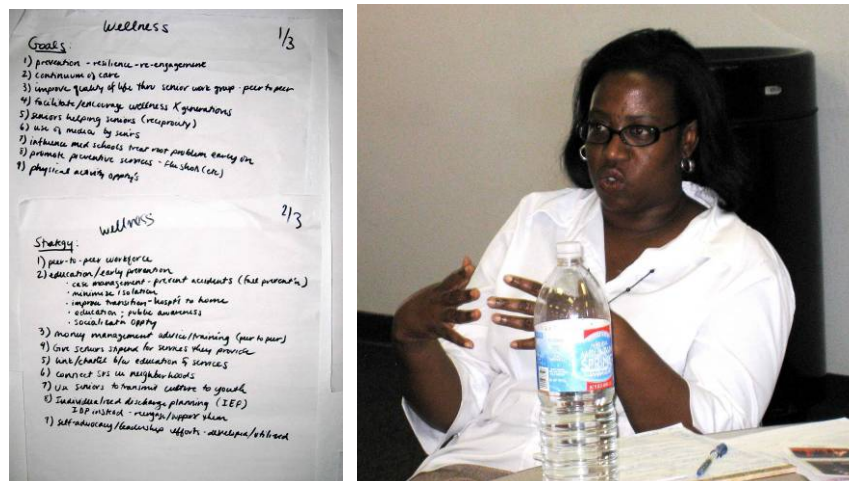
## HEALTH AND WELLNESS

The **goals** for Health and Wellness include improving overall quality of life by promoting positive continuum of care and socialization opportunities for seniors.

The group came up with a number of **strategies** for meeting these goals. The first strategy is to develop a stronger peer-to-peer support network through a senior work force. The “Senior Corps” focuses on bringing seniors together to educate each other. The group agreed that this strategy could not only provide many needed educational programs, but just as importantly, improve the lives of those seniors teaching. Participating seniors could be provided a stipend for their work. Dr. Fetterman commented that this effort could reflect a “Habitat for Humanity” model to link seniors together for helping with basic needs.

Two areas of educational programming were also discussed. One, basic life issues such as how to manage money, bookkeeping, filing medical records, buy insurance, houses, or cars, and how to effectively manage household help. Participants highlighted the Money Matters Group, a group meeting at the Saratoga center for 15 years, as a possible model. Two, more educational programs focusing on public health issues are needed. Topics could include managing chronic illness and fall prevention.

A third strategy is to coordinate services and education that promote a continuum of care for seniors. The group discussed topics such as how to prevent accidents and hospitalization, prevent and manage chronic disease, prevent hospitalization and illness, promote resilience (if hospitalized), and support a positive transition into society after hospitalization. These strategies may include preventing hospitalization through case management to help people take better care of themselves. Current initiatives by The Health Trust to promote preventative services such as screenings and flu shots could also be increased and connected to this continuum of services. A strategy that includes coordinating with the hospital providers to develop individualized discharge plans (IDP) could improve transitions out of the hospital. Further, when seniors transition from the hospital back home, there is a need to better integrate socialization into this process, to reengage them into their community, and decrease feelings of isolation. The prevention strategies should also target both youth and adult children. Opportunities for physical fitness could also be integrated in to available services.



Also, to encourage coordination of services and education, seniors could become more involved with media coverage. Seniors could participate in radio spots, television shows, and internet sights to regularly educate other seniors about basic life and public health issues. Participants discussed that this strategy had been implemented in the past and should be revisited.

A final strategy focuses on increasing opportunities for neighborhood level advocacy. This might include organizing neighborhood action groups to provide education and explain how to social network. Seniors would participate at the local level, so they wouldn't have to get into a car to attend the gatherings. There could also be opportunities for seniors to sit on neighborhood councils so their talents could be expanded and better utilized in their community. Finally, this strategy could help promote a culture of transformation with youth by encouraging story telling and writing about experiences.

The group discussed two types of **evidence**. One, tracking number, types, and implementation of service and two, survey questions to tap into knowledge and attitudes of the senior population.

Identifying a baseline and tracking improvements on a variety of services could provide evidence that interventions are working. For example, evidence could include tracking the number of gyms available to seniors, number of services that integrate physical activities, number of inter-agency collaborations, and number of inter-agency collaborations including with hospitals. Tracking the number and type of educational programs could also provide evidence that strategies are working. In terms of IDPs, it would be important to track and monitor who participates, for how long, whether it is a realistic plan, and

whether there is buy-in from hospital care providers. Agencies could also be surveyed on their overall ongoing activities.

Furthermore, using previously collected data such as clinic records of provided services, and aggregated county-level health information data could provide a base line and help monitor improvements (assuming this type of data can be collected and meet human subjects privacy standards and statutes).

