Partnering to Promote Healthy Aging

CREATIVE BEST PRACTICE COMMUNITY PARTNERSHIPS

"Partnerships are very valuable because the collaborative process brings different kinds of people and organizations together, making it possible for them to accomplish much more than they can on their own."

—Center for the Advancement of Collaborative Strategies in Health

THE NATIONAL COUNCIL ON THE AGING

center for Healthy Aging
model health programs for communities

THE NATIONAL COUNCIL ON THE AGING

About The National Council on the Aging

Who We Are
Founded in 1950, The National Council on the Aging (NCOA) is the nation's first charitable organization dedicated to promoting the health, independence, and continuing contributions of older Americans. NCOA is a 3,200 member national network of organizations and individuals including senior centers, adult day service centers, area agencies on aging, faith congregations, senior housing facilities, employment services, and other consumer organizations.

What We Do
To accomplish organizational objectives, the following core competencies guide our activities:

NCOA is a national voice and powerful advocate for public policies, societal attitudes, and business practices that promote vital aging. A founding member of the Leadership Council of Aging Organizations, NCOA often leads campaigns to preserve funding for the Older Americans Act. We currently chair and lead the Access to Benefits Coalition to help lower income Medicare beneficiaries find prescription savings. We regularly do public awareness studies such as the Myths and Realities of Aging ™ that have helped shape the attitudes of millions.

NCOA is an innovator, developing new knowledge, testing creative ideas, and translating research into effective programs and services that help community service organizations serve seniors in hundreds of communities. NCOA is the leader in identifying and disseminating best practices and evidence-based programming in community-based physical activity, chronic disease management and health promotion activities. In its long history, NCOA has also shaped many innovative aging programs, including Meals on Wheels and Foster Grandparents.

NCOA is an activator, turning creative ideas into programs and services that help community services organizations organize and deliver essential services to seniors. This includes Family Friends and its Center for Healthy Aging. NCOA also administers two federal Programs (Senior Community Service Employment Service and Senior Environmental Program) and the Maturity Works partnership to provide employment and training opportunities for mature adults through offices nationwide.

NCOA develops decision support tools such as BenefitsCheckUp® and the Long-term Care Counselor™, enabling consumers to make optimal decisions and maximize all available resources and opportunities, whether they are looking for prescription savings or understanding their risk of needing long-term care.

NCOA creates partnerships that bring together a wide variety of voluntary, philanthropic, and public organizations to spark innovative solutions and achieve specific results. Each year, for example, NCOA and the American Society on Aging partner to bring a joint annual conference to 4,000 professionals in the field.

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Creative Best Practice Community Partnerships

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Section One

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Purpose of This Manual

Over half the causes of premature death in Americans can be attributed to unhealthy behaviors, including poor diet habits, inactivity, and smoking. As a direct result of these behaviors, the majority of adults aged 50+ are at significant risk of developing or exacerbating one or more chronic diseases such as hypertension, heart disease, diabetes, some cancers, and stroke.

Not surprisingly, efforts to promote healthy aging have centered on educating and empowering older adults to adopt health-promoting behaviors that reduce the risk of injury and disease and increase self-management of chronic conditions. The aging services network has a key role to play in these efforts by providing high-quality, effective programming in health promotion, physical activity, and chronic disease self-management. This role, however, is complicated by inconsistencies in the depth and breadth of program offerings, disparities among an increasingly diverse population of older adults, access to information and support services, and the lack of partnerships between community services to pool expertise and resources that can enrich, extend and sustain health promotion programming for older adults.

In 2001, NCOA and several other aging organizations began collaborating with the Health Care and Aging Studies Branch of the Centers for Disease Control and Prevention in order to motivate partnerships at the state and local level between public health departments and aging services to promote healthy aging. This initiative has fostered an array of activities including a consensus meeting to establish criteria for best practices in aging, and a study of effective partnerships that facilitate and sustain healthy aging programs. After identifying a diverse array of health promotion and chronic disease management programs in the national aging services network, we selected eight "best practice" programs from around the country. Seven of the programs agreed to participate in in-depth interviews to discuss their partnerships. The findings from these interviews are summarized in this manual, with particular attention to "lessons learned" and practical suggestions for replicating these types of partnerships in your community.

Thus, the purpose of this manual is to provide insights and ideas for building state and local level partnerships between aging, health, and public health services that promote healthy aging. In spite of organizational cultures that differ, we believe that agencies can maintain congruency with their respective organizational missions, and at the same time, form interagency linkages of pooled expertise that can serve as a major resource in developing effective and efficient programming, targeting outreach, and augmenting staff

The growing activities in health promotion of the aging population are encouraging heretofore untapped partnerships. By increasing teamwork across the network of services for the aging, the health sector, public and private organizations, and academe, there is great opportunity to identify new and better ways to enhance the health and well-being of all older Americans through the communities in which they reside (Beattie, Whitelaw, Mettler & Turner, 2003, p. 203).

capacity and service quality. For example, collaborative activities can result in coalitions of relevant stakeholders that can facilitate community assessment and joint planning for creative and comprehensive healthy aging programs. Collaborative activities can also increase program impact by enriching the development of broader community healthy aging awareness campaigns and targeted education and prevention programs. Such collaborations can reach out to more communities and at-risk populations than just one agency can serve. Moreover, collaborative activities can enrich agency capacity through coordination of interagency team building and reciprocal staff and volunteer training activities.

The design and content of this manual is intended to be succinct and in an easy to read format that provides both conceptual information from the literature and practical suggestions from the NCOA advisors and the seven featured programs. The manual is divided into three sections. This first section briefly highlights important aspects of partnerships and partnership processes that we culled from the literature. It also provides details related to the health promotion and aging best practice study conducted by the NCOA. Specifically, Section One

- lays out our definition of healthy aging
- explains why we focused on partnerships in healthy aging
- takes a closer look at partnerships
- describes our consultation with aging and health expert advisors about best practices in healthy aging and partnerships
- provides details on how the best practice partnership study was conducted.

Section Two offers descriptions of each of the seven best practice programs that we interviewed. The descriptions sometimes summarize and paraphrase interview data, but often we quoted verbatim the staff comments. We briefly note some of the characteristics of the programs in terms of their target populations, healthy aging program components, partnership compositions, their ways of operating as a partnership, and their creative use of resources. To help you consider replication of the programs or program partnership components, we highlight the key "lessons learned" and also provide each agency's contact information. Where available, we also provide the agency website link.

The seven best practices span the country and include:

- African American Elders Program, Seattle, WA
- Jefferson Area Board for Aging, Charlottesville, VA
- Johnson City Seniors' Center, Johnson City, TN
- Lafayette Senior Center, Lafayette, CO
- Lancaster County Office on Aging, Lancaster, PA
- Northshore Senior Center, Bothell, WA
- Partnership for Healthy Aging, Portland, ME

We are pleased to draw attention to two of these organizations that have received previous recognition for their programming. NCOA, with support from The Robert Wood Johnson Foundation, conducted a national competition to identify best practices in physical activity programming for older adults. The Johnson City Seniors' Center was among the ten programs that received top honors, including a certificate of achievement and a monetary award. Additionally, Partnership for Healthy Aging was selected as one of twelve organizations receiving a three-year grant from the U.S. Administration on Aging to implement an evidence-based falls prevention program, *A Matter of Balance*, in a community setting.

Coalitions and community partnerships maximize the cooperation and the resources that can be focused on specific health issues and/or subpopulations. Benefits include the collection of a diversity of skill sets, knowledge, expertise, and associated networks that can be brought to bear in a united effort. Additionally, partnerships may influence larger policies and resource utilization that could benefit the entire community.
(Ohio Center for Action, 1992).

Section Three contains the Appendixes. This section includes the list of advisors who helped establish criteria for best practices in healthy aging, the advisors who helped establish criteria and recommendations for best practices in partnerships, the NCOA partnership interview tool, references to the literature on partnerships, and additional web-based resources for building best practice health promotion programs and partnerships.

Our Definition of Healthy Aging

Healthy aging is a broad concept that is more than just physical health status or absence of disease. It encompasses all of the intellectual, emotional, social, and spiritual facets of our being. While healthy aging is driven by *internal dimensions* such as our beliefs, attitudes, and intentions about our health, it also depends on *external supports* including our social networks, community services, public policies, and the built and natural environment. These dimensions are interrelated, affecting behavior and lifestyle choices. When one or more of these factors is problematic, optimal health may be impaired. Therefore, internal dimensions and external supports are integral to the adoption, promotion, and maintenance of well-being and self-management of health and chronic diseases (Prevention Research Centers' Healthy Aging Research Network, 2002). To be successful over the long run, a program designed to promote healthy aging must address education and behavior modification at the individual level, as well as supportive environments and collaborative efforts at the community level (NCOA, 2001).

Why We Focused on Partnerships

Despite this multidimensional definition of healthy aging, it often seems that health promotion strategies are aimed solely at individuals and typically entail health education and social marketing carried out by a single agency. For example, agency health programs educate people about the importance of a proper diet and getting exercise. We impart the latest knowledge, try to change attitudes about one's capacity to cope with health needs and challenges, and hope that these efforts will result in changes in behavior toward healthier lifestyles and chronic disease management. However, individuals live in communities, and communities have the potential to pool resources to offer a wide array

Participatory change through partnership can help build the capacity and commitment necessary for sustainability. Participation by a variety of key stakeholders facilitates a more balanced community assessment, solution design and implementation; thereby influencing the entire community (Castelloe, Watson, and White, 2002).

of integrated and supportive health promotion approaches and activities. Thus, community-based aging services can enhance their somewhat limited and short-term impact on individual-level health behaviors by collaborating with academic institutions, health care and public health entities, and community leaders in order to pursue broader long-term health goals for the older adult population. Such external support strategies can help document program effectiveness and promote and sustain more comprehensive long-term behavior change among target populations. In addition, collaborations can help assess and improve the efficiency of program operations, and cut or avoid duplication of programmatic costs incurred in meeting mounting state and federal mandates. Moreover, such partnerships are becoming increasingly essential for responding to funding opportunities in healthy aging initiatives (Mattessich et al., 2001).

However, the focus on partnerships is not just about cost containment and leveraging resources. Partnerships can also maximize collective competence of the members and the community, develop community ownership and role models for promoting community health, establish credibility within various sectors of the community, and help assure that interventions are accessible and appealing, particularly for isolated and diverse populations. Ultimately, the value of these partnerships will be reflected in the community's enhanced ability to address the multidimensional, interdisciplinary nature of health promotion and chronic disease self-management, and to promote holistic and enduring healthy lifestyles of its older adults.

Section Two of this manual provides examples of creative partnerships that were developed and sustained by communities to institutionalize agency and community capacities for promoting healthy aging and chronic disease management. However, to provide an overarching framework of concepts related to partnership development and operations, a quick review is in order. We look first to the literature to answer the question, "What are the key ingredients of partnerships that make them work?"

