

“In the end, it's not the years in your life that count. It's the life in your years.”

-Abraham Lincoln



GIVE. ADVOCATE. VOLUNTEER.
LIVE UNITED 
United Way of Greater Rochester

United Way of Greater Rochester Blueprint for Change: Aging

Setting the Stage

Our mission is to magnify and focus the power of community resources to prevent and address our most pressing social needs. Among the key strategic priorities integral to accomplishing our mission is to advance the common good by making a measurable impact in our community. This blueprint represents a new approach for planning how we will invest resources. While it does not fundamentally change our work, it likely will change how we go about that work.

In preparing for this new process, our Community Investment Cabinet worked with staff to develop the following resource investment philosophy.

Our investment philosophy builds on the foundation of our mission, vision and values and is intended to guide our work in making resource investment decisions that will accomplish meaningful and lasting change in peoples' lives.

- Our first responsibility is to serve our community.
- Our focus is clear—we identify priorities and implement effective and efficient strategies to achieve measurable results.
- We work for long-term success and seek to address the root causes of social problems.
- We hold ourselves accountable for the prudent investment of community resources.
- We are willing to take calculated risks and move with urgency to address our community's most pressing needs.
- We value transparency and accessibility through honest and full disclosure to donors, agencies and the general community.
- We build constructive relationships based on mutual respect, candor and understanding.
- We value the perspectives, opinions and experiences of the broadest-possible cross section of people to inform our decisions.
- We set high standards for all we do, assess our performance and learn from our mistakes.

It's also important to note that our blueprint helps guide our resource investment decisions. Just what does that mean? There are three major kinds of resources that the United Way can invest in particular areas of focus:

- 1) Give The United Way makes a financial commitment to a particular program in support of a strategy focused on a community need.
- 2) Advocate The United Way serves as a convener, advocate and champion for issues identified by our blueprint process. This may result in a public policy initiative or simply convening community leaders for dialogue.
- 3) Volunteer The United Way serves as a catalyst in identifying volunteer needs to advance a strategy. For example, if more adults are needed to deliver meals to homebound members of our community, we'll issue a "call to action" to the community.

Any combination of these resources may be invested with the intent of making long-term, sustainable change in our community.

We began our work by learning from the community what matters most to them. After conducting surveys engaging more than 1,200 people, and talking with more than 100 human-service professionals, we learned that people are most concerned about these eight issues:

- 1) violence and unsafe neighborhoods
- 2) family violence, child and elder abuse
- 3) poverty/low income
- 4) support for non-professional caregivers
- 5) adequate food, shelter and clothing
- 6) young children prepared for school
- 7) low graduation rates
- 8) safe, affordable housing

Starting at the Beginning... Aging is Not the End

With such a compelling list of challenges, where do we begin? To understand how best to tackle the issues and to gain insight into the most effective preventive approaches, we turned to a variety of sources. The answer was quite simple and resoundingly endorsed: start at the beginning. We began by focusing on early childhood and published *The Blueprint for Change: Early Childhood* in November 2008; investments guided by that blueprint began in August 2009. To build upon our work in early childhood and to ensure a continuum of supportive services for youth, we felt it imperative to concentrate next on school age youth. *The Blueprint for Change: School Age Youth* was published in July 2009. Now our focus turns to older adults and their caregivers.

“We are a society of people that are living much longer than ever before and the time for thoughtful, purposeful solutions for aging in place is now. We have the right technology, people and resources at our fingertips to start the communication around this much-needed area and the means to better equip our aging population with the education and resources available for us to continue to live a safe and productive life well into older age.”

The Future of Living: Independently, International Longevity Center-USA

The field of aging services has come a long way and still has a long way to go, an observation articulated by John Rowe and Robert Kahn of the MacArthur Research Network on Successful Aging in their book, *Successful Aging*:

“Thirty years ago, something called “disengagement theory” was influential among gerontologists. This theory defined the main task of old age as letting go. The argument was that old age was a time at which people were required to give up their jobs, could no longer take part in the more strenuous forms of recreation, and sadly, had to say farewell to many old friends and family members. The final act of relinquishment was letting go of life itself. Fortunately, this theory is much less influential today.”

The shift in philosophy has not been unique to the United States. A report by the Audit Commission for the National Health Service in England and Wales, entitled “Older People—Independence and Well-Being,” states:

“Older people need an environment that they can shape, thrive and live life to the full for as long as possible. The challenge for communities and councils is to be inclusive, to help older people to stay healthy and active and to encourage their contribution to the community. Councils need to accept responsibility for investing in opportunities and services for older people; to see them as full citizens and a resource for society, rather than as dependent on it. Those whose health has begun to fail also deserve to enjoy life as fully as possible and we need to find new ways to support them.”

This much is clear: Our community benefits when older adults maximize their independence and successfully age. Based on research from the MacArthur Foundation, researchers Rowe and Kahn have identified three key characteristics of successful aging: avoiding disease and disease-related disability; maintaining high mental and physical function; and active engagement with life.

Declaration: Through our blueprint conversations and listening sessions, we have learned that bigger isn't always better. This concept seems to ring particularly true when considering services and supports for older adults. The philosophy of focusing on longer-term, higher-quality interactions and adopting a person-centered approach has guided us as we consider which initiatives to support.

The Blueprint Process

The blueprint process is simply an enhanced planning tool that allows us to be more...

Inclusive

More than 100 people were engaged in developing this blueprint. As we shared the process, it changed along the way, thanks to invaluable input of everyone from donors to field experts. The names of those who helped bring our blueprint to life are listed in the acknowledgements at the end of this report.

Transparent

The blueprint provides important documentation of our thinking, our approach and how we intend to accomplish our goals.

Proactive

We have devoted resources to identify the most advanced approaches to community problem-solving so that our community invests its limited resources in strategies that will best address its problems.

We researched a continuum of program models, from emerging to evidence-based. Where possible, we continue to strive for evidenced-based programs, which are programs that have been evaluated using randomized control trials; have been replicated in other communities; and have strong, positive, long-term outcomes. Where available and affordable, evidence-based programs are preferred.

When evidence-based programs are not identified, we look to emerging practices. These are practices that show promise and may achieve evidenced-based status.

In short, we plan on investing in programs that have been proven to work wherever we can. Where we can't, we'll devote the resources needed to evaluate emerging practices.

Evaluative

Historically, the United Way has tracked program outcomes. The blueprint process truly raises the bar to look at broader impact. Are our strategies working? What progress are we making toward our long-term goal? The blueprint will help us answer such questions.

The blueprint also articulates a formal assessment and evaluation plan that will ensure transparency to our provider partners and others. Program-level evaluation will be particularly important with this blueprint, given the relatively small number of programs that have been rigorously evaluated on similar populations and that meet the standards to qualify them as evidence-based programs.

The importance of program evaluation is underscored in a report by the Center on the Developing Child at Harvard University:

“No single program approach or mode of service delivery has been shown to be a magic bullet. The key is to select strategies that have documented effectiveness, assure that they are implemented well, and recognize the critical importance of a strong commitment to continuous program improvement.”

Collaborative

We can't address this work alone, nor can we do it by ourselves. We need strong funding, advocacy and volunteer partnerships. The blueprint process has already proven to be an invaluable tool in sharing our intentions and investments with those partners to help them make decisions and create increased synergy of community resources.

Culturally Competent

Cultural competency and sensitivity was a recurring theme voiced by many of those we talked with throughout the blueprint process. We know that in order to make a positive impact, services must be designed to respect and honor the beliefs, attitudes and behaviors of the people being served as well as those providing the services. Ensuring that this happens will be a continuing focus for the United Way as the process moves forward.

