Community Partnerships for Older Adults
An RWJF National Program

Community Partnerships for Older Adults was an eight-year, $28 million national initiative of the Robert Wood Johnson Foundation (RWJF) that ran from 2002 to 2010 and supported communities to:

- Foster collaborative partnerships at the community level
- Build community capacity to meet the needs of an aging society
- Create long-term-care and supportive systems improvements to better meet the needs of vulnerable older adults

CONTEXT

America’s population is growing older and living longer. The senior population (age 65 and older) is expected to double in the coming decades, according to the U.S. Census Bureau. The fastest growing segment of the population is people age 85 and older—those who are most likely to need help maintaining their daily lives.

The long-term-care system is not prepared to meet these changes. It is underfunded, uncoordinated, biased toward institutional care and characterized by significant gaps in essential services. Accessing long-term, community-based health and social services is a challenging task for America’s older adults and their family caregivers, with consequences that include reduced quality of life, unnecessary health problems and premature disability.

In general, communities have not been included in the policy discussions that attempt to address the system’s challenges. Where there is community representation, it has tended to be that of a specific interest group, rather than an entity that speaks for the collective interests of an entire community.

The communities that have been able to respond to the needs and preferences of older adults and their caregivers have typically emphasized the importance of sharing information, coordinating services and systems, and promoting changes in practice and policy.
RWJF program staff believes that the best way to improve long-term care and supportive service systems is for communities to reach across institutional and generational boundaries to form partnerships. “A lot of solutions for potentially helping people age in the community lie outside the health care system,” said RWJF Senior Program Officer Jane Isaacs Lowe, who directs the Foundation’s Vulnerable Populations Portfolio.

**RWJF’s Interest in This Area**

*Community Partnerships for Older Adults* continues a longstanding effort by RWJF to help older adults remain in their homes and communities and continue to live full lives while maintaining autonomy and control over their long-term care and supportive service needs.

RWJF has funded a number of programs aimed at improving the integration of acute and long-term care, including:

- **PACE® (Programs of All-Inclusive Care for the Elderly)** coordinates and provides all needed social and medical services, including preventive, primary, acute and long-term-care, so that older individuals can continue living in the community. The target population is low-income vulnerable elders. See [Program Results Report](#) for more information.

- The Wisconsin Program to Promote Long-Term Care Insurance for the Elderly created a conceptual model for a public-private partnership that included asset protection for consumers, subsidies for purchasers of qualified policies, and incentives for purchasers and insurers. The Wisconsin Department of Health and Social Services guided the project, which was part of RWJF’s national Program to Promote Long-Term Care Insurance for the Elderly. See [Program Results Report](#) for more information.

- Under its *Medicare/Medicaid Integration Program*, RWJF funded seven states to pilot new strategies for integrating care. For example, Texas Star-Plus contracted with health maintenance organizations to integrate acute and long-term care for the Medicaid population, including nursing home care and expanded home and community-based services. The target region was Harris County, which includes Houston. For more information, see [Program Results Report](#).

- The *Home Care Research Initiative* supported primary research projects to improve knowledge about home care health policy and practice. Its projects addressed gaps in knowledge that are relevant to policy and synthesized existing research; the program worked to develop consensus on home and community-based service goals and successes, and advanced new concepts and paradigms. For descriptions of the projects funded see [Program Results Report](#).
A number of RWJF publications provide an overview of the Foundation’s work in this area, including “Integrating Acute and Long-Term Care for the Elderly,” in the RWJF Anthology, volume IV.

THE PROGRAM

Community Partnerships for Older Adults was an eight-year, $32.4 million national program that supported communities to:

- Foster collaborative partnerships at the community level
- Build community capacity to meet the needs of an aging society
- Improve long-term care and systems of support to better meet the needs of vulnerable older adults

“There is a patchwork in long-term-care services in communities,” RWJF’s Lowe said, “One of the goals was to make that patchwork behave more like a coordinated system, and to make sure that along that continuum of care, elders in communities had the breadth of services they needed.”

This program, she noted, “was an attempt to reach across the medical care system into social service and other agencies…. to try to grow awareness and interest among other sectors of the community, like transportation, and policy-makers of all sorts.”

Program Design: “One Size Does Not Fit All”

The Community Partnerships program was designed in the belief that the needs, priorities and resources of every community are unique and that bringing together resources and organizations that have historically operated in silos sets the stage for implementing a rich and varied set of solutions.

The program gave each partnership the freedom to develop products and programs that reflected their particular circumstances, rather than requiring them to apply a template set by the national program office. “We wanted to try to improve from the bottom up,” said Lowe.