A Closer Look at Partnerships

Sofaer (1999) defines an effective partnership as being made up of two or more people or organizations that collaborate to achieve a common purpose and a more effective use of resources. Partnerships are also described as *vehicles for structured and purposeful interaction among a defined set of partnering organizations, groups, and individuals* (p.6). Partnerships may vary in structure, size, and level of formality depending upon needs. Such collaborations are a logical way of mobilizing power and influence to address community issues, pool resources, enhance coordination for planning and implementation, and minimize duplication of effort. Sofaer further delineates other important functions served by collaborative activities, including

- information exchange and networking
- increased visibility of participating organizations
- implementation of joint interagency programs.

Before initiating the partnering process, however, it is essential for each participating organization first to reaffirm its own program vision and goals. According to the Wild Rose Foundation (2001), each organization must

- establish its priorities and expectations
- identify expectations for its partners
- determine its readiness to collaborate to make the partnership successful
- be aware of the limitations of the partnership.

Key questions an organization needs to ask are, "Is our organization willing to commit resources and time?" and "Are there certain goals we will not pursue, certain tasks we cannot do, or potential partners we would be unwilling to support?" Each member organization being clear about its values, priorities, and caveats is a fundamental component of the partnership communications and decision-making processes.

Partnership activities require close attention in order to nurture and facilitate evolving relationships and action plans. In reviewing the literature, Mattessich et al. (2001) have identified key factors that influence successful community collaborations. These include

- mutual trust and respect among the partners
- an appropriate mix of stakeholder representation
- membership cohesion
- collaborators who value cooperation and see advantages to participation
- members who are able and willing to compromise.

Skills in meeting management and communication are effective tools in sustaining a partnership. Kumpfer et al. (1993) found that members report more satisfaction and commitment to the partnership process and program outcomes when leaders employed the following strategies:

- encouraged and supported contributions by all the members of the partnership
- used a democratic decision making process
- encouraged networking and information exchange.

This brief review and the additional highlighted quotes about partnership components and processes underscore the reciprocal, labor-intensive, yet highly valuable nature of partnerships and collaborative activities. If you are interested in reading more about partnerships, the complete references are located in Appendix E, page 46.

Although the sustainability of a partnership is driven by a shared vision and powerful leadership within the organization or community, community participation in sustainability planning efforts is essential. Community participants who are key players in the development of the program should be involved early in the project. (Thompson and Winner, 1999).

As a next step to help "situate" these partnership concepts within health promotion and aging, we solicited expert advice from two panels of professionals in the aging services network. We asked one group to identify criteria for best practices in healthy aging programs and the second group to define best practice criteria for healthy aging partnerships. The details of this activity and their comments follow.

Recommendations from Our Advisors

We asked our first panel of health and physical activity experts (listed in Appendix A, page 39) to identify *best practice* components of exemplary programs in health promotion and chronic disease self-management for older adults. The panel developed the following criteria for successful healthy aging programs. A successful healthy aging program

- offers structured, ongoing programs to facilitate healthy aging through risk factor modification and behavior change
- conducts ongoing measurement of outcomes to demonstrate program effectiveness and incorporates feedback into program revisions
- offers a variety of planned program activities to facilitate behavior change and promote self-efficacy
- facilitates social engagement opportunities to promote peer interaction among participants
- offers an appropriate level and variety of programming to bridge the spectrum of older adult participants from frail to very active
- promotes active networking activities and outreach to other services and organizations
- makes creative use of available resources
- uses well-trained staff, or volunteers and mentors and provide ongoing training opportunities.

The second panel of advisors, listed in Appendix B on page 40, focused on best practice criteria for partnerships. The advisors' recommendations, provided in Appendix C on page 41, answer these questions:

- What are the key benefits of partnering?
- How would you select/identify a good partnership?
- What makes a best practice?
- How would you go about identifying a best practice in partnerships?
- How would you evaluate the effectiveness of a partnership?
- What about nonfunding partnerships?
- How does a good partnership come about?
- What would you want to come away with after attending a session about best practices in partnerships?
- What question would you ask regarding a partnership?
- What are some suggestions for partnerships?

When you read the recommendations, you will see how they augment the general literature on partnership with a wealth of practical experience from the field. It is our hope that you will consider the advisors' comments, along with the tips from the program directors and planners found in the next section, to be practical and thus helpful in the planning and management of your own partnerships.

We next describe how NCOA identified best practice health promotion and aging programs that incorporated many of the partnership elements listed above. We then describe how we surveyed those programs about their effective and creative partnerships.

How the Best Practice Partnership Study Was Conducted

Through support from The Robert Wood Johnson Foundation, NCOA conducted its landmark national survey of 626 reputable, high-quality, and innovative community-based programs that offer an array of social supports, caregiving, chronic disease self-management, and physical activity programs. At the beginning of the survey process, representatives from three national organizations (NCOA and its National Institute of Senior Centers, the National Association of Area Agencies on Aging, and the National Association of State Units on Aging) and other identified leaders in the field of aging were invited to nominate exemplary programs. Over 1,000 directors of nominated programs were subsequently surveyed to rate their own programs and organizations according to a list of predetermined program variables. Analysis of the results provided a comprehensive look at many important program areas including specific services, clients, funding, partnering, strategies to strengthen quality, and barriers to promoting program expansion. An executive summary of this study can be found at the NCOA Web site: http://www.ncoa.org/Downloads/cbo%5Freport%2Epdf%2Epdf.

In a follow-up study of effective partnerships in health promotion and aging supported by the Centers for Disease Control and Prevention, NCOA reviewed the database of nominated aging programs and identified those community-based organizations that specifically provided healthy aging programming. In addition, through its weekly electronic newsletter reaching over 3,500 readers, NCOA queried the aging services network for healthy aging programs that were enhanced by strong partnerships, particularly those with partnership activities with Public Health Departments. NCOA also reviewed available studies such as *The Aging States Project* (2003). Programs offering either chronic disease self-management or physical activity were thus identified, augmented by self-nominated programs obtained through the newsletter inquiry and literature review. Criteria for effective health promotion programming were established by the advisors and used to rank the resulting 122 programs. Criteria for selection also included NCOA guidelines to maximize diversity among selected programs. Eight programs were identified for further study.

Concurrently, the advisors provided guidance for the construction of an interview tool to explore effective partnerships. The tool was pre-tested with two program directors who were not in the pool of selected programs. Once the tool was tested and finalized (see Appendix D, page 44) telephone interviews were scheduled. Questions were provided to the interviewees in advance. The interviews were conducted in early 2003 by two members of the NCOA Research and Demonstrations staff who were assisted by a project officer from the Health Care and Aging Studies Branch of the Centers for Disease Control and Prevention.

The Goal of the Partnership Study and Manual: Disseminating Best Practices

As you can see, this manual is the culmination of a comprehensive and systematic process of information gathering. We designed this manual with the aim of acquainting aging services providers with some key principles about partnerships found in the literature, and with "real life" experiences and practical tips from the expert advisors and the seven programs that have implemented exemplary health promotion programs and partnerships. We believe that the examples that follow are relevant to many state and local organizations, not only public health and aging services networks. It is our hope that the information shared here will help increase the capacity of the aging field to enhance and expand services for older adults by tackling crucial individual- and community-level health issues, creating more effective ways to maintain function and delay or prevent disability, and preserving independence and quality of life.

Section Two
The Seven Best Practice Programs

Selection Criteria

As described in Section One of this manual, one of the NCOA advisory panels helped build a set of criteria for identifying best practice programs in health promotion and aging. We list again their recommendations because three of the criteria italicized at the bottom of the list—active networking, creative use of resources, and use and training of staffing/volunteers—can readily be met through partnerships and collaborative activities. The recommended criteria for a best practice health promotion program includes

- structured, ongoing programs to facilitate healthy aging through risk factor modification and behavior change
- ongoing measurement of outcomes to demonstrate program effectiveness and incorporates feedback into program revisions
- a variety of planned program activities to facilitate behavior change and promote self-efficacy
- facilitation of social engagement opportunities to facilitate peer interaction among participants
- an appropriate level and variety of programming to bridge the spectrum of older adult participants from frail to very active
- *promotion of active networking activities and outreach to other services and organizations*
- *creative use of available resources*
- *utilization of well trained staff, or volunteers and mentors, and provides ongoing training opportunities.*

The descriptions for each of the featured best practice programs were derived from the responses to the Partnership Interview Tool (see Appendix D, page 44). In each program description, we begin with an introduction to the aging service organization, its contact information, and general program features. We then present the organization's best practice healthy aging program. These program descriptions are intentionally brief, with enough information to give you a sense of how the program meets several of the best practice criteria.

Because our aim is to focus more on the details of the program's partnerships, we move to an expanded discussion of the partnership, including its evolution and member roles. A summary of the perceived value and effectiveness of the partnership from a number of perspectives follows. Regardless of the levels of commitment, composition, focus, objectives, or longevity of the partnership, we found that effectiveness of the partnership was more often reported by anecdote rather than through formal evaluation that used objective measures and systematic data collection. Occasionally, programs indicated success through other less direct, but related outcome data, including general service

achievements and enhancements, increased numbers of program participants served, and client satisfaction surveys. Apparently, as revealed by the comments of the program directors, informal process evaluations do routinely occur, and these reviews help to facilitate internal adjustments.

The program descriptions next detail the various methods used to sustain the partnerships. Finally, we summarize the "key lessons learned" that are paraphrased or reported directly from the comments of the program directors or planners.

Throughout the interview process, several general themes emerged across all or many of the programs which we summarize in the box below. These study findings are consistent with the principles cited in the partnership literature in Section One. Thus, we believe that the findings of the NCOA partnership study not only verify expert views of the relevant components of building and sustaining partnerships, but also provide concrete evidence that the aging services field can readily implement these components and by doing so, achieve successful program outcomes through their health promotion partnerships.

You will find other specific suggestions and unique ideas within each program description that add to the body of wisdom generated by these best practices. We thank these seven program directors and planners for their willingness to reflect on their activities and partnerships, and for their generosity in sharing their experiences and wisdom with the larger aging services networks.

NCOA Partnerships to Promote Healthy Aging Study: Major Themes

- *Establishing the mutuality of common goals is crucial to focusing and sustaining the partnership.*
- *Regular forms of communication keep partners on track, updated, and feeling part of the process.*
- *Agreements, whether formal or informal, are needed to clarify member roles and assess program achievements and problems.*
- *Staff orientation to new programs and partnerships is essential for effective and efficient program operations.*
- *Recognition of the efforts of partners, staff and volunteers, and sharing of publicity of program successes is a win-win strategy for maintaining investment in the program while, at the same time, raising public awareness.*
- *Developing partnerships and trust takes time. Give them time and reap the rewards.*

African American Elders Program

Seattle, WA

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The African American Elders Program is an example of a community partnership that came together to address an underserved minority population in urban Seattle. This partnership brings together culturally sensitive staff members to provide outreach, service coordination, and health education for older adults who are isolated and do not normally use existing traditional services. The target client population is age 60 years and older, chronically ill or disabled, with low income. The service population is evenly distributed in South and Central Seattle.