What We Believe about Aging and Caregiving

“What we believe” represents a compilation of all that we know, assume and believe about older adults and their caregivers:

- Older adults are an important resource. They are active contributors to society, not a drain on it.
- Independence is characterized by safely living at home or at the lowest level of care, remaining active, maintaining health, and giving back to the community.
- Informal care partners are integral to the well-being of the care recipient. Their role is becoming more important as the cost of care rises and economic resources are diminished. Support for informal care partners is critical.
- Healthy habits, such as nutrition and physical activity, go a long way toward preventing chronic health conditions that reduce older adults' ability to remain independent in the community.
- Badgering people about their bad habits has very little impact.

- Greater Rochester has a wide array of services for older adults. Connections to and among those services is crucial, but complicated. Failure to access services in a coordinated or comprehensive way has the potential to compromise older adults' independence. Fundamental access to services includes case management and transportation.
- Older adults are vulnerable to many kinds of abuse that threaten their safety, well being, and ability to remain independent in the community.
- Mental health issues among the older adult population, specifically anxiety and depression often related to isolation and chronic health conditions, are important but difficult to identify, treat and measure. The appropriate approach and treatment setting is critical to success.
- A broad selection of safe housing options is important for older adults to maximize their independence.
- From a systems perspective as well as an individual one, timely, quality information and advance planning are essential to good decision-making and resource management.

What We Know about Aging and Caregiving

- According to the 2000 census, 95,779 people age 65 or older lived in Monroe County, 23% of whom reside in Rochester, 77% in the suburbs. Thirty percent of Monroe County's older adults live alone. Six percent live in institutions such as nursing homes.¹
- Cornell University's Program on Applied Demographics projects that the number of older adults in Monroe County will be 139,930 in the year 2030, a 46% increase over 2000. In 2000, 13% of Monroe County residents were older adults; in 2030, it is estimated that older adults will make up 20% of the county population.²
- In 2000, national poverty rates varied significantly by race and ethnicity, with 8% of older non-Latino whites living in poverty compared with 24% of older blacks and 20% of older Latinos.³ In our community, our experience is somewhat different—6% of Monroe County's white older adults live in poverty, compared with 22% of its black older adults and 26% of its Latino older adults. Fifteen percent of Rochester's older adults live in poverty, compared with 5% of suburban older adults.⁴
- 2000 census data indicates that 18% of Monroe County's older adults living in the community self-identify as having one disability; 19% say they have two or more.
 - 12% have a sensory disability such as blindness, deafness, and/or a severe vision or hearing impairment.
 - 24% have a disability that limits basic physical activities like walking, climbing stairs, reaching, lifting or carrying.
 - 8% have a disability affecting learning, remembering or concentrating.
 - 8% have a self-care disability causing difficulty in dressing, bathing, or getting around at home.
 - 19% have a disability making it difficult to go outside the home to shop or visit the doctor.⁵
- Elder abuse as defined by the New York State Governor's Task Force includes physical, psychological and financial abuse, as well as neglect by caregivers. In 2006, 8% of Monroe County adults were at risk for elder abuse. Thirteen percent of Rochester residents were at risk, compared with 5% of suburban residents.⁶

- In 2006, 3% of Monroe County's older adults did not have a health care provider. Five percent of Rochester's older adults had no health care provider, compared to 2% of older adults living in the suburbs.⁷
- Among older adults, falls are the leading cause of accidental death, non-fatal injuries and hospital admissions for trauma. Twenty to thirty percent of people who fall suffer moderate to severe injuries, including hip fractures and head traumas that can limit independent living.⁸ During 2004-2006, an average of 0.6% of Monroe County adults age 65 to 74, 2% of those age 75 to 84, and 5.2% of those age 85 and older were hospitalized because of falls.⁹
- Increasing physical activity and improving nutrition can have a substantial impact on upgrading the overall health of the community. Physical activity has been shown to reduce the pain of arthritis, reduce symptoms of anxiety and depression, reduce falls among older adults, and help older adults maintain their ability to do everyday activities and live independently. Physical activity and proper nutrition can also help postpone the onset and reduce the risk of developing chronic diseases like heart disease, stroke, diabetes, high blood pressure, arthritis and osteoporosis.¹⁰
- Research shows that if seniors maintain just three healthy habits—moderate physical activity, good nutrition, and no smoking—they may be able to delay disability by as much as 10 years.¹¹
- In 2006, 24% of Monroe County's older adults were obese, which is defined as having a body mass index (BMI) of 30 or more. This is significantly worse than the Healthy People 2010 goal of less than 15%.¹²
- The 2006 Monroe County Adult Health Survey report illustrates the significant role that chronic disease plays in older adulthood:
 - The number of older adults who have been told that they have diabetes increased from 12% in 2000 to 22% in 2006.¹³
 - Among the 61% of older adults who had been told at some point in their lives that they had high blood pressure, 82% were under a doctor's care for the condition. Eighty percent of older African-American adults had been told that they had high blood pressure, compared with 59% of older white adults.¹⁴
 - Fifteen percent of older adults had suffered a heart attack at some point in their lives. Among this number, 25% were older men and 8% were older women.¹⁵
 - Stroke affected 9% of older adults at some point in their lives—13% of older men, and 7% of older women.¹⁶
- Prevention and screening are essential, yet in Monroe County, many national goals remain unmet:
 - The Centers for Disease Control and Prevention (CDC) recommends that older adults receive an annual influenza vaccine. The percentage of adults who received a flu shot in 2006 was 82%, falling short of the Healthy People 2010 goal of 90%.¹⁷
 - The CDC recommends that older adults receive a one-time pneumococcal vaccine. In 2006, 79% of older adults had been vaccinated for pneumonia, again falling short of the Healthy People 2010 goal of 90%.¹⁸
 - The U.S. Preventive Services Task Force recommends that all adults age 50 and older be screened for colorectal cancer. In 2006, 76% of adults in that age range had a fecal occult blood test within the past two years and/or at least one sigmoidoscopy or colonoscopy in their lifetime.¹⁹
 - The percentage of women age 65 and older who had received a mammogram in the last two years declined from 95% in 2000 to 89% in 2006.
- People who report many depressive symptoms often experience higher rates of physical illness, greater functional disability, and higher health care utilization. In the 2004 Health and Retirement Study, 17% of older American women and 11% of older American men reported clinically relevant

depressive symptoms. Depressive symptoms increased with age, with 19% of adults age 85 and older reporting them, compared to 15% of adults age 75 to 84 and 13% of adults age 65 to 74.²⁰

- The 2002 Health and Retirement Study estimated that nationally, 26.5% older adults not living in nursing homes have some type of limitation that affects their abilities to live independently or perform basic activities such as eating, bathing, dressing, using the toilet, preparing meals, managing finances, and shopping for groceries. More than three out of four adults who received help relied exclusively on unpaid assistance from friends and family, primarily their spouses, their children, and the spouses of their children.²¹
- A 2006 national survey indicated that an estimated 33.9 million adults (16% of the total population) provide unpaid care to adults age 50 or older.²²
 - A second 2006 survey of unpaid caregivers for adults age 50 and older found that the caregivers spend more than 10% of their median income of \$43,026, an estimated average annual amount of \$5,531, for expenses related to providing that care.
 - The more a caregiver spends on care-related expenses, the more likely he or she is to experience negative effects such as health problems, feeling depressed and/or stressed, increased use of alcohol and other drugs, weight changes and sleep difficulties.
 - As a result of their caregiving responsibilities, 37% of caregivers have quit their jobs or reduced their work hours.²³
- The “elderly dependency ratio” is an estimate of the average number of retired persons each working adult must support in the population.²⁴ In Monroe County in 2000, the ratio was 20 people age 65 and older for every 100 people age 15 to 64. In 2030, this is projected to increase to 32 older adults for every 100 working adults.²⁵
- In 2005, 41% of households with older adults had significant housing-related problems, such as paying more than 30% of household income for housing and utilities; physically inadequate housing, such as incomplete plumbing or multiple upkeep problems; and crowded housing.²⁶
- As older Americans age, the risk of isolation increases.
 - The proportion of leisure time spent socializing and communicating—such as visiting friends or attending social events—declines with age, from 13% for those age 55 to 64 to 10% for those age 75 and over.
 - The proportion of leisure time devoted to sports, exercise, recreation and travel also declines with age.
 - On an average day, average Americans age 55 and older spend more than half their leisure time watching television.²⁷
- Barriers to engaging in healthy behaviors, including exercising and eating a healthy diet, include:
 - Lack of knowledge and motivation
 - Lack of support from family and peers
 - Poor access to effective programs that promote healthy behaviors²⁸
- In Monroe County and some of the surrounding counties, older adults volunteer at the highest rate of any other age group. About one in three (33%) adults 65 and older volunteer; rates for other age groups range from 17% to 29%. Nationally, trends are different—adults 75 and older have the lowest volunteer rate (21%), while those age 35 to 44 have the highest (32%).²⁹