However, the process by which the local partnerships engaged their communities was to be similar. Each partnership was expected to:

- Directly involve older adults as members and leaders. They were also to engage partners not traditionally involved in long-term care, such as local businesses, public health and safety officials, transportation providers, community developers, school districts, and policy-makers.
● **Develop a strategic plan supported by the community.** The plan would define the roles of individual partners and the partnership itself; articulate the community’s vision for itself; outline priorities; and identify the steps necessary to move the community toward its vision.

● **Mobilize community resources to implement the strategic plan.** This would involve identifying matching sources of funds, as required by the grant, convening individuals with influence, educating local and state decision-makers, and building support and momentum through the media and outreach.

● **Share leadership among the organizations and workgroups involved in the partnership.** While there could be several lead agencies, one organization was to serve as the partnership’s home base. The overall leadership structure of the partnerships was to represent the entire membership, fully and fairly.

● **Provide a neutral table for open and regular discussions about shared resources, sustainability and a long-term vision.** The partnerships were to nurture relationships over months and years, to enable trust to grow among members. Partners were to share decision-making and move beyond their individual organizational agendas and adopt a community-wide focus.

● **Have paid staff dedicated to supporting the partnership.** The program required that one or more individuals support the partnership on a daily basis—to plan and facilitate meetings, serve as a communications conduit among members, carry out follow-up activities, conduct research and generate reports, and coordinate work groups to ensure progress and reduce duplication of effort.

This bottom-up approach allowed each partnership to establish its own priorities among members and to promote the concept that grantees “competed against themselves and not each other in the evolution of the products and programs of their partnership,” according to a national program office report to RWJF.

The bottom-up approach had its challenges, though. Because the partnerships did not pursue a common set of activities, it was more difficult for the evaluators to make useful comparisons across sites and for the program office and its contractors to communicate what strategies worked best. See Evaluation Findings for more details.

**Management**

**National Program Office**

The Muskie School of Public Service at the University of Southern Maine in Portland, Maine, served as the national program office for the *Community Partnerships for Older Adults*. Elise Bolda, PhD, and Laura Bly, MSW, co-directed the program.
National Advisory Committee

Thirteen experts in aging and elder health and a retiree representing older adults served on a national advisory committee. The committee participated with the staffs of the national program office and RWJF in developing application guidelines, review criteria and scoring guidelines; conducting site visit/reverse site visit interviews, and assisting with applicant technical assistance. See Appendix 1 for a list of members.

Two Phases of Grantmaking

Community Partnerships was carried out in phases with two rounds of grantmaking. National program staff and the national advisory committee selected grantees through an online, competitive proposal review process that began with a national solicitation of letters of intent.

During the two grantmaking cycles, more than 1,000 applications from communities in all 50 states submitted letters of intent to apply for a grant. The review team asked a subset of those communities to submit full proposals. See Appendix 2 for eligibility criteria.

Twenty-four communities were awarded 18-month, $150,000 development grants (13 awards in 2002, 11 in 2004). The communities were quite diverse, ranging from large metropolitan areas to suburban areas to small rural towns. (See the text box on the next page.)

A lead agency or community organization in each community served as the fiscal agent for the partnership. Some leads, such as the local Area Agency on Aging, already had a primary focus on aging issues. Others were community groups with a broader mandate, such as United Way and Easter Seals; and some were small, local, public or nonprofit service providers. The main task of each partnership during the development period was to create a community-wide strategic plan.

All recipients of the development grants then submitted full proposals to implement the plans. The program awarded 16 four-year, $750,000 implementation grants, eight in each round of funding (2004 and 2006). Implementation grants required the partnerships to further develop and implement their strategic plans—including creating and executing annually revised work plans and budgets, evaluation plans, and communication plans. See Appendix 3 for a list of the projects with contact information.

Implementation Grantees

2004
Atlanta, Ga.
Binghamton (Broome County), N.Y.
Boston, Mass.
El Paso, Texas
Houston, Texas
Kahului (Maui), Hawaii
Milwaukee, Wis.
San Francisco, Calif.

2006
Ann Arbor (Washtenaw County), Mich.
Culpeper (Rappahannock-Rapidan region), Va.
Fremont (Tri-City), Calif.
Jacksonville, Fla.
Manchester, N.H.
Oak Park (Lyons Township), Ill.
Sequim (Port Hadlock), Wash.
Waynesville, N.C. (Haywood County)
Partnerships were also required to match the RWJF grant through cash or in-kind contributions at increasing levels over the course of the program—representing 20 percent of the total budget for development grantees, increasing to 25 percent in the first year for implementation grantees, and to 50 percent in the fourth year.