The African American Elders Program was created, and continues to be supported, by a partnership among public and nonprofit organizations, including the Mayor's Council on African American Elders, the Seattle Human Services Department, Public Health of Seattle/King County, and Senior Services of Seattle/King County. Each organization contributes to the program in a different but important way. The Mayor's Council provides oversight and advocacy functions. The Area Agency on Aging (AAA) of King County and the Seattle/King County public health departments provide direct case management and nursing support services, while Senior Services of Seattle/King County conducts outreach to identify isolated seniors in need of social and health services.

Description

The African American Elders Program folds its health promotion activities within its broader services that are designed to help maintain African American elders in their homes and communities for as long as possible. The goal of the African American Elders Program is to identify isolated, older African Americans and assist them, through ongoing case management, support, and referral, in accessing needed social and health promotion/disease prevention services. The program operates through the mutual cooperation and coordination of an interagency team of case managers, an outreach specialist, and a public health nurse. The target population is mostly female (75%), mostly over 75 years of age (61%), chronically ill, frail or disabled, not able to obtain services or perform activities of daily living, at risk of premature institutionalization and in need of multiple services in order to remain in their home, and lacking formal and informal

support systems. About 11% of clientele have been diagnosed with Alzheimer's Disease or dementia.

The Evolution and Roles of the Partnership

In 1994, the Mayor of Seattle sponsored roundtable discussions involving African American community leaders. The outcome was a report entitled, *Developing Long-Term Care Options in Seattle's African American Community*. A 12-member Mayor's Council on African American Elders was subsequently formed to monitor development of projects on behalf of African American elders. This council invited key community organizations to come together to address gaps in services and to mobilize resources and other organizations to create solutions. Those key organizations included the Seattle Human Services Department; Public Health of Seattle/King County; and Senior Services of Seattle/King County. In 1997, the African American Elders Program was created through this spirit of cooperation, fostered by the power of the Mayor's office, and the provision of some additional support through Medicaid Title XIX, local general funds, and in-kind support. The African American Elders Project was presented with the task of addressing the lack of a continuum of long-term care for underserved African American elders in the Seattle/King County area. These services had to be created or carved out of existing services offered by the different participant organizations, and additional financial support had to be found to ensure sustainability.

Each partner brings unique strengths to the partnership. The Seattle Human Services Department, through its Division of Aging and Disability Services, contributes case management services to participants in the Elders Program. Case managers visit the clients in their homes and complete comprehensive assessments. These assessments identify specific care needs so that individualized service plans can be developed. A public health nurse from the Public Health Department of Seattle/King County advocates for services from medical providers. In this role, the nurse is able to provide health care needs assessments, health education and referrals, and medication management. Senior Services of Seattle/King County participates in the partnership with the help of a senior services outreach specialist. This specialist informs older adults or their caregivers about King County services, makes initial home visits to determine the type of help clients need, makes referrals, provides follow-up to services received, escorts seniors to appointments, and assists clients with forms and applications. The Mayor's Council on African American Elders continues to provide leadership and advocacy for all of the partners. Since this council was essentially the catalyst that began the African American Elders Program, its role is to ensure community guidance and advocacy for the continuation of the project and the achievement of its goals.

The Value and Effectiveness of the Partnership

In anecdotes about service results reported by the program planner, more African American elders have been able to remain independent. The program planner also reports that the African American Elders Program networking of activities has been successful because the partnership was tailored to meet the specific service needs of African Americans and because each partner continues to contribute distinct, yet equally important efforts to the project. As a direct result of this partnership, service provision is no longer fragmented because of the increased coordination and cooperation among

service providers. Moreover, duplication of services has been eliminated, and the range of services has been maximized. From a networking perspective, the program planner reports that a whole new trusting and focused relationship exists between the primary partners.

The African American Elders Program uses satisfaction surveys to monitor health care–related service utilization rates and participants' feedback. Also, Senior Services recently provided funding for the evaluation of the types and frequency of services offered through this partnership. Because these measures demonstrated the value of the program and its contributions to the health of aging African Americans, the program now seeks to make the transition to a community-based management and governance structure.

Maintaining and Sustaining the Partnership

The program staff reports that when the different partners within the African American Elders Program first came together they had a difficult time establishing a cohesive group. According to the program planner, there were many "turf issues" that needed to be resolved in order for the group to put aside their differences and work together to serve the African American elders in their community. For example, the representatives of one organization felt that they were already providing outreach to African American elders in the community, but other partners disagreed. Eventually, the group crafted a partnership agreement that identified the role of each partner, what each person and/or organization would bring to the table, and "how all the pieces would fit together."

They also developed a client information system agreement that defined how the partners were to proceed with data collection and reporting. The information system agreement had a significant impact on the group. Before the agreement was reached, some of the partners had different understandings and approaches to client confidentiality and the permissibility of information-sharing. Thus, the process of reaching a common agreement helped all the partners settle on a common basis of understanding and secondarily, helped them to form a more trusting relationship. A related, successful communication strategy for the partnership has been a monthly AAEP data report that serves as a major information linkage vehicle for the Council's use.

Lessons Learned for Replication

Although the impetus for this partnership originated in the Office of the Mayor, the rallying element was the mutual goal to provide outreach to the underserved elderly African American residents of Seattle and surrounding communities. According to the program planner, the shared desire to help an underserved population enabled the partners to put aside their differences, compromise for the good of the community and support efforts to keep the partnership together. The identification of efficient ways of organizing services made possible through collaboration was a key ingredient of the early formation and operations of the partnership. Other lessons shared by staff include:

- Time is needed to pace the development of new partnerships. The development of the African American Elders Program required three years of discussions and progressive joint activities among the initial partners.

- Flexibility is crucial, especially when trying to combine several different layers and different groups with diverse specialties.
- A key element to maintaining group focus was a consensus around the goal. The group focus on a common partnership goal that was periodically revisited by the partners was key to this successful resolution.
- Developing formal agreements can help partners have a better understanding of what each person brings to the group and how people will work together toward common goals. Through a series of discussions and internal disagreements as to how client information could be effectively compiled and shared, the partners came to realize the importance of a formal agreement.
- In-kind resources, though valuable, may not be sustainable over time.
- Valuing volunteers and/or participants is key to a program's success and sustainability. Recognition of the contributions of volunteers and the participants' investment in the program is essential.

The JABA Health Services

Jefferson Area Board for Aging (JABA)
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The Jefferson Area Board for Aging (JABA) is a nonprofit area agency on aging (AAA) based in Charlottesville, Virginia. It serves the Thomas Jefferson Planning District, which is located in the central part of Virginia and includes three predominately medically underserved counties, Fluvanna, Louisa, and southern Albemarle, and the City of Charlottesville. The proportion of adults age 60 years and older in the area is 16% of the total population. One of its programs, JABA Health Services, exemplifies how several local and county governments came together to address regional aging services needs within the planning district.

JABA has been providing services to elders in central Virginia and their families since 1975. Such services include adult day health care, case management, health services, assisted living, and other similar forms of assistance that are essential for people to be able to remain independent and actively engaged in life. The agency also leads collaborative planning efforts. Currently, it is working with the Piedmont Housing Alliance and a host of other organizations to develop *The 2020 Community Plan on Aging*. This plan will enable communities in the Thomas Jefferson Planning District to prepare for the doubling of the senior population that is anticipated in the next 25 years.

As a AAA, the majority of JABA's programs are supported financially by public funds from federal and state levels. However, JABA Health Services is not primarily supported by these funds, so the program seeks support from the local participating counties and the City of Charlottesville, as well as the United Way, in order to ensure sustainability.

Description

The precursors of the JABA Health Services were the Geriatric Assessment Intervention Team (GAIT) clinics. The GAIT clinics were funded through a three-year grant from the Virginia Health Care Foundation in 1997. Managed by nurses, the clinics provided a variety of health screenings (e.g., blood pressure, blood sugar level) and one-on-one counseling for Jefferson Area seniors at three senior centers. The three-member assessment team, only one of whom was a full-time employee, also held group health education sessions for groups of 35 to 70 people. Health information materials tailored for low income, low literacy and underinsured populations were distributed at these

sessions to help increase knowledge about healthy aging. For those frail elderly who were unable to leave their homes, GAIT clinic staff members made home visits to provide some services.

When the GAIT clinic grant ended in 2000, the program expanded to become JABA Health Services, and it is currently funded by a number of sources. Under the JABA Health Services program, there are now ten program sites that include senior centers, Section 8 government housing, and residential facilities located throughout the Thomas Jefferson Planning District. The majority of this growth took place after the first two years of the program. During the latter part of the third year, the JABA Health Services program gained significant support from area governments, particularly the governments of Fluvanna and Louisa Counties, the city of Charlottesville, and the town of Scottsville, in the southern part of Albemarle County. All of these entities now help fund JABA Health Services. JABA Health Services also developed a relationship with the University of Virginia Health System (UVAHS) and an academic medical center that provides in-kind service support. The University of Virginia School of Nursing and University of Virginia Medical Center provide support to the nurse practitioner who collaborates in the care of patients with multiple chronic diseases and the medical center oversees on-site clinical care educational opportunities for medical residents and nursing students.

The Evolution and Roles of the Partnership

It took three years to build a strong foundation of trust in the partnership between JABA and the county and local governments in its service area. In the early years of the Geriatric Assessment Intervention Team program, the governments of Fluvanna and Louisa Counties, the city of Charlottesville, and the town of Scottsville watched the program develop but did not participate. According to program staff, these governmental agencies wanted to see whether the GAIT program would be accepted by the local communities and whether it would be successful. The program director reports that when the GAIT program gained widespread popularity that resulted in an increased demand for program expansion, the governmental groups developed a better understanding of what the program was capable of and how much it was needed and wanted by the community.

As is the case in many partnerships, each partner brings something to the relationship that is beneficial to the other partners and/or to the group as a whole. While each of the three counties and the local governments of Charlottesville and Scottsville provide funding to the project, they also bring in-kind benefits. Both Fluvanna County and Scottsville have experience in working with local Parks and Recreation Departments. The senior centers in both of these areas are actually housed within Parks and Recreation facilities, and they provide space to the JABA Health Services nurse-managed clinics and health education sessions. JABA and Louisa County have recently built an extensive intergenerational center, which includes a senior center, adult day health care center, a teen center, a daycare center, and a center for retarded citizens. As with the Parks and Recreation facilities in Fluvanna County and Scottsville, the intergenerational center is the site of one of the JABA Health Services programs. Scottsville, in Albemarle County, has created a senior center and a site for JABA Health services attached to a County Section 8 Housing project.