- A 2003 survey indicated that the extent to which older Americans obtain, process and understand the basic health information and services needed to make appropriate health decisions—such as adhering to prescription instructions, filling out patient information forms, and giving informed consent—was lower than that of any other age group, and continued to decrease with age. Thirty-nine percent of people age 75 and over had below basic health literacy, compared with 23% of people age 65 to 74, and 13% of people age 50 to 64.³⁰
- Individuals with Alzheimer’s disease experience memory problems, may have other cognitive impairments such as loss of judgment and problem solving skills, and may exhibit behavior problems such as agitation and wandering.³¹
 - The risk of developing Alzheimer’s disease increases rapidly with age. Because the number of Americans surviving to 85 or older is expected to continue to grow, so will the number of people with Alzheimer’s.³²
 - Currently, an estimated 5.1 million Americans 65 and older have Alzheimer’s disease.³³ In 2030, this is estimated to grow to between 7.2 million to 8.6 million older adults unless a way is found to effectively prevent the disease.³⁴
 - Having fewer years of education is associated with a greater likelihood of developing dementia.³⁵
 - Individuals with Alzheimer’s and other forms of dementia are five times more likely to be admitted to a nursing home than others of the same age.³⁶
- In New York state, seven out of ten Medicaid long-term care dollars for older people and adults with physical disabilities are spent on nursing facility care even though most people prefer to live at home or in their communities. Medicaid pays for most formal long-term care in the United States.³⁷
- The average Medicaid expenditure in New York state per older adult and adult with physical disabilities receiving services in a nursing home is \$32,134. This is substantially more than the \$19,551 average cost for those receiving home and community-based services.³⁸

Goal and Objectives for Aging and Caregiving

Goal: Older adults and their caregivers will have the resources the need to remain vital and independent as long as possible

- In our community...
 - Everyone is a vital, contributing member.
 - Older adults thrive to their greatest desire and capacity.
 - Older adults are integrated to the greatest possible extent.
 - Older adults successfully age in place.
 - Older adults continue living independent and active lives.
 - All our residents are cared for.
- Our community is livable for older adults. It includes affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life.
- Our role is “to help older citizens remain in their homes and neighborhoods and to continue to live full, rich lives,” as articulated by the Robert Wood Johnson Foundation.
- Older adults and their caregivers have the resources they need to remain as vital and independent for as long as possible.

With that as our backdrop, we established the following outcomes and indicators.

**Maintained or Improved Physical and Mental Well-Being for Older Adults:
Multipurpose Community Aging Resource Centers**

- a. Maintained or improved nutritional status of older adults
- b. Maintained or improved social wellness of older adults
- c. Maintained or improved physical health of participants
- d. Increased number of older adults with chronic illness receiving screening and referrals

Care Management and Support for Older Adults

- a. Maintained or maximized independence and self-determination of older adults
- b. Maintained or improved emotional, mental and physical wellness of older adults
- c. Maintained or improved financial stability and independence of older adults
- d. Reduced abuse (physical, emotional, active neglect, financial exploitation) of older adults
- e. Maintained or improved mobility of older adults outside the home

Caregiver Support and Education

- a. Increased caregivers, knowledge of and access to appropriate resources in the community
- b. Increased caregivers' ability to plan for the future and to take care of themselves
- c. Increased ability of non-professional caregivers to access, understand, locate and obtain appropriate services to assist older adults to function independently

More Effective Service Delivery

- a. Increased coordination among agencies serving older adults and their family caregivers
- b. Increased level of caregiver satisfaction with services
- c. Increased level of older adults' satisfaction with services

Strategies for the United Way's Resource Investments

The United Way has developed three strategies to achieve our goals and objectives. For each of these strategies, our investments may take the form of financial support, advocacy on issues, volunteer mobilization, or a combination of all three. Additionally, for those strategy areas in which the United Way will make a financial investment, we have identified from our research both specific evidence-based programs and best practice programs that will address our goal and objectives. Detailed information on the research elements of those programs and interventions is available on the United Way of Greater Rochester's website, www.uwrochester.org, under the "For Service Providers" section.

We recognized that in the areas where we invest financially, we must consider funding some emerging practices in order to achieve our goal and objectives. We also recognize that each strategy area will require some level of advocacy and mobilization of volunteers.

Strategy 1: Multipurpose Aging Resource Centers

As articulated by authors Rowe and Kahn in *Successful Aging* (based on research funded by the MacArthur Foundation), one of the three components of successful aging is remaining actively engaged in life. There are natural systems that keep individuals active and connected to the larger community—for youth, the systems are in school; for adults age 18 to 65, they are in the workplace. For older adults, the structure is not as clear. Older adults are much less likely to engage with either system, and as a result often find themselves disconnected from daily interaction and activity. "Old age has been called a "roleless role;" a time when it is no longer clear what is expected of the elderly person, or where he or she can find the resources that will make old age successful," write the authors.

Multipurpose Aging Resource Centers help combat isolation and promote community by providing a site where older adults and their family caregivers can maximize their independence by participating in a variety of programs and activities.

Aging resource centers come in all shapes and sizes—their individuality is important because they need to represent the communities in which they function. Despite their diversity, however, they all have common core elements. According to the National Council on Aging’s National Institute for Senior Centers, senior centers are places “where older adults come together for services and activities that reflect their experience and skills, respond to their diverse needs and interests, enhance their dignity, support their independence, and encourage their involvement in and with the center and the community.” Beyond that, centers have the potential to provide the community at large with quality information about aging, including eligibility for benefits, as well as offer support for family caregivers. They also afford us the opportunity to help maintain the health of older adults by providing critical health screening and wellness programming.

The United Way believes that aging resource centers also provide an excellent opportunity to maximize the reach of the aging-services network into some of our community’s more economically and/or culturally vulnerable populations, who may have fewer resources to pursue services that maximize their independence. In 1965, the Older Americans Act (OAA) targeted senior centers to serve as community focal points, which were defined in part as facilities established to encourage maximum co-location and coordination of services for older people.

The United Way will make a financial investment in aging resource centers that meet a set of quality practices and structures to ensure exposure to many key program elements.

The following structural elements are the minimum required for funding programs. Programs must:

- Have a full-time program coordinator
- Have consistent older adult participation
- Incorporate evidence-based and/or promising programs for the Health and Wellness component
- Ensure participant input in program development and activity choices
- Provide a nutritious daily meal
- Offer a variety of activities for older adults under the categories of Health and Wellness, Socialization and Recreation, Lifelong Learning, Volunteerism, and Caregiver Support

While there are no evidence-based models that encompass all that an aging resource center might offer, we expect to invest in these evidence-based and promising programs as elements of aging resource centers:

- **A Matter of Balance**

This program is designed to reduce fear of falling and to increase activity levels among older adults. The program recognizes that fear of falling in older adults often results in them curtailing activity. This can cause loss of muscle strength and balance, which can actually increase the risk of falling. The program acknowledges the fear of falling and emphasizes practical strategies to reduce both the risk and associated fears. Trained facilitators conduct eight two-hour sessions for 8 to 12 participants to help participants understand that falls and fear of falling are controllable, set realistic goals for increasing their activity, change their home environment to reduce the risk of falls, and perform simple exercises known to reduce the risk of falling by increasing strength and balance.