Technical assistance experts and contractors from the national program office, and local consultants at each program site provided technical assistance and direction through site visits, telephone consultation, extensive one-on-one coaching, and workshops at annual meetings.¹ See Appendix 4 for a list of these experts.

The national program office also compiled an array of resources on its public website to assist the partnerships and other interested communities. In addition, a password-protected website allowed staff of the partnerships to post updates and get responses from others participating in the program.

A technical assistance consortium, developed and managed through a contract with Duke University’s Long Term Care Resources Program, provided additional support. The consortium recruited teams with expertise in strategic planning, inclusion and diversity, communications, evaluation, and fiscal strategies to work with the partnership leaders.

See Appendix 5 for a list of consultants and their areas of expertise.

**Funding Match**

The partnerships met the requirement for matching RWJF funds through a host of corporate and private foundations, United Way organizations, and other private and public sources.

**Communications**

Several communications consultants worked under contract with the national program office:

- Spitfire Strategies, headquartered in Washington, provided periodic workshops on strategic communications and individual consultation to help the partnerships understand their target audiences and how best to broadcast their messages.

- Washington-based Burness Communications helped to craft focused messages about the program, produced communications products, and guided a national summit near the end of the program.

- Phyllis Bailey served as senior information officer, helping to document the impact of the partnerships.

¹ A number of the consultants were identified through the partnerships, “reinforcing the program premise that grantee communities themselves are a rich resource for program development,” noted the program’s summative report to RWJF.
See Communications Results for more information.

**The Evaluation**

A research team at Mathematica Policy Research led by Valerie Cheh, PhD, created an evaluation strategy that aimed to:

- Determine whether the program strategy helps communities design, build and strengthen their capacity for providing long-term-care services
- Inform RWJF, the national program office and the broader long-term-care delivery community about the lessons learned from the process of implementing change in communities
- Assess program outcomes over time

Evaluators first surveyed the 13 communities that had received the first round of development grants. They measured each community’s awareness of the implications of an aging society and whether they possessed the information to be knowledgeable consumers of long-term-care and supportive services.

The survey also collected baseline data to guide the partnerships as they developed their community-wide strategies.

The evaluators then did a follow-up survey of the eight communities that received the first round of implementation grants, allowing them to track changes in community awareness of aging issues and long-term-care services. They also collected information about outcomes, such as level of coordination among providers and knowledge in the community.

The evaluation strategy evolved over time to accommodate the diverse approaches of the partnerships. See Evaluation Findings for details.

**SNAPSHOTS OF THE PARTNERSHIPS’ WORK²**

Each community partnership defined its own priorities and approach to meeting the needs of older adults and their caregivers. Strategies included: developing neighborhood networks; improving the transition from hospital to home; removing cultural barriers to existing services; educating providers; supporting caregivers; expanding transportation options; and responding to crises.

---

² These snapshots are drawn from Community Partnerships for Older Adults: Local Solutions for National Long Term Care Challenges, 2009, a publication prepared by Burness Communications in consultation with RWJF and the Community Partnerships national program office, and based on interviews and site visits.
The project snapshots offered here are in no way comprehensive—each provides only a glimpse into the efforts undertaken in these communities.3,4

**Developing Neighborhood Networks**

**Milwaukee, Wis.**

The vision of the Connecting Caring Communities partnership in Milwaukee was to create communities “where older people are able to draw upon and contribute to the resources of their neighborhoods and community at large.” Residents have consistently highlighted four priorities: access to information and resources, safety, socialization and transportation.

In the Layton Boulevard neighborhood, partnership efforts focused on revitalizing the neighborhood senior center, renamed the OASIS, which included a fitness center, wellness clinic, educational programs, a revitalized meals programs, monthly town hall-style meetings of residents and a sheriff’s sub-station. A newly formed senior walking club included a regularly scheduled police escort and a senior shuttle improved access to neighborhood businesses.

The partnership has expanded its efforts to six other neighborhoods and intergenerational programs have become a key activity.

**Atlanta, Ga.**

The Aging Atlanta partnership set out to create “Lifelong Communities,” using GIS mapping to identify regions with concentrations of older adults. It also gathered demographic data and conducted surveys and focus groups to learn about the challenges facing the area’s elderly residents.