Evidence that strategies are working could also come from surveying seniors to obtain base-line data and changes in attitudes and activity levels. Evidence that quality of life has improved could include: having someone to confide in, feeling safe in their neighborhood, overall life satisfaction, increased social activities, number of activities where seniors have a sense of ownership, participation in exercise activities, and realistic money management strategies. A survey could also track the level to which seniors are utilizing their talents to participate in cottage industry, develop media, launch new ventures, enterprise, and engage in self-advocacy.



### **CLARIFYING ISSUES AND EXPLORING THE OPTIONS CONCERNING EACH ISSUE**



## Caregiver Support

### Goals

- Improve quality of life for caregivers and their families
- Diminish burnout for caregivers (allow for balanced work, family, and care giving duties)
- Provide access to caregiver resources
- Engage volunteer caregivers in their communities
- Prevent premature institutionalization of seniors
- Increased quality of life for seniors

### Strategies

- Highlight available resources
  - Define caregiver responsibilities (paid and non-paid)
- Provide services for psychological support and education
  - Establish Caregiver alliance
  - Create support network with experienced and beginning caregivers
  - Create after-care grief support program (after loved one passes)
  - Provide opportunity for caregivers to talk about their issues
  - Provide email support
  - Address burnout
  - Develop opportunities for counseling and precise mental health interventions for caregivers
  - Education about anxieties of patients
  - Train and educate men and boys as caregivers
- Provide education regarding neglect and abuse
  - Safe alternatives to getting care for elders
  - Elder abuse
  - Laws regarding abuse and neglect
  - Available services, such as Maven
  - File reports on observed self-neglect or witnessing events
  - Educate immigrant and monolingual communities
- Promote caregivers as part of the overall care system for seniors
- Address gaps in economic structure of caregivers
  - Expand respite care resources for caregivers (Paid Family Leave Act)
  - Housing and transportation
  - Promote financial compensation for caregivers
- Provide more peer to peer work for seniors
  - Develop “Senior Corps” for younger seniors to help provide care
- Connect with San Jose State’s Older Lifelong Learning Institute (OLLI)

**FIGURE 9: Goals and Strategies**

## Caregiver Support

### Evidence

- Pre-post counts of available services
  - Increased number of people using hospice or end of life care
  - Increased number of people using anticipatory grief counseling
  - Increased number of seniors who are paid peer educators
- Use current statistics from the caregiver website to create a base line ([www.caregiver.org](http://www.caregiver.org))
  - Decrease morbidity, mortality, depression among caregivers

FIGURE 10: Evidence

## CAREGIVER SUPPORT

The overall **goals** related to Caregiver Support include: improving the quality of life for caregivers and their families in order to provide better care for Seniors; diminishing burnout for caregivers; providing access to more resources, and helping engage volunteers in their communities.

The group identified a number of **strategies** to meet their goals in promoting Caregiver Support. The first strategy is to highlight available resources, similarly to the efforts in Marin County. This might include implementing a media campaign (including posters, radio spots, television, and internet sites.) The information could also include information that helps educate the public about the difference between paid and non-paid caregivers and explicitly defines caregiver responsibilities.

A second strategy is to establish and promote a caregiver alliance. The group suggested that this alliance would include the creation of a support network that connects experienced with beginning caregivers, creates after-care grief support programs for after a loved one passes, and provides opportunities for caregivers to discuss issues together. This alliance could meet in person as well as possibly provide email support on an ongoing basis.

A third strategy is to develop ongoing educational opportunities for caregivers to prevent abuse and neglect. Topics could include how to: find safe alternatives for care to reduce elder abuse, identify and prevent elder abuse, introduce the laws regarding abuse and neglect, gain access to services such as Maven (a program for women over 50 in abusive situations), and file reports on observed self-neglect or abusive events. There is also a specific need to educate the immigrant and monolingual communities about these issues. Furthermore, participants suggested a need to train men and boys on how to become caregivers, since most caregivers are women.

A fourth strategy is to address psychological support needs for both the caregiver themselves and support they need to give to seniors. Caregivers themselves may need precise mental health interventions and counseling to avoid burnout and provide good care. The job can be very stressful, so they need resources that help them cope with their own anxieties as well as the anxieties of their patient.

A fifth strategy is to promote Caregivers as part of the overall system of care. Since so many caregivers must manage chronic illness, they should be compensated for their time and money. One strategy is to advocate for expanding current protocols and laws to allow caregivers to be financially compensated the caregivers for money and donated time. Gaps in the economic structures should also be addressed to compensate for housing and transportation costs.

Another strategy is to increase the number of people participating as “Senior Corps,” an organization where younger seniors work to help provide care for older seniors. Connecting with the San Jose State courses by the Older Lifelong Learning Institute (OLLI) may be a good resource.