- **EnhanceFitness**

This program is a multi-component group-exercise program for older adults to improve their overall functional fitness and well-being. Designed to be implemented in community-based organizations, it includes balance, strength, aerobic conditioning and flexibility exercises. Classes are taught by certified fitness instructors and are held three times a week for an hour at a time.

- **Chronic Disease Self-Management Program**

CDSMP is a lay-led education program for adults with chronic health conditions such as arthritis, lung disease, stroke and heart disease. Its goal is to enable participants maintain their health and manage their health conditions. Facilitated by two trained leaders, CDSMP workshops are held in community settings, and meet 2 1/2 hours a week for six or seven weeks. Program topics include coping strategies to deal with problems associated with chronic disease; appropriate exercise; appropriate use of medications; communicating effectively with family, friends, and health professionals; nutrition; and how to evaluate new treatments.

Aging resource centers should also have access to the following tool and know how to use it:

- **BenefitsCheckUp**

The United Way considers BenefitsCheckUp to be a tool rather than a program, and would like to see it more widely implemented by multipurpose aging resource centers. It is a service of the National Council on Aging, which says,

“BenefitsCheckUp® is an online service developed by the National Council on Aging (NCOA) to help seniors, family members, and organizations find out if they are eligible for public and some private benefits programs... Millions of dollars of assistance for older Americans go unclaimed each year because people are often unaware of the benefits they are eligible to receive. Since 2001, close to two million people have used BenefitsCheckUp to find benefits programs that help them pay for prescription drugs, heating bills, rent, and other needs.”

Consistent with the National Institute of Senior Centers, we believe that whenever possible, aging resource centers should foster collaborations with a wide variety of organizations working in the field of aging, including health care institutions, health care providers, Monroe County Office for the Aging, New York State Office for the Aging, researchers, local educational institutions, and community-based service providers.

While this may be a lot to expect from a resource center, we anticipate that a combination of additional staff and trained volunteers will be able to provide participating centers much of this programming on a roving or rotating basis. Some of this volunteer training and scheduling will be considered in the allocation of resources.

We also will be asking each resource center to participate with the United Way in the National Institute for Senior Centers’ accreditation process. Currently, 153 centers across the country are accredited through this process, which is designed to establish thoughtful, robust centers that are able to deliver the best programming suited to the participants’ wishes and desires. The accreditation process consists of nine modules: purpose, community, governance, administration, program planning, evaluation, fiscal management, records and reports, and facility.

Including these three programs and BenefitsCheckUp will not be enough to round out the schedule of a rigorous, comprehensive aging resource center. Additional program options, based on input from center participants and staff, are critical. Additionally, to remain compelling and relevant, programs may regularly rotate or shift. As noted above, program planning is one of the components of the process, and will vary from center to center, based on the population and community with which it is working.

Possible Components of Aging Resource Centers

Health and Wellness	Socialization and Recreation	Lifelong Learning	Volunteerism	Caregiver support
Possible Programs				
<ul style="list-style-type: none"> • EnhanceFitness • Arthritis Foundation exercise program • Falls prevention: <i>A Matter of Balance</i> • Chronic disease screening/management <ul style="list-style-type: none"> • CDSMP • Heart disease • Diabetes • Asthma • Vaccinations • Tai Chi • Line dancing • Yoga • Weight training • Nutrition 	<ul style="list-style-type: none"> • Games • Crafts • Trips • Music 	<ul style="list-style-type: none"> • Computer classes • Computer games • Book club • Photo club • Brain fitness • Genealogy • Local history • Music • College courses • Guest speakers 	<ul style="list-style-type: none"> • <i>BenefitsCheckUp</i> • Transportation • Program facilitation 	<ul style="list-style-type: none"> • Alzheimer’s education/support • Support groups • Case management • <i>BenefitsCheckUp</i> • Guest speakers

Strategy 2: Case Management and Support for Older Adults

Multipurpose aging resource centers are only one strategy to maximize the independence of older adults in our community, and not all older adults or caregivers will be able to—or want to—access services from a senior center. Therefore, the United Way will continue to provide funding for direct support that maximizes independence for older adults outside of community-based centers.

“There are two key ways to determine people’s ability to remain independent. One is to assess their ability to manage their personal care. The personal care activities include basic functions, such as dressing, bathing, toileting, feeding oneself, transferring from bed to chair, and walking. The second category of activities is known as nonpersonal care. These are tasks such as preparing meals, shopping, paying bills, using the telephone, cleaning the house, writing, and reading.”

Successful Aging, John W. Rowe, M.D. and Robert L. Kahn, Ph.D.

The United Way recently conducted a survey of 95 older adults and their family caregivers. In that survey, transportation, health care, income and finances, food and nutrition, and light housekeeping were ranked as the most prevalent challenges faced by older adults in our community. These results are consistent with both input from community experts and findings from other community needs assessments. Within this strategy, United Way will focus on core services outside the traditional health care system that support independence, including case management, transportation, chore services, nutrition, mental health care, elder abuse prevention, and legal and financial services.

While there is not a preponderance of evidence-based programs for each type of service, this community is fortunate to have considerable depth in delivering effective, independence-maximizing services for older adults, including:

- **Case Management**

As older adults in Monroe County navigate the complex system of aging services with the goal of maintaining their independence, the importance of high-quality information and care-management services cannot be overstated. Unfortunately, while our existing systems of case management, information and referral are well regarded, highly professional and effective, not enough older adults and their caregivers recognize, understand, or even know about these resources. Additionally, we need to make sure that services are available to an increasingly diverse aging population.

We will commit resources both to support ongoing services as well as develop a higher profile and increased community presence so that older adults and their family caregivers aren't missing fundamental connections to services that maximize independence.

- **Transportation**

The National Center on Senior Transportation notes, "Reliable, accessible transportation is key to a full life in the community. Regardless of age and ability, residents need to get around within their communities to take advantage of services, see the doctor, shop for necessities, visit with friends and family, and participate in community and social life."

Although our community has many transportation programs focused on the needs of older adults, transportation is consistently identified in community needs assessments. Local program models vary and services are often fragmented, with different levels of service, eligibility definitions and cost. The United Way will fund a system of transportation services that interweaves the best of these programs, reaching a greater segment of the community and matching consumer needs with the appropriate transportation provider in a way that is seamless to the user.

- **Expanded In-Home Services for the Elderly Program**

EISEP provides older adults with non-medical in-home services including housekeeping, personal care, respite, case management as well as related services such as emergency response systems. The Finger Lakes Health Systems Agency states that EISEP is a critical component of the community-based long-term care system for Monroe County's older individuals and their care partners. In 2007-2008, 1185 Monroe County older adults and their caregivers received case-management services from EISEP. Approximately half of those also received personal-care services.

The Council of Senior Centers and Services of New York City, Inc. states, "Operational experience with EISEP revealed that early intervention, while families were still intact, building partnerships with the family along with case management, low-level social services, and home care could divert or defer a frail person's use of Medicaid."

The United Way will expand EISEP funding, specifically focusing new dollars to serve subpopulations of older adults who are less likely to take advantage of this critical service that supports independence.

- **Nutrition**

It's fairly straightforward—adequate nutrition is key to successful aging. In an August 1998 *Journal of Aging and Health* article, authors Wolfe, Olson, Kendall and Frongillo note, "Food insecurity contributes to malnutrition in the elderly, which in turn exacerbates disease, increases disability, decreases resistance to infection, and extends hospital stays."³⁹

Brandeis University researchers have observed that food insecurity in older adults rises significantly with isolation. Minority households with older adults experience food insecurity at much greater rates than their counterpart white households. Several factors come into play in understanding why many older adults struggle with inadequate food consumption, including: functional impairments, social isolation, reduced ability to regulate energy intake, depression, reduced sense of taste and smell, poor health status, and poor dentition.⁴⁰

Strikingly, according to a March 2002 report from the U.S. Department of Health and Human Services, *the cost of one year's supply of home-delivered meals is about the same as one day in the hospital.*⁴¹

The United Way will invest both financial and volunteer resources in programming that provides home-delivered meals.