As a result, the partnership’s first priorities became housing, zoning, community design and transportation. Older adults clearly needed policy-makers and planners to consider their needs in community infrastructure decisions. The partnership began helping local communities develop and pass zoning ordinances to encourage the development of elder-friendly housing. The first such ordinance was passed in Cobb County, with six more jurisdictions following suit, resulting in 1,500 new housing units intended for seniors.

---

3 For current information about the partnerships, see the Community Partnerships Staying Connected website. Partnership websites, where they exist, are listed in the Project List.

4 The partnership in Port Angeles, Wash., is not described here as its members were unable to move forward. The partnership faced a number of challenges, including transfer of the partnership to a new agency with a different mission and goals, simultaneously loss of all staff to new jobs, and almost wholesale change in the core leadership of the partnership. Many partnerships contended with one or more of these issues, “but Port Angeles had a firestorm of all of them at once,” according to Program Co-Director Elise Bolda.
Aging Atlanta also helped low-income seniors remain in their homes by strengthening naturally occurring retirement communities to decrease isolation and increase access to services. In the East Point community, for example, the partnership created the “Safe Homes for Seniors” home repair and modification project, which has attracted support from other funders.

And in a Marion Road high-rise building, the partnership helped the Atlanta Housing Authority work with residents so that they can stay in their apartments as they age and their needs increase. As a result of this collaboration, the local Area Agency on Aging received a $375,000 grant from the federal government to expand services at the Marion Road site and two others.

**Improving the Transition From Hospital to Home**

**Jacksonville, Fla.**

Life: Act 2, the Jacksonville partnership led by United Way of Northeast Florida, identified the hospital-to-home transition needs of seniors as a top priority. Area hospitals reported a backlog of elders remaining hospitalized unnecessarily or being quickly readmitted following discharge due to difficulties accessing needed services.

In response, Life: Act 2 placed full-time elder advocates in two major area hospitals to anticipate and plan for post-discharge needs.

The Advocacy and Transitional Care Management Program—the first of its kind in the nation—was launched with Baptist Medical Center in 2008, and SHANDS Jacksonville Health System in 2009. Since then, the program has helped more than 1,400 older adults manage the transition from hospital to home and both hospitals have embedded the elder advocate program in their own operations. Efforts to expand to more area hospitals are underway.

Read *Smoothing the Transition From Hospital to Community for Older Adults in Jacksonville, Florida*, a Grantee Profile of Mark LeMaire, who directed the partnership.

**Binghamton (Broome County) N.Y.**

In rural Broome County, N.Y., where the aging population is both larger and poorer than the national averages, the well-established Aging Futures partnership also saw the hospital-to-home transition as a top priority. As a result, the Return to Home Caregiver Project offered family caregivers three months of telephone support and education after their elder left the hospital. The project also produced a video, “Now That Your Loved

---

5 Naturally occurring retirement communities are neighborhoods or buildings in which a large segment of adults are elderly, typically because they have aged in place.
One Is Home, What Do You Do?”, which was distributed to caregivers through hospitals and placed in local libraries.

An evaluation of these efforts found that 82 percent of family caregivers said their older adult would have been at risk for nursing home placement had the stress-reducing supports not been available.

**Removing Cultural Barriers to Senior Services**

*San Francisco, Calif.*

In San Francisco, the Partnership for Community-Based Care & Support focused on improving services for underserved populations, including Blacks; Latinos; Asian Pacific Islanders; and lesbian, gay, bi-sexual and transgender (LGBT) communities.

A Latino workgroup, for example, uncovered a need for multilingual case managers while a LGBT workgroup highlighted a gap in training for service providers. Workgroups produced a variety of resource materials, including information on disparities, cultural competence, and community-specific programs and services.

In 2004, the Area Agency on Aging adopted the partnership’s strategic plan as its guide for addressing the long-term-care needs of San Francisco’s aging and disabled population. Many partnership members now sit on the Long-Term Care Coordinating Council, which reports directly to the mayor’s office and offers policy recommendations. Read *Bringing the Table to the Community in San Francisco*, a Grantee Profile of the effort.

*Fremont (Tri-City), Calif.*

English is not the first language for just over half the older adult population in Fremont, and 14 percent live in households where no one speaks English. The Pathways to Positive Aging partnership of the Tri-City Elder Coalition reached out to a wide range of immigrant populations, whose seniors typically don’t interact beyond their own families or close-knit communities.

To reduce their isolation, Pathways to Positive Aging created the Community Ambassador Program, which trained 88 volunteer “ambassadors” from seven ethnic and faith communities to provide information and referral services to seniors. It also created ethnicity-based support groups for local older adults, and provided health-promotion training for the Afghan community, which worked well enough for the neighborhood hospital to detect a drop in emergency visits among that population.