The Value and Effectiveness of the Partnership

The coordinators of the JABA Health Services program leveraged the acceptance and success of the original GAIT program to gain the support of the local governments. The resulting partnership between JABA Health Services and the local governments has created programs that the *Virginia Health Care Foundation 2002 Annual Report* characterizes as "Models That Made It." In addition, physicians have endorsed the program as an excellent means for assuring continuity of care and patient compliance with physicians' orders. The city of Scottsville was the location of the area's First Annual Senior Fair. This event included a variety of health-related activities, such as health screenings and educational programs, and showcased some of the local services including home health care agencies, hospitals, and residential facilities. Scottsville's senior citizens were offered valuable health resources that could help them maintain their independence and well-being, and the Fair was an excellent opportunity for the community to become more aware of JABA Health Services. Such outreach to the community is particularly important when serving rural populations, where there are high rates of poverty, low literacy, underinsured residents, and little access to health education and health-related services.

The qualitative findings from client satisfaction surveys of JABA Health Services have documented positive outcomes. People report that they are pleased to have access to these health services in their communities. These results will be augmented by a quantitative study being conducted by the University of Virginia that will explore the effect of the nurse-managed clinics at each of the JABA Health Services locations. Although great strides have been made, there are still many more services that JABA Health Services staff members would like to develop. For example, a future goal for their partnerships is to provide services that address depression and arthritis.

Maintaining and Sustaining the Partnership

The project director reports that one of the keys to ensuring the sustainability of the JABA Health Services program has been to maintain open lines of communication. Having very little staff turnover has helped significantly to build and maintain trusting partnerships, but at the same time, relationships are never taken for granted. Making certain that all partners are aligning their goals is another continuous process.

The program director reports that throughout the evolution of this health program, starting with the Geriatric Assessment Intervention Team program and evolving to the JABA Health Services, it has been important for staff members and consumers of the service to actively promote the services that are offered. This marketing effort has been crucial not only in promoting the program to older residents in the Jefferson Area, but also in advocating for the importance of the program with the local governments and elected officials. Program staff members also report that, although at times it has been a struggle to encourage government officials to visit service sites, they nevertheless are persistent in their efforts to acquaint these officials and others with their programs. JABA staff members also make an effort to participate in interagency meetings and councils such as the Quality of Life Council of Scottsville. Having a presence in such team-building events is a continual reminder to government officials and those who take part in these interagency gatherings that JABA Health Services is an important player in the Jefferson Area.

Lessons Learned for Replication

The experience of JABA Health Services illustrates the importance of working with local governments and taking the time and continued effort to build strong, trusting relationships with them and other entities in the community. The use of start-up funding from The Virginia Health Care Foundation and the services of nurses in the community were also likely contributors to the strong foundation upon which JABA was able to build some of its partnerships. Other lessons learned by staff and shared for replication include:

- Take the time to plan and plan well. Being in a hurry to get an important program going may result in pieces being left out or overlooked. By doing things right and planning ahead in the beginning, future issues and cultural barriers can be avoided. The expansion of programs, services, and diverse locations was not undertaken until the partnership had achieved important local successes.
- Outcome measurements should be decided early on in the program development. All partners involved need to agree on what data will be collected, how, and where. This can save a lot of time and confusion further down the road.
- Market the successes of the program and engage the partners within the community in the marketing. This can increase the enrollment as well as the number of affiliating partners.
- Promotion of an evidence-based or best practice model addressing local needs can help gain early support from physicians and other health care providers for a new program, and help sustain the programs and partnerships in the long term.

The Fitness Room Program

Johnson City Seniors' Center
Johnson City, TN

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The Johnson City Seniors' Center program exemplifies a community-based health alliance that evolved from a potentially divisive situation and went on to become an effective partnership that includes many nontraditional collaborators. This program also employs various methods to assure that volunteers and program participants are included as equal and essential partners. Located in Johnson City, Tennessee, Johnson City Seniors' Center serves a mix of rural and urban residents within the city limits. An estimated 30% of area residents are over age 55.

The Johnson City Seniors' Center was founded in 1961 to offer adults age 55 years and older a place to come together to participate in programs, experience personal growth and enrich their quality of life, support the needs of others, enhance their independence, and broaden their community and civic involvement. The center provides activities and services in 13 branch sites in Johnson City, including off-site locations such as churches, senior housing and other nonprofit organizations where seniors congregate. The Seniors' Center also serves as a resource for information on aging, training, professional leadership, volunteer leadership, and the development of new approaches to aging programs. The Seniors' Center is primarily funded by local government sources, but it also has modest funding support from the Area Agency on Aging. Additional monies for specific projects are acquired through an annual community appeal. The Seniors' Center members are not charged membership fees, but they do pay for the services and activities they use. Scholarships are available so that no one is turned away. Participants are also given the opportunity to donate, as able or in-kind, to specific projects. For example, the acquisition of a transportation vehicle for the center was fully funded through participants' fund-raising activities.

Description

While the Johnson City Seniors' Center offers a variety of health promotion activities, the Fitness Room Program is particularly noteworthy because it is the centerpiece for the partnership described here. Participants are oriented to the program, assessed individually in the fitness room, instructed in the use of equipment, assisted in the development of a

personalized health promotion program, and reassessed at regular intervals by qualified fitness professionals. A variety of preventive health screenings and activity classes are designed to complement the health promotion program. There is a nominal fee for center members for the use of the fitness room and this cost covers the mandatory yearly fitness orientation. Volunteers, trained by an exercise physiologist, provide the primary staffing of the fitness room. As an emergency response measure, center staff and volunteers have been trained, with the help of the Johnson City/ Washington County EMS, in CPR, first aid, and the use of a defibrillator that was provided by the partnering pharmacies.

The Evolution and Roles of the Partnership

In the late 1980s, the Johnson City Seniors' Center had existing partnerships with traditional players such as the local Area Agency on Aging and Parks and Recreation. However, after attending an aging conference where the then relatively new concepts of wellness, health promotion, and physical activity for older adults were discussed, the Seniors' Center director was eager to introduce health promotion programming that would appeal to members. Strategically, such programming seemed to be an appropriate way to seek new partners from the health care sector and to explore other nontraditional community partnerships.

At the same time, a separate entity called the Mountain State Health Alliance was becoming more active in the community. The Health Alliance began to focus on the aging adult population in Johnson City, in part, because of the large numbers of residents who were aging in place and, in part, because of increasing competition from a second area hospital. The Health Alliance conducted a business feasibility study for building a new Senior Center or absorbing the existing Johnson City Seniors' Center. As a one-sided venture, this action almost destroyed any likelihood of building a trusting partnership with the Johnson City Seniors' Center. However, when the study failed to show economic gain in a solo venture, it became clear that the real value was in building a long-term partnership that could share, rather than compete for, resources and good will. So relationships were brought back on track when the Health Alliance aligned itself with the Johnson City Seniors' Center vision of health promotion. Eventually, the competing hospital was bought by the Health Alliance, and thus the original relationship between the partners significantly expanded its reach.

The Seniors' Center/Mountain State Health Alliance now includes a variety of health-related entities, all contributing to the partnership to promote healthy aging for residents of the Johnson City area. These members include the Mountain State Health Alliance, the Johnson City Wellness Center (located adjacent to the Medical Center), the Health Resource Center located at the area mall, and Senior Friends (a group sponsored by the Medical Center). As part of this larger partnership, two volunteer certified exercise physiologists from the Wellness Center donate their time three days per month (funded by the Wellness Center) to support the health promotion activities of the Seniors' Center Fitness Room. One physiologist administers and reviews the Physical Activity Readiness Questionnaire (PAR-Q) that is completed by new participants and assists in the development of tailored fitness programs. The second physiologist works with lay volunteer monitors and coaches who staff the fitness room. In addition, routine health screenings and health promotion education presentations are provided by the Medical Center staff throughout the year and free of charge to members of the Seniors' Center. A

separate partnership with the Medical Center Hospital and the local mall has resulted in a well-attended Seniors' Center–sponsored walking program called *Heart and Sole*. At the monthly orientation meetings, participants learn about the program, obtain health-related information, and have their blood pressure measured.

The Value and Effectiveness of the Partnership

The Seniors' Center and staff benefit from the partnership by the addition of health care professional expertise that is not otherwise affordable, and also by the increased capacity to offer a variety of health promotion programs. The Mountain State Health Alliance continues to benefit by gaining broader access to older adults as well as increasing opportunities to promote senior health. Both the Seniors' Center and the Health Alliance benefit through enhanced visibility, community outreach and mutual marketing of services and programs, through the Fitness Room Program and related events. For example, the two partners jointly host an annual Senior Expo that targets adults aged 50 years and older with health promotion messages, educational activities, and free health screenings. The Area Agency on Aging annually provides Title III D health promotion funds to the partnership. In return, the Area Agency can demonstrate that it is achieving its own program goals by supporting many of the activities offered by the Seniors' Center. At the time of the best practice survey interview, the City Parks and Recreation Department was an important partner providing modest funding and in-kind support, including classroom and activity space and a venue for recruitment. Since that time, in a major reorganization, the Seniors' Center has been placed in the Parks and Recreation Department. This new configuration has proven very valuable to the Seniors' Center, because of the effective relationship between the two organizations and the willingness of the Parks and Recreation director to support the efforts of the Seniors' Center.

Clients benefit by receiving high-quality, relevant health education materials, monitored health screenings, and a fitness program that has little or no cost. The Seniors' Center staff tracks the use of the equipment, the number of assessments and screenings conducted, and the general attendance at health promotion programs in order to gauge participation relative to prior years. Seniors' Center staff members also track newspaper articles and other published stories about the partnership activities. Participant satisfaction is monitored through surveys. The staff is currently working on a new partnership with East Tennessee State University to develop participant outcomes measures and to conduct an outcomes assessment on the impact of the health promotion program. Currently, university students serve as volunteers and assist in health screening activities, but on a limited basis.

Maintaining and Sustaining the Partnership

The program director reports that sustaining the partnership with Mountain State Health Alliance is imperative to the success of the Seniors' Center and its programs. Each month the center's program director sends a thank-you letter to the Health Alliance and includes an updated in-kind contribution form. This form describes the in-kind services that were performed by the Health Alliance for the Center, and what these services would normally cost had they not been donated. The two organizations also participate in a monthly information exchange. The center sends the Health Alliance its newsletter and, in return, the alliance sends its health brochures and updated program information to the center. At a volunteer recognition luncheon, the Johnson City Seniors' Center presented the

Distinguished Service Award to the CEO of Mountain State Health Alliance for the organization's outstanding contributions to the center.