- **Mental Health Services**

Depression and anxiety are the prevalent mental health issues experienced by older adults. Both can erode an older adult's independence in multiple ways, compromising the ability to function outside the home and to participate in programs that promote wellness. In addition, the older adult population attaches significant stigma to mental health issues. Given the importance of this issue, and because older adults are often reluctant to seek treatment in a clinical setting, the United Way will focus resources on **PEARLS**, an evidence-based program providing in-home mental health care. An acronym for "Program Encouraging Active and Rewarding Lives for Seniors," PEARLS is an intervention for community-dwelling adults 60 and over who have minor depression or dysthymia, a form of depression. The goals of the program include reducing depressive symptoms and improving quality of life. Depression care members use three depression-management techniques: 1) problem-solving treatment, which involves teaching participants to identify and address problems of daily life that are causing and maintaining depressive symptoms, 2) having participants plan pleasant activities in which to engage between sessions, and 3) social and physical planning to increase participants' physical activity and social interactions outside the home.

- **Elder Abuse Prevention:**

Elder abuse and neglect can take many forms, including physical, sexual, emotional and financial. The 2004 Survey of State Adult Protective Services, funded by the federal Administration on Aging, found a 19.7% increase from 2000 to 2004 in the combined total of reports of elder and vulnerable adult abuse and neglect. In that same time period, substantiated cases increased by 15.6%. Additionally, in 20 states more than two in five victims (42.8%) were age 80 or older. Most alleged perpetrators in 2003 were adult children (32.6%) or other family members (21.5%). Spouses or intimate partners accounted for 11.3% of the total in 11 states.

However, current data about the actual number of cases is unknown; experts estimate that one in six or fewer cases is reported. The New York State Office of Children and Family Services is currently funding a study through Cornell University that will more thoroughly document the prevalence of elder abuse in our state. According to the American Psychological Association, caregiver stress is a significant risk factor for elder abuse and neglect.

The United Way will fund elder abuse programming that focuses on prevention, education and counseling.

- **Financial Services**

Many older adults in our community face the prospect of balancing decreasing financial resources with increasing costs associated with living independently, such as health care and in-home services. To ease that burden, the United Way will make an investment in services for older adults and their family caregivers that provide knowledgeable and impartial financial and legal counseling to help them make wise choices that maximize independence.

Strategy 3: Informal and Family Caregiver Support and Education

As the population of older adults grows, many will find themselves needing some additional support to help them achieve their desire of aging in place. Older adults often provide support for one another, but unfortunately, the number of older adults who live alone increases markedly with age.

In many cultures, taking care of elders is a natural part of the family dynamic. For elders who don't have family, their friends and neighbors often take on that role. Serving as a family caregiver can create significant stress—physically, emotionally and financially. This is also a substantial issue for family caregivers in the workforce, who are charged with coordinating care for older relatives while dealing with the demands of their own lives.

Additionally, the ratio of caregivers to potential care receivers is shrinking. The National Alliance for Caregiving writes:

“Caregivers face multiple responsibilities and complex demands of their time, energy and efforts. Many caregivers work full-time outside the home and care for spouses and children as well as frail or ill family members. As a result, caregiving can take a significant physical and psychological toll. It is therefore important for you as a caregiver to take steps to maintain your health and well-being. While many caregivers report feeling loved, appreciated and needed as a result of their caregiving, many also feel worried, frustrated, sad or depressed, and overwhelmed.”

Professional caregiving is an option for some, but many elders are unable to sustain the costs associated with long-term professional care.

It's incumbent upon the community to support family caregivers so they and their care receivers can continue to maximize their independence. The United Way can help strengthen informal caregiving networks by providing support for education, counseling, care planning and respite.

Once again, in the area of Improved Informal and Family Caregiving, this community has considerable depth in the delivery of quality caregiver support programs.

The needs of a family caregiver can vary widely and have the potential to be both unique and complex. Therefore, the United Way will make a financial investment in programs that provide a holistic approach to caregiver support that includes information and referral, care consultation, support groups, and caregiver education.

We will also invest in programs that support the deployment of highly trained and supported volunteers to provide respite for those who care for older adults. As articulated by the American Psychological Association, “Respite care—having someone else care for the elder, even for a few hours each week—is essential in reducing caregiver stress, a major contributing factor in elder abuse. Every caregiver needs time alone, free from the worry and responsibility of looking after someone else's needs. Respite care is especially important for caregivers of people suffering from Alzheimer's or other forms of dementia or of elders who are severely disabled.”

Strategy 4: Systems Improvement

Improving the quality and accessibility of services for older adults and their caregivers is as critical as implementing effective programs. This is especially true in the current environment of increasingly complex needs and decreasing resources to address them. The United Way is committed to planning, implementing and sustaining high-quality systems that connect and improve local services for older adults. We envision a three-pronged approach to achieve this.

Learning Circles involve staff from United Way-funded aging services programs. They will meet regularly to increase coordination among their agencies and share information about emerging programs to reduce duplication of effort and to increase overall provider knowledge for the benefit of their clients.

Knowledge Management is a practice of harnessing intellectual capital by identifying, documenting and sharing information. During 2010, the United Way will launch an internal knowledge-management system designed to systematically capture information gained from meetings with experts, presentations, literature reviews and provider reports. This will serve as the foundation for a larger knowledge-management system in which funded agencies will participate. Participation includes the ability to add to the system's resources as well as retrieve information and post comments. This approach is intended to increase overall institutional memory and learning among the community of funded service providers. In the long term, we envision that the information harnessed through knowledge management will be made available to any interested party in our community.

The United Way's Synergy Fund provides technical assistance to agencies interested in exploring a different relationship in order to increase their capacity to pursue their mission. The United Way has entered into a partnership with the Council of Community Services of New York State (CCSNYS), an Albany-based organization with extensive experience in organizational re-engineering, to provide technical assistance to local agencies interested in exploring this opportunity. The process begins with an assessment of goals of the respective agencies, missions review, and assessing organizational cultural compatibility. Also provided are facilitation and preliminary due diligence necessary for the boards of both agencies to decide whether to enter into a good-faith agreement to negotiate a different kind of relationship, as are the accounting and legal services required to bring about an envisioned re-engineering that will achieve affiliation, consolidation or merger.

Integrated Strategies for Our Work

Integrated Strategy 1: Advocacy

The United Way engages in advocacy because we know that real and sustained change in community conditions requires more than money. Our advocacy efforts include public policy work as well as identifying opportunities to convene stakeholders to address local systemic issues.

These efforts, at the local, state and national levels, are often conducted in partnership with United Ways across the state and the country, magnifying our influence to further the goals of our aging strategies. We'll continue efforts to develop an advocacy agenda in support of aging strategies to include:

- Advocacy for increased geriatric training for physicians
- Continued partnership with the local aging-services community, through the Greater Rochester Area Partnership for the Elderly, to identify opportunities to better support the effective and efficient delivery of services to older adults and their caregivers
- Advocacy for funding for 2-1-1 centers to ensure increased access to information and referral
- Advocacy for the development of livable communities for older adults

Integrated Strategy 2: Volunteerism

The gift of time is perhaps one of the most powerful ways to give. As part of our blueprint process, we will continue to work with providers to identify key volunteer opportunities that will help them advance their work. As we identify opportunities, the United Way is committed to actively working to spotlight them and recruit volunteers from the community. Some key volunteer opportunities identified include:

- Recruitment of drivers for Meals on Wheels as well as transportation programs that provide services for older adults
- Recruitment and training for community-based senior center programming including benefits screening, fitness, crafting, club activities, computer activities
- Recruitment, training, and program administration related to volunteer respite care

- Recruitment of older adults as mentors to youth in partnership with the Rochester Area Community Foundation for the Boomer Mentors project

We are committed to continue to identify opportunities and communicate them to the community. We will track and evaluate our ability to mobilize volunteers in support of our work in aging services and caregiver support.