Pathways also secured changes in local bus routes to help isolated seniors reach the India Community Center and the local Sikh temple. Staff trained bilingual volunteers to serve as interpreters and to provide falls-prevention education. Further, the area’s ELDERSafe
Senior Help Line, which links older adults with area services, is now able to respond to callers in English, Farsi, Spanish and Mandarin.

**Educating Providers, Supporting Caregivers**

**Boston, Mass.**

The Boston Partnership for Older Adults found high rates of poverty and lack of access to geriatric health care among the city’s older adult population.

To address the shortage of physicians who understand how best to care for older adults, the partnership worked with several local geriatric specialists to develop a functional assessment tool. Available to all primary care physicians, the tool helps to identify issues that are important to their older patients.

The partnership also created a questionnaire to help patients interact more effectively with physicians who have not been trained in geriatrics. The questionnaire is available in English, Chinese and Vietnamese. Both the functional assessment tool and patient questionnaire were available on the project’s website.⁶

**Waynesville (Haywood County), N.C.**

In Waynesville, Haywood Community Connections recognized the vital role that family caregivers play in long-term care and sought ways to support them.

The partnership sponsored a conference for caregivers, held November 2007, and featuring panels and discussions on topics that included caring for people with Alzheimer’s disease and dementia. A “Kit for Caregivers” with a variety of resource materials for caregivers was distributed at the event.

The partnership also successfully advocated to expand Project C.A.R.E. (Caregiver Alternatives to Running on Empty), a comprehensive respite program piloted by the state, and promoted the Alzheimer’s Association’s Safe Return program, which helps to identify with wristbands older people found wandering in the community.

Read *Overcoming Scandal and Promoting Collaboration to Benefit Vulnerable Elders*, a [Grantee Profile](#) of the partnership.

**Kahului (Maui), Hawaii**

In Maui, the Aging with Aloha® coalition worked with high schools to increase the supply of long-term-care workers on the island.

---

⁶ “Functional Assessment Tool for Primary Care Physicians” and the “Patient Questionnaire” were previously available online.
The partnership developed and piloted a caregiving curriculum and career-shadowing program, called Health and Medical Career Pathways, for students enrolled in four high schools. The curriculum, which covers the challenges of aging, types of aging services, and the structure and function of the aging services system, is now being considered by the state Department of Education as a model for similar programs around the state.

Many students who complete the high school curriculum continue to study long-term care at Maui Community College, which hosts the partnership.

To further expand the long-term care workforce, the partnership also created the Volunteer Caregiver Pilot Project and the Maui Care Corps Initiative, which has recruited and trained more than 80 volunteers each year for three years.

Read Getting Ready for the Looming “Silver Tsunami” in Maui, Hawaii, a Grantee Profile of Rita Barreras, who heads the partnership.

**Expanding Transportation Options**

**Culpeper (Rappahannock-Rapidan), Va.**

The Aging Together partnership in Culpeper, which serves five rural counties in the Rappahannock Rapidan region, identified mobility and transportation as priorities for older adults. According to Aging Together, isolation is a problem in remote areas of central Virginia, especially for at-risk, low-income elders and their caregivers.

The partnership created the Consolidated Human Services Transportation Plan to bring regional transportation partners together. The region then received federal funds to hire a mobility manager to implement the plan, which has been cited as a model by the state Department of Transportation. The federal government also funded a mobility specialist to assist area seniors and people with disabilities in using the transportation system.

Aging Together also secured funds from the Virginia Department of Rail and Public Transportation to support volunteer transportation networks for seniors in all five counties. One such network, VolTran in Fauquier County, draws on the services of some 30 volunteer drivers.

**Ann Arbor (Washtenaw County), Mich.**

In Ann Arbor, where transportation needs ranked high in a survey of area seniors, the Blueprint for Aging partnership launched a pilot transportation voucher program that has since become part of Washtenaw County’s transportation plan.

The program gives vouchers to seniors, who can then “spend” them on formal transportation providers, such as taxi and ride-sharing services, or on informal providers, such as family and friends; the vouchers can then be turned in for cash. Seniors who
participated in the pilot used the vouchers primarily with informal providers and said they felt like less of a burden when they were able to give their drivers vouchers in exchange for rides.