The program director also emphasizes that the center values its volunteers and their contributions to the health and well-being of older adults served by the center. To sustain volunteer activities, the center hosts an annual volunteer recognition luncheon and awards activity. The center also values program participants as equal partners. To sustain continuing involvement of participants, the center staff sends out monthly thank-you notes to those individuals who participated in that month's activities. These efforts help communicate to volunteers and clients that their participation is highly valued. The center staff employs other methods to empower older adults to participate in the program. For example, when the center acquired a new bus to transport participants to and from the center during meal services, participants themselves helped to raise money for its purchase. The investment by participants in the center and their determination to help it succeed and expand to meet the changing needs of Johnson City's senior population is viewed as tangible evidence of the appeal and success of the program.

Lessons Learned for Replication

Partnership building and maintenance has been crucial to the continued growth and success of Johnson City Seniors' Center. In particular, this collaboration illustrates how potential competitors can become successful program partners and how program participants can be listened to and treated as essential partners. Other key lessons learned shared by the program director include:

- Partnering with a leading health care community organization seeking to enhance its position within the aging services network can result in greater positive public awareness about health promotion and aging and thus benefit all involved organizations.
- There is great value with sharing media recognition among partners. Each of the partners has an interest in seniors' health and in being recognized for their contributions to this effort. The program director reports that sharing recognition helps immeasurably to promote that important image and in no way deters from the center.
- Similarly, recognition of volunteers and participants as equal partners reinforces interest and commitment in the program and helps to assure that the program is grounded in the needs of those it serves.
- It is important to emphasize the significance of the partnership with new staff members. The orientation of new staff members includes the introduction of key partnership organizations and how they contribute to the Seniors' Center mission.

Note: In 2003, Johnson City Seniors' Center was acknowledged for its excellence in physical activity programming for older adults. NCOA, with support from the Robert Wood Johnson Foundation, conducted a national competition to identify best practices in physical activity programming for older adults. Ten programs, including the fitness room at Johnson City Seniors' Center, received top honors and were presented with a monetary award and a certificate of achievement.

The Exercise for the Homebound Program

Lafayette Senior Center Senior Services
Lafayette, CO

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The Exercise for the Homebound Program is an example of a city coalition that is a creative blend of professional and volunteer services. This partnership addresses the needs of an increasing number of homebound elders, particularly those who do not have access to rehabilitation resources, general exercise programs, or opportunities for socialization. This program also illustrates the effective use of lay "exer-leaders" as partners in implementing the program.

Lafayette Senior Center Senior Services is a division of the City of Lafayette Parks and Recreation Department in Lafayette, Colorado. The Senior Center offers a number of activities for people 55 and older, including health and wellness recreational activities; information, referral, and support for older adults and their families; and opportunities for meaningful educational, leisure and social enrichment.

In 1999, five members of a community senior wellness coalition attended a statewide wellness conference where they were awarded $500 to explore the feasibility of home-based health promotion activities. This modest funding was used to develop the Exercise for the Homebound Program. To implement the program, additional sponsorship and grant funding was obtained from area businesses, Boulder Colorado Aging Services, local hospitals, and banks. The program's leaders report that many local businesses and organizations were willing to provide modest financial support for a successful intervention that could demonstrate its ability to reach underserved members of the community.

The Lafayette Senior Center assumed the coordinating role for the Exercise for the Homebound program. The program is designed for people age 55 years and older who are living alone or being cared for at home. The program evolved in response to the needs of Medicare patients who were discharged to the community from a hospital or rehabilitation facility without continued rehabilitation support options. After one year of operation the Senior Center and its many partners assessed the impact and revised the pProgram. They decided to include increased resources for socialization by offering social

outings to the Senior Center for all homebound participants. The majority of the participants are identified and referred to the Homebound Program by the Senior Center's resource specialist/social worker, through her linkages with many community social and health care programs and the Medicare discharge system. A registered nurse and a certified occupational therapist and physical therapist are contracted with privately. They provide initial evaluations and semiannual follow-up assessments. Local home health providers and a representative from the county mental health center meet quarterly (as volunteers) with the nurse, occupational therapist and senior center resource specialist to help create special fitness plans for each participant. Their services are supported by the program's grant funds. The exercises prescribed by this team are geared toward improving the client's ability to perform activities of daily living (ADLs); maintaining independence; enhancing strength, flexibility, and balance; and potentially breaking the cycle of loneliness and isolation that is often experienced by the homebound. When the client is approved and willing to begin the program, a volunteer "exer-leader" makes a home visit one to three times per week, and exercises "side-by-side" with the client, but does not perform any hands-on assistance.

The exer-leaders obtain comprehensive and ongoing training in the issues of aging, the effects of medication, how to facilitate exercise, effective feedback strategies, coaching and monitoring, safety concerns and the setting of boundaries and limits, as well as a clear delineation of their role in this program. Under the regular monitoring of a certified senior physical activity trainer or an occupational therapist, the exer-leaders keep the staff informed of any problems that may arise with a homebound client. Because the exer-leaders actually perform the exercise activities along with their clients, they also obtain similar personal health benefits.

The Evolution and Roles of the Partnership

The original Senior Wellness Coalition has become an advisory oversight board for the Exercise for the Homebound Program. A variety of community partners are now also providing significant contributions to the program. The city of Lafayette has been a strong partner providing some funding and staffing support. The City Parks and Recreation Department provides the facility space for the Senior Center, which is the home base for the program. Within the health care community the program has developed strong collaborative activities with nurses, physical therapists and occupational therapists, and senior wellness consultants, who assist with the assessments of potential clients. Pharmacists in the community have also contributed in-kind services by evaluating clients and educating them, along with the exer-leaders, about the potential effects of medications and how possible side effects may impact their respective exercise programs. A few physicians have also partnered with the coordinators of the program to make referrals and track clients' participation and improvement. Lastly, partnerships have been created between the program and some of the families of clients. Many family members have not only provided continuous encouragement to their relatives who are participating in Exercise for the Homebound, but also have become ardent advocates for this intervention.

The Value and Effectiveness of the Partnership

Program staff members describe this program as a "win-win" community activity. Older adults have access to home exercise programs and enhanced socialization opportunities.

Volunteers and program staff have an opportunity to contribute to the community and receive recognition for their important contributions. Health care providers have program options for their patients. Moreover, the hosting senior center has experienced an increased public interest in their general activities. Finally, major funding organizations receive positive public relations.

The staff considers the success of the Exercise for the Homebound Program to be a result of the partnerships and the depth and breadth of community involvement. The volunteers, who are recruited from Lafayette area senior centers, local community members, and from the city itself (i.e., city employees), provide the backbone of the program. In fact, the Senior Center has cited its volunteers as the most important partners in this program. The program director reports that without the volunteers' dedication to the Exercise for the Homebound Program and its clients, this program would not have evolved, or possibly even survived through the past three years. The program coordinators, occupational therapists, physical therapists, senior wellness consultants and nurses are able to perform their assessments and make recommendations to clients because they know that the volunteers are dependable—motivating clients, effectively leading the exercise sessions, and providing opportunities for social interaction.

Participants, exercise leaders, family members, and health professionals benefit from the program. The clients improve their fitness levels and are able to resume more Activities of Daily Living (ADLs) and typically, are more functionally independent than when they began the program. Also, participants gain social benefits because of the companionship provided by the exer-leaders. As their physical functioning improves, short outings into the community with the exer-leader are encouraged and facilitated, which further expands the impact of the Program on reducing isolation and encouraging social engagement. The exer-leaders are rewarded by their clients' improvements. In addition to their enjoyment in helping others, they also benefit physically because they are exercising too. Families of clients benefit from the program as their family member's health and functioning and level of independence improves. Finally, the health professional community at large becomes more aware of aging issues and develops positive images of aging that result from observing how older adults can improve and maintain their health functioning.

The program director reports that the Exercise for the Homebound Program has experienced an increase in the number of physicians and other health professionals who are making recommendations to the program because they attribute the positive changes in their patients' health and functioning to participation in the Program. From an outreach perspective, more people have come to the Senior Center, explicitly seeking information about the Exercise Program. These informational visits to the center provide increased opportunities for older adults to learn about other center activities and this, in turn, has resulted in a growth in overall participation levels in ongoing programs.

Maintaining and Sustaining the Partnership

The program director reports spending a great deal of meeting time in making the Exercise for the Homebound and its healthy aging partnership successful. There are monthly team review meetings among the senior center resource specialist, nurse, and

occupational therapists where exercise plans are developed and other resource needs are discussed. Meetings are also held monthly where all the volunteer exer-leaders can meet with the resource specialist to discuss their experiences and brainstorm solutions together. Team-building strategies have played important roles in dealing with barriers and conflicts. For example, it is sometimes difficult for older clients to accept and work with younger exer-leaders. By brainstorming and problem solving about these intergenerational issues as a group, the team meeting members were able to generate effective approaches to dealing with these situations.

The core organizational partners meet annually to review goals and progress in the community. They use a variety of measures to assess the effectiveness of the partnership, including the growth of referrals and number of formal client assessments, the number of news stories solicited by the local papers, physicians' feedback, clients' and families' feedback and testimonials, and the increasing number of volunteer exer-leaders. Biennially, the senior center resource specialist, the nurse and occupational therapist evaluate the program.

The program director reports that in order to maintain the involvement and interest of the exer-leaders, team-building strategies such as the brainstorming and problem-solving sessions described above and constant communication have been vital. On-going communication, enthusiasm, and dedication are always emphasized as important components of the program's success. A quarterly Exercise for the Homebound Program newsletter is published to inform and update participants and the larger community. The resource specialist/program coordinator also promotes awareness, communication and linkages by meeting with other senior centers in the Denver Metro area to discuss the program and how to reach out to the homebound.

Lessons Learned for Replication

Program staff members advise that replicating the Exercise for the Homebound Program model is definitely possible, but caution that it is very important to "start small and grow slowly." This approach is particularly crucial for establishing relationships with city officials, who are responsible for approving the use of volunteer exer-leaders to go into the homes of seniors. It is also important when seeking funding from area business leaders. Other key points that are lessons learned for replication include:

- Dedicated and enthusiastic volunteers are very important, especially to those programs that heavily depend on their contributions for sustainability and success. Volunteer exer-leaders are carefully selected and trained. A variety of retention strategies are used to promote their value. It is important to recognize the contributions of volunteers publicly. For example, public recognition at the annual volunteers' luncheon is an important activity.
- Peer support groups can help exer-leaders cope with difficult times and situations with clients. Clients' illness or death can be stressful for exer-leaders, because many of them form strong bonds with their clients. A peer support group that provides an outlet for any emotionally difficult situations that may happen should be created specifically for the exer-leaders.