Assessing the Strategies

We are committed to an outcomes evaluation that will assess the effectiveness of individual funded programs, overall strategies and the blueprint. Evaluations will be designed to identify challenges and clarify accomplishments. All evaluations will focus on program outcomes. They will also include measures of process and implementation to maximize understanding of relationships between service delivery and results.

We expect that most of the programs supported will be evidence-based programs that have already demonstrated effectiveness through rigorous evaluation. For these programs, we will rely on the data-collection tools already in use by, or available to, service providers as the primary means of obtaining data for evaluations. Each program, however, will have an individualized evaluation design and plans for data collection and analysis.

For programs that do not rely on evidence-based models, we will require the design of program-specific data-collection tools. Each of these programs will also have a specific evaluation design, data collection, and analysis plan. We will work with all providers and evaluators to ensure that data-collection tools are valid and appropriate.

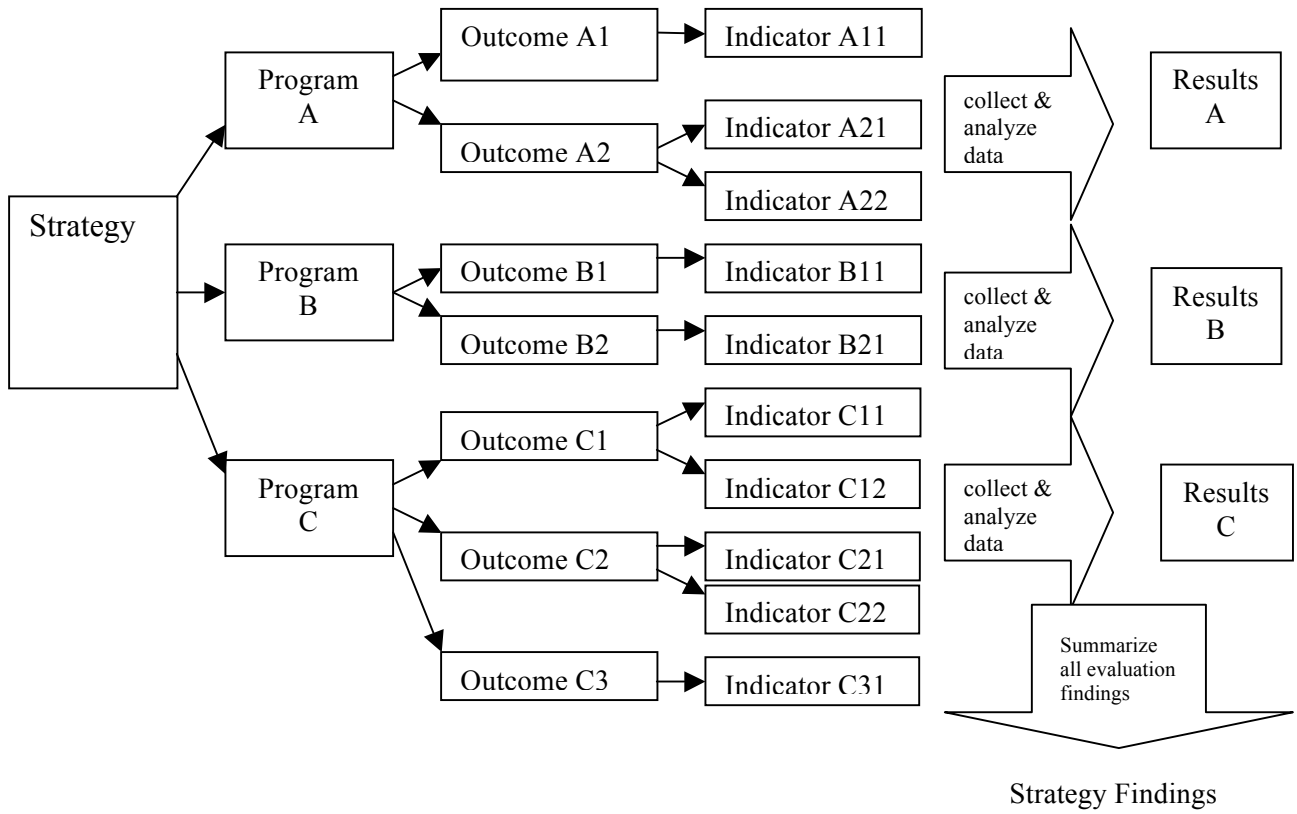
Results of all program evaluations will be reported on schedules developed for the individual evaluation design. Funded programs will be required to regularly submit specific outcome data (as specified in their evaluation design) and/or participate in evaluations commissioned by the United Way.

We anticipate that we will commission an outside evaluator to assist in this multi-dimensional evaluation process. In addition to program evaluations, there will be strategy evaluations informed by the results of multiple program evaluations. We will also seek to understand the outcomes of the overall blueprint. To accomplish this we intend to evaluate the results of all strategy evaluations.

In many program evaluations, we will require evaluators to collect specific feedback from key stakeholders. Additionally, we may commission strategy-level collections of feedback by surveying stakeholders about the effectiveness of the strategy.

We plan to share with the broader community key lessons from the results of our strategy and blueprint evaluations so that our results can influence and inform other efforts.

The following diagram illustrates a strategy-level evaluation that looks to the programs funded at the outcome and indicator level, and seeks to find commonalities across the indicators where possible to aggregate results. The strategy evaluation may also select from funded programs and require sharing client-level data with an outside evaluator who will conduct an analysis and provide feedback on the impact of the overall strategy.



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Aging Services Advisory Council

Our Aging Services Advisory Council works with staff to identify, prioritize, focus and support initiatives and programs. They provide insight that informs strategic investment of resources and advocacy as well as expertise that guides effective investment decisions.

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The role of the Peer Review Panel was to offer feedback and counsel on the final draft of the blueprint.

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AGING SERVICES GLOSSARY

Advisory Council: A group of United Way volunteers who work within a focus area with United Way staff to identify, prioritize, focus and support initiatives and programs. They provide insight that informs strategic investment of resources and advocacy as well as expertise that guides effective investment decisions.

Advocacy: The act increasing public awareness of a particular issue or set of issues, actively supporting a cause and deliberately influencing those who make policy decisions.

Best Practices: Processes, practices or systems widely recognized as improving the performance and efficiency of organizations in a target area such as aging services.

Blueprint for Change: A planning tool that will inform the United Way's investment strategies as well as its advocacy and volunteer efforts. The Blueprint for Change is based on the Theory of Change. (See Theory of Change.)

Caregiving: Caregiving may include accessing, arranging and coordinating hands-on personal care; emotional and financial support; managing medical care and other care; transportation; shopping; cleaning; and decision-making about health, financial, personal and legal matters. This care may be full time or part time, and may be shared among family caregivers.

Care Receivers: Care receivers are individuals with adult-onset long-term disability or illness who need ongoing or intermittent assistance with everyday tasks in order to function. They may or may not live with the family caregiver. They may receive all or part of their care from family caregivers, or may receive care from others.

Community: an interacting group of people living in the same territory: town, village, suburb, or neighborhood.

Cognitive Health: Most experts agree that the components of cognitive health include language, thought, memory, executive function (the ability to plan and carry out tasks), judgment, attention, perception, remembered skills such as driving, and the ability to live a purposeful life.

Cultural Appropriateness: Relates to sensitivity to the differences among ethnic, racial and/or linguistic groups, and awareness of how people's cultural background, beliefs, traditions, socio-economic status, history and other factors affect their needs and their response to services.