**El Paso, Texas**

The SALSA (Successful Aging Through Long-Term Strategic Alliances) partnership in El Paso focused on improving aging services in this low-income community on the U.S.–Mexican border. Among other efforts, SALSA successfully brought aging issues to the forefront of a local transportation summit. As a result, a regional mobility coalition was formed, with county government as the lead, to blend local, state and federal funds in order to consolidate transportation services region-wide.

**Responding to Crises**

**Manchester, N.H.**

Seniors Count created several new programs for at-risk seniors in Manchester, where many frail, low-income seniors live alone and have significant unmet needs.

The Community Liaison Initiative sends case managers to their homes to function as “surrogate eldest daughters,” helping them apply for assistance, find alternative living arrangements, obtain needed services and more. Community liaisons also help seniors access a “Flex Fund,” intended as “unconditional, hassle-free” assistance in paying for such things as prescriptions, food, microwaves, refrigerators, air conditioners, heating oil, wheelchair ramps and home repairs.

Seniors Count also developed a respite care model that allows short-term nursing home stays for seniors for a variety of reasons, including when a sole caregiver is temporarily unavailable or extra care is needed. A social worker coordinates the stays and ensures a smooth transition back to the community. The average length of stay is about two weeks.

Read *Bringing Community Supports to “Invisible” Frail Elders in Manchester, N.H.*, a Grantee Profile about the partnership’s activities.

**Houston, Texas**

In Houston, the Care for Elders partnership was put to the test following Hurricanes Katrina and Rita in late 2005.

Through its existing ties, Care for Elders mobilized volunteers quickly and was able generate contributions of cell phones, computers and other resources from partners to help support seniors. The partnership developed and deployed a rapid screening tool, called SWiFT, which allowed volunteer teams of medical providers and social workers to quickly assess cognition, physical abilities, and medical and social service needs among
at-risk, displaced seniors who had been evacuated to Houston’s Astrodome and other shelters in the Gulf Coast region.

Following SWiFT assessment, Care for Elders coordinated case management services to some 2,000 older adults at four locations.

Based on these experiences, the partnership contributed to the report: *Recommendations for Best Practices in the Management of Elderly Disaster Victims*.7

See Grantee Profile of project director Jane Bavineau.

**Oak Park (Lyons Township) Ill.**

A major priority of the Aging Well partnership in Lyons Township was to get isolated and at-risk seniors the help they need immediately.

After a community survey found a dire lack of information about where to find help for seniors, Aging Well created the “One Call” campaign, which marketed a single phone number that anyone could call to link an older adult to services. The partnership has attempted to saturate the local area with the phone number, developing a variety of marketing materials and using teams of volunteers to reach out to local governments, service providers and businesses frequented by seniors.

The partnership also has trained 300 first responders—police and firefighters—to recognize the signs of distress in older adults and make that “One Call” to locate appropriate help.

Read *Older Adults Spearhead Grassroots Effort in Lyons Township, Ill., to Promote Age-Friendly Communities*, a Grantee Profile of Aging Well’s activities.

**OVERALL PROGRAM RESULTS**

The national program reported the following results to RWJF.

**The Influence of Community Strategic Plans**

In a number of cases, the strategic plans developed by the partnerships became benchmarks for funding organizations as they considered how best to allocate local resources for programs targeting older adults. They also served as a foundation for community dialogue. For example:

- Some local foundations in Boston, Houston and Milwaukee required potential grantees to explain how their work fit with the community-wide strategic plan.

---

In Boston, one foundation decided to continue its focus on supports to older adults as a result of the strategic plan and used the plan to frame its priorities.

- In Ann Arbor, Mich., United Way tapped the partnership to help guide its funding for programs working with older adults.

- Several communities built on the strategic planning process to hold annual community conversations or community-wide events to celebrate and review their progress. Several communities also developed new, multi-year strategic plans to improve support systems for older adults after Community Partnerships funding ended.

**Raising Awareness of Aging Issues**

The community partnerships helped put aging issues on the civic agenda by consolidating data about aging adults and making it more readily accessible. For example:

- In Ann Arbor, the partnership created a “Senior Data Book” that contained information about the needs and issues of aging adults. Before the partnership existed, “aging did not have a place on the community agenda,” said Jill Kind, the director. “In fact, the most important community survey in the county did not even separate ‘older adults’ and consequently there was little funding for aging issues.”

- The Boston partnership’s data collection “was the first time anyone had pulled together the whole picture of aging in our city,” said Emily Shea, executive director of the Boston partnership. “People are still using this information when they prepare grants…. The maps of services we created are still being used for community planning.”