Finally, the group articulated that an important strategy to improve the quality of life of caregivers is to expand their respite care resources. The Paid Family Leave act only pays for employees who are taking care of their parent or spouse, not more distant in-laws, siblings, or grandparents. Advocates attempted to expand this legislature, but the Governor vetoed the bill. Therefore, they group suggested continuing to advocate and possibly resubmitting the expansion under a new name.

The group highlighted two types of **evidence** to help identify whether strategies are implemented successfully. The first is to document whether there is an increase in the number of seniors who are paid as peer educators and whether more seniors are using services such as hospice and end of life care and anticipatory grief counseling. It will be necessary to record baseline data for each of these services by identifying how many services currently exist as well as the approximate number of caregivers utilizing the services.

The second type of evidence pertains to the psychological and physical health of caregivers themselves. The group was especially concerned that morbidity, mortality, and depression among caregivers represent significant public health issues. Therefore, they suggested that a decrease in physical and psychological problems could provide some evidence that their strategies were working in the community. Using statistics currently collected on [www.caregiver.org](http://www.caregiver.org) may provide some aggregated baseline to compare similar issues in Santa Clara County.

## Housing

### Goals:

- Expand housing maintenance and repair program
- Improve access to housing
- Improve the quality of senior housing facilities
  - Recreational activities
  - Shared common spaces
  - Kitchens
  - Easy access to transportation
  - Opportunities or activities focused on intercultural exchange
- Improve integration in senior housing
  - Promote diversity in ethnicity, age, and income level
  - Provide family housing

### Strategies:

- Develop mixed-use housing complexes
- Develop sustainable, profitable housing
- Create a transit village
- Improve housing design and living environment
  - Make accommodations for wheelchairs and walkers
  - Offer varied housing designs to meet varied income levels
  - Focus on aesthetics: color, light, materials, integral design
  - Develop system for emergency first responders to locate seniors when phone lines are down
- Use the “Habitat model” for home maintenance
  - Solicit volunteers
  - Provide light construction assistance
- Improve cultural services and programming to support diversity
  - Housing services should be community-supported and intergenerational
  - Provide case management on site available in multiple languages
  - Expand interagency culture-specific collaboration
- Survey and interview seniors about their housing needs and the quality of their living environment.
- Advocate to have MediCal pay for licensed board and care
- Buy land for low cost senior housing

**FIGURE 11: Goals and Strategies**

## Housing (continued)

### Evidence

- Measure rates of involvement of the neighbor-to-neighbor program (volunteers doing home repairs for seniors)
- Report on economic and social value (medical costs saved) by providing care for seniors
- Track depression and suicide rates—see if there are declines
- Look for quality of life indicators—how well are people living (not just longevity)
- Track the activities in housing complexes provided to help get seniors out of their rooms (e.g. Halloween activities)
- See if there are reductions in the numbers on housing waiting lists
- Identify numbers of culturally competent centers
- Monitor whether the number of “cottage industries” increases
- Identify the numbers/type/quality of relationships with city planners and city councils.
- Explore whether there is data (census) tracking seniors living at home versus institutions
- Assess extent to which insurance premiums accommodate seniors’ housing needs.
- Measure amount/frequency of collaboration between agencies to support housing needs
- Count how many housing complexes are wired to the larger community
- Track senior community involvement/leadership (community meetings, etc.)
- Conduct online survey of seniors regarding their needs/environment
- Identify (and try to increase numbers of) seniors who have individual, listed phone numbers

## HOUSING

The **goals** for Housing are to improve both the quality and quantity of housing available to seniors. In addition, the group set as a goal providing assistance for seniors in the form of light construction, home maintenance, and accommodations so that seniors can stay in their existing homes. The group felt it was important to provide housing that was transit-oriented, culturally rich, and diverse, particularly in terms of age, ethnicity and income. They wanted to expand co-housing, in which seniors have private living spaces as well as shared dining, recreation, and cooking facilities. Developing intergenerational or family housing was also a priority.

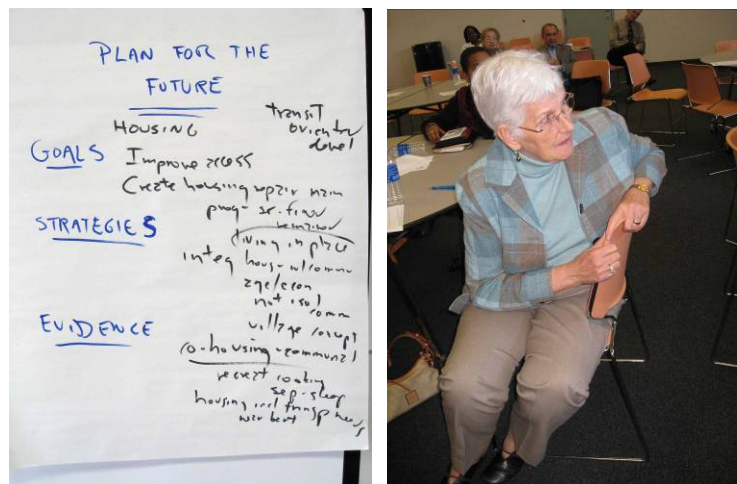
The group had a number of **strategies** for meeting their housing goals. One strategy is to take an entrepreneurial approach, such as developing housing for communities that is mixed-use (with retail and daycare centers in the same complex), so that housing could be profitable and not dependent on government funding.