Cultural Competence: The knowledge and sensitivity necessary to tailor interventions and services to reflect the norms and culture of a target population and avoid styles of behavior and communication that are inappropriate, marginalizing or offensive to that population. Because of the changing nature of people and cultures, cultural competency is seen as a continual and evolving process of adaptation and refinement.

Elder Abuse: Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult. Elder abuse also can take the form of financial exploitation or intentional or unintentional neglect of an older adult by the caregiver.

Emerging Practices: Practices that appear likely to ultimately be effective, but which have yet to be evaluated at the same level of rigor as evidence-based practices.

Evidence-Based Practices and Programs: Approaches supported by scientific evidence showing that a practice is effective in increasing positive outcomes, such as increasing mobility, or reducing negative ones like elder abuse. Although there is no universal standard to define the quality or quantity of research necessary to conclude a practice is "evidence-based," experts use the following factors to determine the weight of evidence supporting the effectiveness of a program or practice.

- 1) The type of study used to evaluate the program. Well-executed randomized control trials are generally considered to be the strongest evidence. This design involves randomly assigning participants to receive intervention. Differences between those getting intervention and those serving as the control group are due to the intervention. The next level involves quasi-experimental designs. Here, results for the intervention group are weighed against those of a group that matched as closely as possible on relevant demographic and other characteristics, but did not receive treatment. However, one cannot rule out that differences in outcomes between the two groups are due to unmatched-for characteristics, rather than the intervention itself.
- 2) The sample size of the study. Larger sizes are generally better, as they are more likely to detect significant effects.
- 3) The degree of participant attrition during the study. High attrition may indicate problems with program implementation and can compromise the integrity of the original randomization or matching process, and thus erode confidence in the results.
- 4) The quality and integrity of the measurement tools and procedures used to measure outcomes.
- 5) The strength of the outcomes observed.
- 6) Whether the positive effects of the intervention are sustained after it has ended compared to the control/comparison group.
- 7) Whether the study has been independently examined by a peer review panel and accepted for publication.
- 8) Replication of positive results across more than one site and/or more than one study.

In selecting evidence-based programs to include in the Aging Blueprint for Change, the United Way strove to find those with the highest-quality evidence of effectiveness in achieving the outcomes outlined in the blueprint, particularly in lower-income, minority, and urban populations.

Family Caregiver: A non-professional who provides unpaid care for relatives and loved ones in the home. The care recipient might be a member of the caregiver’s family of origin; or family of choice—such as a special friend, neighbor, support group member, or life partner.

Fidelity: Fidelity of implementation occurs when implementers of a research-based program or intervention, such as teachers, clinicians or counselors, closely follow or adhere to the protocols and techniques that are defined as part of the intervention. It could also mean correctly sequencing multiple program components, and conducting assessments and evaluations using the recommended or provided tools.

Food Insecurity: Food insecurity occurs whenever the availability of nutritionally adequate and safe food, or the ability to acquire foods in socially acceptable ways, is limited or uncertain.

Geriatric: The practice of providing care to persons who are older and/or of studying how to provide care to persons who are older.

Goals: Broad outcomes expected for the community and its older adults, which, unlike objectives, are not directly measurable.

Hunger: The uneasy or painful sensation caused by a recurrent or involuntary lack of food and is a potential, although not necessary, consequence of food insecurity. Over time, hunger may result in malnutrition.

Independence: The capacity to make choices and exercise control over one’s daily life.

Interdependence: A central component of older people’s well-being, it is characterized by helping others and receiving help themselves.

Indicators: Quantifiable measures of program performance that signify progress (or lack of it) toward a result.

Informal Caregiving: A catch-all phrase that refers to unpaid care and financial support provided by family or friends of people with chronic illness or disabilities.

Integration: The process of bringing diverse groups together in the same system.

Intervention: Anything meant to change the course of events for someone—such as a treatment, medicine, surgery, information or education program, or counseling.

Knowledge Management: Strategies and processes designed to identify, capture, structure, value, leverage and share an organization’s intellectual assets to enhance its performance and competitiveness. It is based on two critical activities: capture and documentation of individual explicit and tacit knowledge; and disseminating that knowledge within the organization.

Livable Community: a livable community is one that has affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life.

Nutritious: providing one-third of the recommended dietary allowances established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences and adopted by the United States Department of Health and Human Services’ Administration on Aging.

Older Adult: An adult age 55 or older.

Objectives: Specific, measurable aims for a strategy that have matching outcomes by which to measure them.

Outcomes: A change in behavior, physiology, attitudes, or knowledge that can be quantified using standardized scales or assessment tools.

Peer Review Panel: A group of locally and nationally recognized experts, all within the field of aging services, who offered feedback and counsel on the final draft of the Aging Blueprint.

Public Policy: Any foundation or public-charity activity intended to affect governmental actions. Activities may include building coalitions, community organizing, convening stakeholders, funding demonstration projects, issue advocacy, leadership development, litigation, media and communications, policy research and analysis, public education and voter registration

Respite: A short period of rest or relief. This may be an afternoon, a day, or even a week off from caregiving responsibilities, typically provided on a regular basis by an informal caregiver, home health care aide or community-based provider.

Screening: a procedure that is performed to detect the presence of a specific disease. The individual or group of individuals does not present any symptoms of the disease.

Social Isolation: The lack of contact and interaction with other people; the feeling of loneliness or lack of companionship or close and genuine communication with others^{42,43}

Strategy: An approach chosen to bring about a desired future, such as achieving a goal or solving a problem. Also, the art and science of planning and marshalling resources for their most efficient and effective use.

Target Population: The specific group of people or the beneficiaries of a grant project. The individuals in the target population share common characteristics.

Theory of Change: By mapping a process from beginning to end, a theory of change establishes a blueprint for the work ahead and anticipates its likely effects. In addition to revealing what should be evaluated, a theory of change also reveals when and how the evaluation should be conducted.

Wellness: A proactive, preventive approach designed to achieve optimum levels of health, social and emotional functioning. Wellness can also be defined as an active process through which one becomes aware of and make choices to achieve a more successful existence⁴⁴.

What We Know and Believe: “What we know” represents what the data tells us about our community and its elder population. “What we know and believe” represents a compilation of all that we know, assume, and believe about aging.

¹ Population numbers obtained from and percentages calculated from 2000 census data obtained from <http://factfinder.census.gov/>.

² Population numbers obtained from and percentages calculated from 2000 census data obtained from <http://factfinder.census.gov/> and “Preliminary New York State Projection Data by County (November 2008)” obtained from Cornell University’s Program on Applied Demographics at <http://www.human.cornell.edu/che/BLCC/pad/data/projections.cfm>.

³ Calculated from 2000 census data obtained from <http://factfinder.census.gov/>. All poverty rates calculated from the relevant population of adults 65 and older for whom poverty status is known. White poverty rates were calculated from those who identified as white only and black poverty rates from those identifying as black only (i.e. persons identifying themselves as multiracial were not included). The census treats Latino ethnicity as distinct from race so that persons who identify as Latino may also be represented in the white and black racial categories. Suburban rates were calculated by subtracting Rochester data from Monroe County as a whole data. Poverty data excludes individuals living in nursing homes and certain other institutional group quarters; see <http://www.census.gov/hhes/www/poverty/povdef.html>.

⁴ Calculated from 2000 census data obtained from <http://factfinder.census.gov/>. All poverty rates calculated from the relevant population of adults 65 and older for whom poverty status is known. White poverty rates were calculated from those who identified as white only and black poverty rates from those identifying as black only (i.e. persons identifying themselves as multiracial were not included). The census treats Latino ethnicity as distinct from race so that persons who identify as Latino may also be represented in the white and black racial categories. Suburban rates were calculated by subtracting Rochester data from Monroe County as a whole data. Poverty data excludes individuals living in nursing homes and certain other institutional group quarters; see <http://www.census.gov/hhes/www/poverty/povdef.html>.