**Partnerships as a Resource and Problem-Solver**

Many partnerships became resources in their communities and offered a safe forum at which to discuss community challenges and get help in identifying solutions. “A trust factor has been developed,” Program Co-Director Bolda said. “I hear them talk about it: ‘When I get into this room, I feel safe.’ They will say, ‘Our agency was in trouble and we brought the problem to the group, and the group helped to find a solution.’”

For example:

- In Waynesville, N.C., the core leadership group implemented an emergency plan to maintain services following the collapse of the local human services infrastructure in the midst of fraud and corruption charges. As a result, they continued providing key home- and community-based services when county officials abruptly shuttered the multi-service agency responsible for most services and supports to older adults.
- After the state closed the county Adult Protective Services Unit (again, for mismanagement), the El Paso, Texas, partnership helped to fill some of the voids in service with public education programs and neighborhood watch groups.

- Several partnerships (including in Houston and Broome County, N.Y.) built on their collaborative relationships to mount community-wide responses to natural disasters. As a result, they were able to deliver needed supports to older adults in crisis.

- Recognized as a source of information, support and linkages, many partnerships functioned as conveners to address new issues, collaborators on grant proposals, and brokers of technical assistance to benefit the broader community.

  “People saw the ability of the partnerships to get things done,” said Bailey in the national program office. “A number of the partnerships were approached by other groups in their communities, asking ‘Gee, I want to try to do x. Can you teach me how to do that?’”

**Reaching the Underserved**

Several partnerships redefined services to target frail elders who had previously been at the edges of the system. They also strengthened diverse groups—defined by geography, race/ethnicity or affinity—in order to improve neighborhoods and increase access to services for underserved older adults.

One example, described in Snapshots of the Partnerships’ Work, is the community ambassador program created by the Pathways for Positive Aging Partnership in Fremont, Calif., which reached out to seven faith and ethnic communities. Other examples:

- **After a survey revealed that many isolated, homebound elders in San Francisco public housing lacked access to needed supports, the partnership invited service providers in and created service teams to link them with residents.** This helped to break through many organizational silos and connect residents to transportation, home care, medical care, meals, exercise programs and other services.

  Building on a strengthened relationship with city public housing officials, the partnership and the Housing Authority jointly applied for a ROSS Service Coordinators program grant through the federal Housing and Urban Development (HUD) and won a $375,000 award.

- **In Boston, the partnership’s Elder Protection Committee trained more than 600 officers and command staff in the Boston Police Department to recognize signs...**

---

8 The Resident Opportunities and Self Sufficiency (ROSS) Service Coordinators program provides funding to hire and maintain service coordinators who assess the needs of residents in public housing or Indian housing and coordinate available resources in the community to meet those needs. See HUD website for more information.
of elder abuse, neglect and financial exploitation. After this training, reports to Elder Protective Services increased by almost 800 percent from 2004 to 2007.

- **Aging Atlanta’s outreach to under-served populations included a door-to-door survey of isolated older adults in conjunction with the fire department and other partners.** Staff also created training materials about the needs of gay, lesbian, bisexual and transgendered adults as they age.

After determining that many residents of the Cherry Blossom neighborhood of East Point were afraid to leave their homes unescorted and had not exercised in many years, the partnership established a walking club. Along with improving their health, participants commented on the opportunity to meet their neighbors.

**Recognition and Awards**

Several partnerships received recognition or awards that they attribute, at least in part, to their work under the Community Partnerships program. For example:

- **Four grantees received “Livable Community” awards from the federal Administration on Aging.** The awards contributed to the growing awareness of the program through media coverage.

- **The Haywood partnership in Waynesville, N.C., was awarded an Acts of Caring award** at a National Association of Counties meeting in Washington in April 2008.

- The Department of Aging and Adult Services in San Francisco received a national award in 2010 for its Alzheimer’s disease program. Parts of the initiative grew out of the original San Francisco Partnership for Community-Based Care & Support.

**Sustainability of the Partnerships**

- **Four of the eight communities that received only development grants ceased their work as staffed partnerships at the end of the grant period.** Some of these communities, especially those in rural areas, did not have the resources for ongoing staff and infrastructure support for collaborative community-wide partnership development.

One exception was the partnership in El Dorado, Ark., which created a strategic plan to provide support to older adults, and became a pilot site for the Aging and Disability Resource Center (ADRC), a federal initiative. Several other partnerships also had ADRC affiliations.

---

9 The awards went to Charlottesville, Va., which had received a development grant; and Atlanta, Broome County, N.Y., and Milwaukee, which had won implementation grants.