A second strategy is to apply the “Habitat” model and recruit volunteers to help with home maintenance, accommodations, and assistance for seniors.

A third strategy is to develop or improve senior housing based on the “universal design” model, meaning planning would take into account the many varied needs of seniors. These needs would include: 1) providing on-site case management, 2) providing easily accessible transit options, 3) paying attention to living aesthetics (use of color, light, materials, etc), 4) providing accommodations for mobility, 5) offering multilingual support, 6) offering cultural exchange opportunities, 7) including varied designs to accommodate seniors of varying income levels, 8) providing intergenerational options for housing, 9) including seniors of diverse age ranges in the same complex, and 10) drawing on existing agencies to participate in cultural brokering.

A fourth strategy is to develop and implement tools to address housing needs. Such tools included: 1) developing a multilingual database so seniors can identify and access housing resources, 2) surveying seniors about their living environment and identifying their needs, 3) establishing individual phone lines for seniors and/or setting up a program to assist emergency first responders in locating seniors.

A fifth strategy is to be forward-looking in terms of future housing needs when the baby-boomer generation retires, specifically by buying land now to develop into senior housing later.



A final strategy is to advocate for having MediCal pay for licensed board and care.

The group highlighted two kinds of **evidence** for measuring the success of Housing goals: evidence that the strategies are being implemented and evidence that the strategies are effective. Its necessary to document how well the strategy is implemented to determine whether it is effective.

Critical forms of evidence include: 1) tracking involvement in volunteer programs aimed at improving senior housing, 2) reporting on medical costs saved by providing housing and housing assistance for seniors, 3) monitoring whether housing waiting lists get shorter, 4) tracking the number of culturally competent centers operating, 5) tracking relationships with city planners and city councils related to housing, 6) tracking numbers of seniors living at home versus in institutions, 7) documenting the frequency of collaboration among senior housing agencies, and 8) identifying numbers of seniors who have listed phone numbers or other ways of being contacted in case of emergencies.

An additional form of evidence concerning whether the strategies are being implemented would be to track seniors' general wellness and how their housing situation impacts their level of wellness. Measures could include: 1) tracking depression and suicide rates, 2) looking at other quality of life indicators, 3) tracking senior community involvement, 4) tracking leadership and participation in activities, and 5) conducting surveys regarding their housing needs and their views on their housing environment.

## CONCLUSION

The first steps in this evaluation relationship were positive and constructive. The group completed an enormous amount in a short period of time. They built an evaluation framework in common, developed an overarching mission, and generated a list of critical activities. They prioritized this list and rated the groups' effectiveness in one day. The group provided documentation to support their assessments. The excitement and engagement of the dialogue spilled over into the breaks and lunch periods. Finally, they established basic plans for the future, representing a secondary intervention accompanying their primary existing plans as outlined in their proposal.

The group valued the empowerment evaluation approach as a means of structuring and systematizing their efforts. This is an important project and all of the key stakeholders are committed to its success. Evaluation is one of the driving forces behind it, but the heart and soul of each director and staff member will be the secret to our success as a team.

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<sup>i</sup> The original group responsible for the development of the plan dissolved. Organizations independently addressed many of the goals, but not in a coordinated fashion. Since that time the Collaborative has reengaged to systematically implement elements of the strategic plan.

<sup>ii</sup> The Health Trust is sponsoring the Collaborative because it is consistent with its newly defined priorities. "One of the three priority focus areas for The Health Trust is healthy aging because we recognize the importance of engaged and healthy seniors to a healthy community," said Todd

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Hansen, Interim CEO of The Health Trust. "We are eager to help the Collaborative tackle projects that can make a difference in the lives of older adults and their caregivers."

The Health Trust is committed to helping the Collaborative develop its own governance structure, funding streams, and initiatives. "The Health Trust will provide skills and resources crucial to the evolution of the Aging Services Collaborative," said Santa Clara County Supervisor Don Gage who co-chairs the group along with San Jose City Councilmember Pete Constant. "It is a generous contribution, and we appreciate what it will mean to the community."

However, the expectation is that the Collaborative become a self-reliant and autonomous entity. According to Hansen, "One of the key resource needs identified in the master plan was leadership and coordination."