- Partnerships with local health care providers can increase referrals and enhance program outreach to home bound seniors.
- Maintain open lines of communication and education with all partners. After the first six months, the partners found it necessary to review the goals and expectations to help build team work.
- It was recognized early that the diversity of the partners could lead to fragmented programs and activities. Agreed-upon policies and guidelines helped to frame those activities. Written policies, guidelines, and clarified boundaries help to focus the partners.
- A periodic review is conducted by the group to insure that the program focus is consistent with the partnership goals. It is important to make time to evaluate and reevaluate the effectiveness of the partnership, even if this is conducted in an informal manner.

Prime Time Health Program

Lancaster County Office on Aging
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The Lancaster County Office of Aging Prime Time Health Program is an example of how a partnership helped nine independent, countywide Senior Center directors overcome barriers to staff availability and training to develop new programs in health promotion and aging. This strategic partnership acquired certified fitness instructors and implemented health promotion programs through a contract with the YWCA. In the initial stages of forming the partnership, the program director spent time gaining the acceptance by the Senior Centers of the YWCA's role and the new activity, and she conducted regular communications between the various partners to manage program issues and continuity.

Initially, Senior Center directors were reluctant to encourage the "commercialization" or outside contracting of their physical activity programming. However, the use of measurable effective outcomes linked to participation helped to overcome that reluctance. The program recently expanded to include classes that are now offered in the county adult day care facilities and high-rise retirement complexes that house appropriate space. There is also a formal, renewable contract with the YWCA to provide qualified instructors on a weekly basis to the nine area senior centers.

Description

Prime Time Health consists of activities and informational programming efforts aimed at older adults with the goal of maintaining and enhancing health and independence. Based under the Pennsylvania Department of Aging, each Area Agency on Aging (AAA) in the state is the primary source of funding for the Prime Time Health Programs. In 1993, each of the state's 52 AAAs was directed to designate a Prime Time Health Coordinator to manage their local healthy aging activities.

The Lancaster County Office on Aging is an AAA. The AAA designated a health coordinator to oversee the Prime Time Health Program. The program offers a wide variety of physical fitness, health promotion, and education and screening activities in the nine Senior Centers that serve the county.

The Evolution and Roles of the Partnership

In 1995, the Prime Time Health coordinator assessed the health promotion activities in the Senior Centers and determined that there was a general lack of physical activity programming. Further, she found that staff members were not certified in physical activities for older adults, nor were they readily available to launch new programs. The coordinator approached the local area YWCA to explore filling this void in qualified staffing. Coincidentally, the YWCA executive director and Health and Fitness coordinator were looking for opportunities to reach the older market in order to fulfill new programmatic goals and to generate more revenue to support programming costs. Thus, a mutually satisfying partnership resulted, funded by the AAA, whereby weekly exercise classes were established in nine Senior Centers, and the YWCA developed a new pool of program participants and revenue.

The YWCA offers trained staff and services to the partnership. YWCA staff members are certified in aerobic exercise, CPR, first aid, and Pennsylvania's Peer Exercise Program Promotes Independence (PEPPI). PEPPI uses an evidence-based model of weight training classes led by volunteers. In this model, volunteers are trained and assisted by a qualified exercise physiologist. At three of Lancaster County's Senior Centers, peer counselors also were trained in conducting the YWCA's PEPPI classes in order to augment each center's weekly health program. Since the partnership began, a water aerobics class has been added at the YWCA facility, and because the class is fully funded by the AAA, there is no cost to older participants.

The Value and Effectiveness of the Partnership

The Lancaster AAA benefits from the partnership by the expansion of staffing resources through the addition of certified instructors to provide new and accessible programs that are part of the Prime Time Health mandate. The YWCA benefits from the partnership by obtaining access to an older adult market and through increased revenues. With the addition of the aquatics programming, older participants are also becoming acquainted with the YWCA facility and its other activities.

The Prime Time Health programs are evaluated through periodic participant satisfaction surveys administered by the senior centers. Participants routinely report increased strength, coordination and balance, endurance, energy levels and mental alertness, and a decreased fear of falling. They attribute these positive outcomes directly to the exercise intervention. Their feedback is used to modify the program elements as well as to assess the value of the partnership. Program staff members comment that expansion of the program offerings and increasing participation rates are viewed as an indication of the value of the partnership.

Maintaining and Sustaining the Partnership

The project director reports that the congruency of mission has been a key unifying element in sustaining this effort. Frequent telephone and face-to-face communications among the director of Prime Time Health, the YWCA directors, the coordinators and the exercise leaders are used to insure all the partners are well informed and focused on the goal. In addition, the Prime Time Health coordinator conducts an annual training session in physical activity programming and about PEPPI for a wide variety of personnel,

including the Office on Aging staff, the YWCA staff, senior center managers, Peer Exercise Program leaders, selected community members, and activity specialists in other county programs. The coordinator also convenes semiannual meetings with the senior leadership of the nine senior centers to discuss issues and brainstorm activities to promote older adult health and fitness.

Lessons Learned for Replication

The program director commented that this partnership can be easily replicated with area YWCAs, health clubs, spas, or recreation centers that are interested in community outreach strategies, provided these facilities have or can hire appropriately certified activity specialists. A formal contract between the YWCA and the Senior Centers and the provision of modest remuneration are important to insure consistency and credibility in programming, as well as shared liability for activities. Early discussion and marketing to all staff and potential participants can facilitate the acceptance of the YWCA as a key partner. Here are other important lessons learned reported by the program director.

- Keeping in close communication with the YWCA continues to be important for program continuity. Ongoing communication has resulted in early warnings of short-term staffing shortages within the YWCA. Working together, solutions can be found to sustain continuation of programs.
- Gaining the trust and support of overburdened Senior Center managers was important. Bringing the Senior Center directors into the planning process at the beginning of the venture facilitated the acceptance of the new programming and a warm reception of the YWCA staff at the centers.
- Conducting joint training sessions for the YWCA and Senior Center directors has enhanced communication among staff and volunteers.
- While finding bilingual physical activity trainers is difficult, cultural barriers must be addressed. To overcome this challenge, one of the senior centers that serves a large Hispanic population offers the exercise program with the cooperation of bilingual center staff to provide translation. Some of the non-Hispanic instructors were willing to demonstrate the exercises in pantomime. Assigning one consistent instructor so that Hispanic participants can become comfortable coping with language challenges is helpful.

The Senior Wellness Project

Northshore Senior Center
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The Senior Wellness Project is an example of how a Senior Center and a large health care system came together through a highly integrated system of referrals, health promotion programming, and medical care to meet the health care needs of seniors residing in the north King/south Snohomish County area of Washington State. Over its twenty-year collaborative history, one of the key elements to the partnership's success has been the involvement of staff with varying roles and levels of responsibility in each of their organizations who came together to share a common goal of health promotion and disease management for older adults.

The Northshore Senior Center is a local nonprofit organization affiliated with Senior Services of Seattle/King County of Washington. Each month, the center offers over 500 activities and services, such as the Senior Wellness Project, to older and disabled adults. The center has a strong cadre of 1,900 volunteers helping to meet the mission of creating wellness of mind, body and spirit.

Description

The Senior Wellness Project is a nationally recognized research-based health promotion and disease prevention program created by the Northshore Senior Center, Evergreen Healthcare, Group Health cooperative, and the University of Washington Health Promotion Research Center. The program aims to promote wellness of mind and body for older adults with chronic conditions. The project, started in early 1993, includes three distinct elements:

- *Health Enhancement Program.* A community-based health promotion program designed for seniors living independently with chronic disease and those currently at risk for further health decline.
- *Lifetime Fitness Program.* A series of low-cost, one-hour supervised classes held for a five-week session of three classes per week. This program includes strength training, aerobics, balance, and stretching.

- *Living Well With Chronic Conditions*. A six-session course, developed by Dr. Kate Lorig at the Stanford Patient Education Research Center, to help older adults with chronic conditions by teaching techniques to deal with a variety of health-related problems.

The Health Enhancement Program component is designed specifically to empower participants to improve their health by facilitating healthy behavior changes and building self-efficacy—that is, the confidence in oneself to be successful in performing a health-enhancing behavior. Each participant undergoes a health and functional assessment and, with the help of a staff nurse, prepares an action plan using this information. The participant is supported through a year-long, progressive program of health and fitness activities to prepare him or her to manage personal health goals and to maintain the changes in health behaviors.

The Evolution and Roles of the Partnership

The Health Enhancement Program, which was initiated in 1995, is supported by collaborations between the Northshore Senior Center and Evergreen Healthcare. Evergreen Healthcare offers a variety of community-based programs, including Evergreen Hospital Medical Center, rehabilitation services, home health and mental health care, hospice, and case management. A major impetus for partnership between Evergreen Healthcare and Northshore Senior Center is their mutual interest in preventive care and the delivery of health care services to the community, particularly through different methods of health promotion, disease prevention, and self-management.

Since its inception in 1984, the partnership between Evergreen Healthcare and Northshore Senior Center has implemented many different approaches to improving the health of older adults in the service region. Older adults who were being discharged from the hospital needed to be referred to other community-based services. To develop these services, Evergreen provided funding for the Senior Center's social services, including Meals on Wheels, in-home volunteer support, and a senior employment program. From these beginnings the relationship between Evergreen Healthcare and the Northshore Senior Center has continued to evolve to address a gap in the care management system by expanding its focus on physical health, including self-management, health promotion, and disease prevention. Another fruitful long-term partnership has been with the University of Washington Health Promotion Research Center and the Group Health Center for Health Studies. The extension of the partnership to these members has led to the development of research and impact studies that document the success of the Senior Wellness Project. In particular, several successful research trials have documented the value of the Health Enhancement and Lifetime Fitness Programs, that has led to replication nationally and in other countries.

The Value and Effectiveness of the Partnership

Program staff report that several services of the Northshore Senior Center would not exist without the financial aid and staff support of Evergreen Healthcare. For example, Evergreen Healthcare provides physical, occupational, and speech therapists for the center's three adult day health centers. Staff members from Evergreen Healthcare also lead health education classes. The partners have developed a dental care program that

includes a volunteer dentist and a medical van that will travel to the Senior Center to provide care for elders with low income who have no dental insurance or state medical support. Evergreen Healthcare provides the funding for this project, and the Northshore Senior Center recruits the volunteer dentists, screens patients, and manages the program at the Senior Center. Evergreen also assists substantially with Health Enhancement Program staff costs at three Senior Center sites.