⁵ Calculated from 2000 census data obtained from <http://factfinder.census.gov/>. See <http://www.census.gov/prod/2003pubs/c2kbr-17.pdf> for the census questions used to define disabilities categories.

⁶ Monroe County Department of Public Health et al. “Monroe County Adult Health Survey Report 2006” September 2007. <http://www.monroecounty.gov/File/Health/2006%20ADULT%20HEALTH%20SURVEY.pdf>. Data in this report came from a countywide telephone survey of adults 18 and over completed in the summer of 2006. Persons living in congregate care facilities, without telephones, and with a primary language other than English or Spanish were not included. Older adults who answered “yes” to at least one of six questions related to elder abuse were considered to be at risk.

⁷ Monroe County Department of Public Health et al. “Monroe County Adult Health Survey Report 2006” September 2007. <http://www.monroecounty.gov/File/Health/2006%20ADULT%20HEALTH%20SURVEY.pdf>. Data in this report came from a countywide telephone survey of adults 18 and over completed in the summer of 2006. Persons living in congregate care facilities, without telephones, and whose primary language was not English or Spanish were not included.

⁸ Centers for Disease Control and Prevention. “Falls Among Older Adults: An Overview.” <http://www.cdc.gov/ncipc/factsheets/adultfalls.htm>.

⁹ New York State Department of Health. “Injury Mortality and Morbidity Indicators—Monroe County.” http://www.health.state.ny.us/statistics/chac/chai/docs/inj_monroe.htm. Data on hospitalizations are collected through the hospital inpatient discharge data system, which indicates the primary reason for the hospitalization. This does not include cases that were only treated in the emergency room and did not result in an inpatient hospitalization. See http://www.health.state.ny.us/statistics/chac/chai/about/about_injurymortalityandmorbidity.htm.

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- ¹⁵ Monroe County Department of Public Health et al. “Monroe County Adult Health Survey Report 2006.” <http://www.monroecounty.gov/File/Health/2006%20ADULT%20HEALTH%20SURVEY.pdf>. September 2007. Percentage of respondents who had ever been told they had a heart attack or myocardial infarction by a medical professional.
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- ¹⁷ Monroe County Department of Public Health et al. “Monroe County Adult Health Survey Report 2006.” <http://www.monroecounty.gov/File/Health/2006%20ADULT%20HEALTH%20SURVEY.pdf>. September 2007. Participants were asked if they had received an influenza vaccination within the past two years.
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- ¹⁹ Monroe County Department of Public Health et al. “Monroe County Adult Health Survey Report 2006.” <http://www.monroecounty.gov/File/Health/2006%20ADULT%20HEALTH%20SURVEY.pdf>. September 2007. Participants were asked questions about whether they had had a fecal occult blood test within the past two years or had ever had a sigmoidoscopy or colonoscopy.
- ²⁰ Federal Interagency Forum on Aging Related Statistics “*Older Americans 2008: Key Indicators of Well-Being.*” http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2008_Documents/OA_2008.pdf. Data based on 2004 Health and Retirement Study and includes civilian non-institutionalized population.
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- ²³ Evercare in collaboration with National Alliance for Caregiving. “Family Caregivers—What they Spend, What They Sacrifice.” November 2007. http://www.caregiving.org/data/Evercare_NAC_CaregiverCostStudyFINAL20111907.pdf. The telephone survey randomly selected 1000 participants who self-identified as providing unpaid care for an adult 50

or older who had a chronic condition making self-care difficult for a minimum of five hours a week over the past month.

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²⁶ Federal Interagency Forum on Aging-Related Statistics. "Older Americans 2008: Key Indicators of Well-Being." http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2008_Documents/OA_2008.pdf. Data based on American Housing Survey of Department of Housing and Urban Development; excludes non-civilian and institutionalized population and those residing in group homes.

²⁷ Federal Interagency Forum on Aging-Related Statistics. "Older Americans 2008: Key Indicators of Well-Being." http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2008_Documents/OA_2008.pdf. Data based on the 2006 American Time Use Survey of the Bureau of Labor Statistics and refers to civilian non-institutionalized population.

²⁸ Center for the Advancement of Health. "A New Vision of Aging: Helping Older Adults Make Healthier Choices." March 2006. <http://www.cfah.org/pdfs/agingreport.pdf>.

²⁹ Percentages for the Rochester, New York Metropolitan Statistical Area (Livingston County, Monroe County, Ontario County, Orleans County, Wayne County) and nation obtained from the "Volunteering in America" website at <http://www.volunteeringinamerica.gov/newprofile.cfm?cityId=124&custom=1> and choosing the "Volunteering by Age Group & Gender" option. Data is an average of that collected in the 2005, 2006, 2007 Current Population Survey supplements. See <http://www.volunteeringinamerica.gov/about/technical.cfm> and http://www.volunteeringinamerica.gov/profiles_info/state_definitions.cfm.

³⁰ Federal Interagency Forum on Aging-Related Statistics. "Older Americans 2008: Key Indicators of Well-Being." http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2008_Documents/OA_2008.pdf. Data based on U.S. Department of Education's National Assessment of Adult Literacy and includes people living in households and prisons. Health literacy is important as it relates to the ability to adhere to prescription instructions, fill out patient information forms, and give informed consent.

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³³ Alzheimer's Association. "2009 Alzheimer's Disease Facts and Figures." http://www.alz.org/national/documents/report_alzfactsfigures2009.pdf.

³⁴ Hebert, Liesi E. et al. "Alzheimer's Disease in the U.S. Population: Prevalence Estimates Using the 2000 Census." *Archives of Neurology*, 60, August 2003, pp. 1119-1122. Estimates were calculated from a study of older adults living in three Chicago neighborhoods.

³⁵ Plassman, B.L. et al. "Prevalence of Dementia in the United States: the Aging, Demographics, and Memory Study." *Neuroepidemiology*, 29, 2007, pp. 125-132. Estimates calculated using sub-sample of 856 individuals age 71 and older from the national health and retirement study that were evaluated with a comprehensive in-home assessment.

³⁶ New York State Department of Health. "Dementias Reported in Hospitalizations among New York State Residents." February 2004. http://www.health.state.ny.us/diseases/conditions/dementia/alzheimer/dementia_registry.htm.

³⁷ AARP. “Across the States: Profiles of Long-Term Care and Independent Living.” 2009 (8th Edition). http://assets.aarp.org/rgcenter/il/d19105_2008_ats.pdf . Data is for 2007. The report contains the following caveat: “It is important to note, however, that a dollar spent on home and community-based services is not equivalent to a dollar spent on nursing home services. Medicaid pays for services and room and board costs in nursing homes. In contrast, Medicaid is required by law to exclude coverage of room and board costs for home and community-based beneficiaries, even if they live in residential care settings such as assisted living. It is also the case that people receiving home and community-based services may have less intense needs, especially for medically oriented services.”

³⁸ AARP. “Across the States: Profiles of Long-Term Care and Independent Living.” 2009 (8th Edition). http://assets.aarp.org/rgcenter/il/d19105_2008_ats.pdf . Expenditure data is for 2005. Note that these are per person costs for persons receiving care any time during the year, and do not reflect the average cost of services for a full year.

³⁹ Wolfe, W. S., Olson, C. M., Kendall, A., Frongillo, E. A. (August 1998). “Hunger and Food Insecurity in the Elderly.” *Journal of Aging and Health*,

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<http://www.centeronhunger.org/hunger@brandeis.edu>

⁴¹ U.S. Department of Health and Human Services (March 2002). “Focus on Your Health: Senior Nutrition.”

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⁴³ Wiess, R. S. *Issues in the study of loneliness*, in *Loneliness: A Source Book of Current Theory, Research, and Therapy*, L.a.P. Peplau, D., Editor. 1982, Wiley: New York. pp.71-80

⁴⁴ DefinitionofWellness.com