In return for the funding and staffing support that Evergreen Healthcare brings to the partnership, the Northshore Senior Center offers as much reciprocal assistance as possible. Senior Center staff members have helped Evergreen to develop its wide array of community services by serving on and chairing task forces, focus groups, and committees on an ongoing basis. On behalf of Evergreen Healthcare, Senior Center staff also advocate for the expansion of hospital services with local and state organizations. In addition, Senior Center staff members make numerous referrals to Evergreen Healthcare and its many different health care services. Evergreen's health screening and education classes at the center provide opportunities for the participants to learn about and connect with Evergreen Healthcare.

The outcomes from the collaborative work with the Senior Wellness Project have been particularly strong. As documented in national research publications, the Health Enhancement Program reported a 72% decrease in the number of hospital days for those who took part in the initial study. The program continues to show a significant decrease in hospital days and an increase in health and functioning. The Lifetime Fitness Program has likewise proven its worth in reducing medical care costs and increasing the health and well-being of enrollees. On the whole, the partnership has led to a higher level of health and personal empowerment for seniors in the community.

Maintaining and Sustaining the Partnership

The Northshore Senior Center and Evergreen Healthcare initially became partners because of their common concern for, and the desire to improve, the health of the older adults in their community. This shared interest and goal has greatly contributed to the sustainability of the relationship between the two partners. The Health Enhancement Program outcomes data has been freely shared by the Senior Center with Evergreen Healthcare, which has helped to generate support by the Healthcare's geriatrics practices and reinforced the value of referring patients to the Senior Center.

In the beginning of the partnership, both organizations put aside turf issues and made conscious efforts to construct their relationship. After twenty years, the program staff members of both organizations report that including one another's perspectives is inherent in their thinking and programming. Because of this closeness, the partners have not needed to craft many formal arrangements. In addition, despite turnover in staff members and some changes in areas of interest, both partners have emphasized effective communication strategies to keep all new and veteran employees updated in matters involving the partnership. Program staff members report that this approach has kept employees involved and refreshed. Further, both partners have involved many different types of staff members (e.g., directors, case managers, nurses) in the partnership projects. Not only has this contributed to the dedication of staff members to the collaboration, but

it also has boosted the success of the partnership. Finally, the Senior Center has made a strong effort to include Evergreen Healthcare in any associated public relations activities. This includes formal recognition of Evergreen Healthcare staff and volunteer support at an annual recognition luncheon, and recognition of Evergreen Healthcare as a sponsor for any awards received by the Senior Center.

Lessons Learned for Replication

Senior Wellness Program has designed replication information that may be accessed at http://www.seniorservices.org/wellness/wellness.htm. The director comments that replication of this partnership depends upon building a history of small, successful joint activities; open communications; and the active involvement of all staff. Other reported lessons learned for replication include:

- Each partner should understand the goals that have been set and the challenges that are faced by the other partners.
- Partners need to determine how they are going to fit together and what they need from the relationship. Each collaborator should not only think of what it would like to gain from the partnership, but also what the other partner is likely to want and need. No partnership is going to be an absolutely perfect match, so it is essential for both partners to realize the boundaries.
- Never assume! One partner may not want to support a project that the other partner assumes that it will. Of course, sometimes it may just take some patience and persistence in order to convince a partner of the value of supporting a new initiative.
- Be alert to financial situations and problems that may arise. Being aware of, and understanding, the environment in which a partnering organization operates is a key element in sustaining that partnership. For example, the Senior Center has recognized the value of educating the older adult community in the issues surrounding hospital bond campaigns and initiatives to obtain certificates of need for expansion.
- Always include the other partners in important opportunities, especially when a collaborative project is recognized or awarded. The program staff reports that the Northshore Senior Center makes a practice of seeking opportunities to acknowledge all its partners. They also host an annual award luncheon to publicly thank their providers, partners, and volunteers.
- Involve employees from many different levels and areas of interest. A more varied connection can facilitate a stronger partnership. This purposeful involvement of staff at different levels of the organization helps to ensure long-term organizational commitment to the partnerships and activities.

Partnership for Healthy Aging

Portland, ME

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The Partnership for Healthy Aging is an example of a coalition between health care and aging organizations in Maine that have bridged their respective medical and social models of care. Acting as the glue between these two service systems and ideologies, the Partnership for Healthy Aging relies heavily on an all-inclusive interagency Wellness Committee to help bridge those differences. The Wellness Committee has become a "neutral ground" whereby diverse and competitive programs can come together to share information and forge collaborative programming and projects. As a result, the Partnership for Healthy Aging has evolved into a strong community resource that also provides statewide support to a variety of community-based organizations serving older adults.

The Partnership for Healthy Aging is a nonprofit (501(c) (3)) organization, established jointly by MaineHealth, the Maine Medical Center, Community Health Services, and the Southern Maine Agency on Aging. It offers older adults and their families a comprehensive resource for health promotion, wellness, family caregiver support, and service integration. The partnership works in collaboration with organizations and resources for older adults throughout the community to provide this continuum of care. The planning stage of the partnership began nearly ten years ago at the Maine Medical Center, in response to the center's interest in linking their social and medical models. It did not become a full-fledged organization until 2000, when the Geriatric Resource Network was formed. The Geriatric Resource Network is the corporate name for Partnership for Healthy Aging.

The funding for the Partnership for Healthy Aging is supported by MaineHealth. The Maine Medical Center provides on-going support for salaries and monetary costs. Community Health Services and Southern Maine Agency on Aging also provide in-kind support each year. Formal relationships exist between the partnership and both MaineHealth and Maine Medical Center.

The Description of the Healthy Aging Programs

The Partnership for Healthy Aging is responsible for implementing and managing a package of evidence-based programs across the state through local partnerships and through staff training and technical assistance programs. These programs include:

- *A Matter of Balance*. A program that emphasizes practical strategies to reduce the fear of falling and increase activity levels.
- *A Matter of Health*. In collaboration with the Sports Medicine program at the University of Southern Maine, the partnership is developing a walking program, which uses pedometers and encourages older adults to walk more.
- *Senior Wellness Project*. A nationally recognized research-based health promotion and disease prevention program created by Senior Services of Seattle/King County that aims to promote wellness of mind and body for older adults with chronic conditions (see the full description of this program beginning on page 31). Three key elements are:
  - *Health Enhancement Program*. A community-based, health promotion program designed for seniors living independently with chronic disease or currently at risk for further health decline.
  - *Lifetime Fitness Program*. A series of low-cost, one hour supervised classes held for a five-week session of three classes per week. This program includes strength training, aerobics, balance and stretching.
  - *Living Well With Chronic Conditions*. A six-session course designed to help older adults with chronic conditions by teaching techniques to deal with a variety of health-related problems.

The Evolution and Roles of the Partnership

When the Partnership for Healthy Aging began to take shape, its coordinators and various volunteers conducted a number of key informant interviews with providers, including the New England Rehabilitation Hospital, University of Maine Lifeline Program, the YWCA, the Office of Elder Affairs, the City of Portland Parks and Recreation of Maine, and AARP Maine. Focus groups were alo conducted among caregivers in the community and older adults participating in physical activity programs at the University of Southern Maine Lifeline Program, senior housing programs, and pulmonary rehabilitation programs in the New England Rehabilitation Hospital. The purpose of the needs assessment was to identify which services were most likely to be needed and helpful to the Portland community. During this process, health promotion and disease prevention emerged as two primary areas of interest. With these areas as their focus, the coordinators established a Wellness Committee composed of members of the health community. The members include representatives from the following organizations: Community Health Services, New England Rehabilitation Hospital, University of Southern Maine (USM) Lifeline, Southern Maine Agency on Aging, Osher Lifelong Learning Institute at USM, Portland YWCA, City of Portland Parks and Recreation, AARP Maine, City of Portland Office of Elder Affairs, MaineHealth Learning Resource Center, and the USM College of Nursing and Health Professions.

Members were invited who could complement each other's expertise and perspectives and provide leadership for health promotion and disease prevention initiatives that incorporated both social and medical aspects of health care. The resulting Partnership for Healthy Aging is a small organization with program coordinators who are committed to creating a "neutral territory" or common ground where diverse agencies with differing ideologies, and sometimes competitive programming, can focus on their genuine and

committed interest in healthy aging. Such commitment to inclusiveness explains the diverse nature of the members of its advisory Wellness Committee.

The Value and Effectiveness of the Partnership

Members of the Wellness Committee as well as the Partnership for Healthy Aging have been able to profit from this partnership. The partnership and its coordinators are able to share knowledge, ideas, and resources from the various members of the Wellness Committee, and the members learn about each other's programs. Participants serve as sounding boards for the generation of programmatic ideas, and everyone is able to maintain currency with the field of healthy aging. Those who take part in the Wellness Committee use it as a vehicle for networking and often collaborate on making grant applications. Many of the members jointly participate in health fairs and other events, and serve as speakers for each other's organizations. They also make referrals to each other's programs, and promote each other's programs in periodic organizational newsletters. Ultimately, by assisting the Partnership for Healthy Aging, the Wellness Committee members are gaining an appreciable amount of publicity for their own organizations as well as connections to new programs and services.

The coordinators view the Wellness Committee as being effective if the Partnership for Healthy Aging programs are successful, participants in the committee are enthusiastic and consistent, and the numbers of clients seeking the help of the partnership is growing. There is a formal assessment process for some of the programs the partnership offers, such as A Matter of Balance and A Matter of Health. The Wellness Committee also conducts an annual survey of membership to assess satisfaction with committee work, suggestions for improvement, and so forth. Informally gathered participant feedback is positive. Success is gauged by the continued growth of the Partnership for Healthy Aging into a bigger, stronger, and more effective organization. New programs have been disseminated, presentations are given throughout the community, facilitators have been trained in order to broaden the impact, and collaboration among community agencies continues to occur.

Maintaining and Sustaining the Partnership

The Wellness Committee meets on a bimonthly basis. There is an agenda for each meeting, which helps maintain focus and ensures that goals are accomplished. Further, participation is sustained because members benefit from the opportunities to actively network and seek advice and brainstorm over specific needs and issues. Occasionally, members have suggestions to modify the committee's common goals for promoting healthy aging, but as long as the broader partnership members feel that they are "kept in the loop," the program coordinators report that there is little conflict within the constituency.

Lessons Learned for Replication

The Partnership for Healthy Aging was created as a separate nonprofit organization financially supported by its founding organizations in a joint effort to integrate the medical model of the health care system with the social model of the aging services network. The partnership can serve as a model for other communities working to link

these medical and social ideologies through the creation of a neutral environment. Other lessons learned reported by program staff members for consideration of replication include:

- Collaboration and communication are essential for making a partnership work. It has been particularly valuable in reconciling the differences between the medical and social models. The Partnership for Healthy Aging developed over a ten-year period of joint projects designed to implement linkages between the medical system partners and the aging services network. This initiative demonstrated that successive, small-scale ventures can facilitate community-wide change.
- It is important to have diverse areas of expertise represented within the partnership, especially if it is a large committee. The eleven-member Wellness Committee includes representatives from the health care sector, social services, academia, the aging network, the YWCA, parks and recreation, and older adults. This diversity ensures that the Partnership for Healthy Aging activities and programs are both practical and valued by the community at large.
- The Partnership for Healthy Aging does not have to be the lead organization on every project/idea that is presented. It is important for everyone to work together to offer the continuum of care. The partnership views its diffusion activities as empowering other organizations to take the lead in implementing programs.

Note: Partnership for Healthy Aging was selected as one of twelve organizations to receive a three-year grant from the US Administration on Aging to implement an evidence-based program in a community setting.

Section Three

Appendix A: Best Practices in Healthy Aging Advisors

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Appendix B: Best Practices in Partnerships Advisors

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Appendix C: Recommendations for Best Practices in Partnerships

What are the key benefits of partnering?

- You can get things accomplished that wouldn't otherwise be possible.
- You can complement your strengths and weaknesses with others' strengths and weaknesses.
- Partnerships are resourceful, not only economically, but in other ways as well. It just makes sense to pool money, talent, and time. Best use of available resources.

How would you select/identify a good partnership?

- Always look for creative models that emerge from the community. They can provide ideas for future collaborations.
- There is a good balance of give and take in the relationship. If it makes sense for someone else to take the lead on the project, other collaborators should be willing to allow that to happen.
- Partnerships including different cultural agencies will help a project reach different areas of the population.

What makes a best practice?

- Sustainability.
- Replicability. People can take the ideas and use them in different settings.
- Applicability. Can be applied in many different settings and people can get results.
- Adaptability. Other people can use the ideas/model even if they are not in the same circumstances.
- Innovative. The practice is unique, but not so unique that it cannot be used by others. It has the right mix of players and brings new concepts to the table without being "beyond reality." The partnership has balance.
- Its successful at meeting well-defined objectives.
- It makes a connection with the "ordinary manager" and was not developed in response to extending circumstances.
- Its creative but useful in "common environments."

How would you go about identifying a best practice in partnerships?

- Conduct an internal analysis: What is it that our group wants to do? Who else has a stake in this or shares the same vision? Who can help get us where we want to be? Primary or secondary level partners may be appropriate.
- Conduct a community assessment: What does the community have ownership in? What is important to the community? May require education of potential partners.
- Brainstorm: Get a group together to do a SWAT (**S**trengths, **W**eaknesses, **A**lternatives, and **T**asks) analysis or some similar types of activities.
- Nontraditional partners may bring resources to the table and meld funds for a project.

- Joint ownership of the development of the partnership and its accomplishments.

How would you evaluate the effectiveness of a partnership?

- If a partner is willing to offer money or in-kind contributions toward the project.
- The ability to pool resources. Achievements can be maximized over those that could be accomplished individually.
- Identify clear objectives, and always collect data in order to measure outcomes, which may also help when determining the effectiveness.
- Recognize issues or opportunities that may alter partners list or may facilitate the sub-grouping of partners.
- Did it accomplish what it set out to do? Measure impact.
- Is there data to support the accomplishments? It is always important to have documented outcomes.
- Ongoing process of evaluation.
- Good front-end planning and objective setting is important.
- A partnership may have to rethink the goals and measures it is using if the project is not having the desired results.
- Need to have a plan for using the evaluation feedback.

What about nonfunding partnerships?

- In-kind support is always helpful, which is more commonly the contribution.

How do we keep a partnership evolving?

- Use common sense!
- Insure congruency of mission, aligning of goals and incentives.
- Bridge the cultural divide naturally occurring between organizations through team building.
- Work together.
- Encourage honesty; be supportive and considerate.
- Share praise, glory, and recognition.
- Build trust and respect.
- Avoid power plays.
- Take down barriers that naturally exist when different organizations come together.
- Make sure everyone is on the same page, has the same goals, and is given the same information. Good front-end planning and objective setting is important.

How does a good partnership come about?

- Strong leaders who can get other people and potential partners interested in a project before anything has really been set are always important.
- Through a solid local network.
- Beginning with a core group of partners and building from there can be helpful.
- Through the use of technology. Communicating via e-mail and the internet can help partnerships build very quickly and evolve over time.

- Long-established partnerships have active involvement tied to the core of the organization they represent.

What would you want to come away with after attending a session about best practices in partnerships?

- The ability to copy/use the examples of partnerships that are given. Any documents, models, etc., that will help a person put the partnership immediately into practice somewhere else. No one wants to reinvent the wheel.
- What were the key factors that made the partnership a success?
- What were the barriers? Maybe if we know them, we can avoid them.

What question would you ask regarding a partnership?

- What is the foundation for the partnership? (transitory or mission driven)
- How are the members of the organizations/groups reacting to the partnership?
- What are the benefits? What keeps partners collaborating?
- How are they measuring effectiveness? Using particular tools?
- Formal vs. informal. If to be a longer-term partnership, formalizing is important to the evolution and roles of the partnership, especially if funds are involved.
- How did they decide on the issue to partner around? What creative idea or opportunity led to the development of the partnership? How was that opportunity identified? (How does the staff keep abreast of needs, opportunities, changes?)
- Solicit tips for bridging the variety of individual and organizational needs with the need for partnership action.

What are some suggestions for partnerships?

- When working with partners it's always important to remember that no one will ever be perfect. Every group has its challenges.
- Try to avoid power players who always think that they are in charge. A partnership should always strive for an even give-take relationship.
- The culture of an organization has an impact on the partnerships. People should be able to have a vision of what will happen in the future. Any partnership should try to tap into organizational culture and core values of partners.
- Healthy cross mix of skills and networks.
- Be able to assess strengths and weaknesses of partnerships: live with or adjust accordingly.
- Facilitation skills are necessary to have an efficient, effective partnership
- Sharing of credit for partnership success is crucial

Appendix D: Partnership Interview Tool

Questions Provided to the Program Staff in Advance

1. Briefly tell us about your organization and mission?
   (verify information we have in the database)
2. Give us a general overview of your organizations community partnerships?
   Do you also have partnerships in the following sectors?
   - Nonprofit _____
   - Government _____
   - Corporate_____
   - Academic _____
   - Health care_____
   - Public health_____
   - Nontraditional_____
3. Give us a general overview of your health promotion programs?
4. What is the one healthy aging partnership that you would like to highlight?
5. Tell us about that partnership: What makes it so effective?
   a. When formed
   b. How formed
   c. Purpose?
      i. What need is addressed?
      ii. What new or different roles did the partnership take on?
   d. Formal or informal
   e. Identify partner(s)
   f. What did the partner bring to the table?
   g. How does each partner organization benefit?
   h. How do the individual members of the partnership benefit?
   i. How does the community benefit?
   j. What are some of the specific healthy aging outcomes or products of this partnership?
6. How did you identify the need or opportunity for the partnership?
7. How does it fit into your organizational strategic plan?
8. Discuss the evolution and roles of the partnership itself (if long term).
   a. What did you have to modify/give up to make the partnership work?
   b. Are there written or agreed upon objectives of the partnership?
   c. Were (all) the partner(s) equally committed to the process?
   d. Were there any difficult or unreliable partners and how did you manage that?
   e. How do you leverage services/partnership?
9. What efforts are made to nurture or sustain the partnership?
   a. Team building?
   b. Behavior change?
   c. Reinforcement?
   d. Aligning goals?
   e. Communication processes
10. What barriers or crises were overcome in the course of its existence?
    a. Cultural issues?
    b. Natural barriers between organizations

11. How do you assess its effectiveness?
    a. Formal or informal assessment?
    b. Measure impact?
    c. Document outcomes?
    d. What do you do with the assessment information?
12. Has the partnership truly made an impact in the advancement of healthy aging of the community?
13. Is this replicable and what are the barriers, pitfalls, benefits of implementing this elsewhere?
14. Summarize for us the key/critical elements of the partnership?

General closing comments, questions:

May we call you back if we have any questions once we begin writing this information up for dissemination? One key objective of Best Practice work is to stimulate dialogue, would you be willing to field calls from your peers interested in replicating your partnership?

Interviewers need to address to the following issues:

Is the partnership taking risks?

Is this a resource rich environment that has it easy, or uphill battles using partnerships innovatively?

Is creativity demonstrated?

Is this an innovative partnership?

Appendix E: References

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Appendix F: Additional Resources

Center for the Advancement of Collaborative Strategies in Health offers a user-friendly tool on the internet that can be used by members of a partnership to assess how well a collaborative process is working and to identify specific areas for partners to focus on to make the process work better. The tool can be found at http://www.PartnershipTool.net.

Center for Medicare Education. (2001). *Building coalitions*. Issue brief 2(3). Available at www.medicareed.org/content/CMEPubDocs/V2N3.pdf (accessed August 10, 2004). This brief explores the topic of coalition building, focusing on specific "how-to's" and using real-life examples from the experiences of the Coalition to Monitor Medicare Managed Care (CMMMC) in Cleveland, OH.

Ohio State University has developed and is offering online a series of twelve fact sheets addressing key elements of effective community collaborations in the context of aging organizations. Topics range from a facilitator's guide to working with culturally diverse coalitions to how to gain support for coalitions from the private sector. These informative publications may be found at http://ohioline.osu.edu/bc-fact/0001.html or in print through the Department of Health and Human Services.

Torres, G., and Margolin, F. (2003). *The collaboration primer: proven strategies, considerations, and tools to get you started.* Health Research & Educational Trust. This manual provides assessment tools, checklists, and models of collaboration to help plan successful partnerships. http://www.hospitalconnect.com/hret/programs/content/colpri.pdf.

University of Kansas has developed a website with the objective of promoting community health and development by connecting people, ideas, and resources. It provides a variety of tools to build healthier and stronger communities. http://ctb.lsi.ukans.edu/. The actual toolkit for facilitating community coalitions entitled, *Working together for healthier communities: A framework for collaboration among community partnerships*, *support organizations, and funders* can be accessed at http://ctb.lsi.ukans.edu/tools/EN/section_1381.htm.

University of Nebraska Cooperative Extension Service also offers guidelines for building and sustaining coalitions: http://ianrwww.unl.edu/pubs/family/g988.htm.

Virginia Health Care Foundation 2002 Annual Report entitled, *A decade of making a difference, one life at a time*, features the GAIT Program, the precursor to the JABA Health Services, as "A Model that Made it." The report can be found at the Foundation's Web site: http://www.vhcf.org.

Wild Rose Foundation, Alberta, Canada, offers a workbook entitled, *Working in partnership: Recipes for success*, designed to provide assistance in developing and sustaining partnerships with community agencies and businesses. Available as a .pdf at http://www.cd.gov.ab.ca/building_communities/volunteer_community/resources/partnership_kit/index.asp

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