10 The Rosalinde Gilbert Innovations in Alzheimer’s Disease Caregiving Legacy Awards awarded $20,000 to three programs at the national 2010 American Society on Aging conference.

11 More information about the Aging and Disability Resource Center is available online.
Thirteen of the 16 partnerships that received implementation grants were continuing their work in some form at the end of the grant period. A mix of funding mechanisms—including no-cost extensions of the RWJF grant, local funding and federal grants—supported their activities.

For example, Chittenden County, Vt., continued their collaborative work and received funding for other, unrelated initiatives, such as RWJF’s workforce development program Better Jobs Better Care. See the Program Results Report on that program.

See Afterward for more details.

Innovation and Spread

A number of the partnerships were able to pilot new or best practices, assess their viability and influence their broader adoption. Some of these local solutions were institutionalized or translated into policy. See Snapshots of the Partnerships’ Work for more about the spread of zoning ordinances in Atlanta to promote senior housing and the embedding of elder advocates in two Jacksonville, Fla., hospitals.

Other examples of spread include:

- **Six counties in the Atlanta region replicated a transportation voucher program that Aging Atlanta initiated in the East Point community, it has since been adopted as a permanent program in DeKalb County.**

- **New Hampshire provided funds to replicate the Manchester partnership model in Portsmouth and Nassau.** Seniors Count offered coaching to representatives of partner agencies in these towns. The Manchester model included a liaison who could work across organizational boundaries and a flexible fund that helped to meet short-term needs without a lot of paperwork (for example, to purchase an air conditioner for an older adult). “The state realized that this was really a different way of doing business that was having an impact and saving money,” noted Phyllis Bailey, senior information officer in the national program office.

- **In Hawaii, the state director of Human Services adopted the Maui partnership’s Going Home initiative, which allows long-term care clients to be discharged from hospitals to a more cost-effective foster family setting.** After the state changed an administrative rule so that Medicaid dollars could follow the client, 750 elders were placed into foster families from 2003 to 2006, saving Medicaid some $70,000 per patient year, or a total of $52 million, according to the grantee.

- **The Milwaukee partnership documented its model in Connecting Caring Communities: Won’t You Be My Neighbor? so that it could be replicated.** Elements of the model included revitalizing neighborhood gathering places, creating a network for caregivers that included training on dealing with grief and dementia care; and developing posters, public service announcements and tool to communicate
with elder residents and their families. Several neighborhood groups used the manual to become more age-friendly.

- **The Boston partnership’s Elder Friendly Business District initiative became a model for “Main Street” groups in other Boston neighborhoods and Massachusetts communities.** The initiative—which promotes improved lighting and product placement within stores, and safe and accessible sidewalks and crosswalks outside—also was presented at a national Main Street conference.

**Public Funding to Support Partnership Goals**

Although public funding for aging services has been hard hit by the economic downturn, some partnerships helped to build a case for increasing the availability of public dollars. Examples of public support for partnership goals:

- **Influenced by the San Francisco partnership’s convenings and discussions, the mayor and board of supervisors allocated $3 million in funding to enable older adults to transition from institutional care to community living, in part due to partnership efforts.**

- **In New Hampshire, state Health and Human Services administrators used state and federal funds to contract with the Manchester partnership to replicate the model in two additional communities.**

- **County funding to help cover partnership operating expenses in Waynesville, N.C., Culpeper, Va., and Kahului (Maui), Hawaii, has been renewed for several years.** In Virginia, the state legislature also renewed state funds for core partnership expenses and specific initiatives.

- **The Manchester, N.H., partnership was one of about a dozen organizations awarded funding in the first round of the federal Community Innovations for Aging in Place grants.** Organizations affiliated with the Atlanta and Houston partnerships also received grants.

**Communications Results**

The national program office found it difficult to sustain a coherent communications effort, in part because of the diverse nature of the partnerships, program staff said. Plans to shift from grantmaking to disseminating experiences in the final years of the program were stymied by the absence of strategic communications capacity, specifically “lack of

---

12 Main Street is a national movement that enables communities to revitalize downtown and neighborhood business districts by leveraging local assets—from historic, cultural and architectural resources to local enterprises and community pride. See the website for details.

13 The Community Innovations for Aging in Place initiative was authorized by Congress in the Older Americans Act reauthorization of 2006 to assist communities in their efforts to enable older adults to sustain their independence and age in place in their homes and communities. See website for details.
staff, absence of leadership and inadequate strategic development,” the national program office reported in August 2006.

Burness Communications became involved in 2008 to help sharpen the program’s message. “We helped craft messages to make sure the work of the program was articulated in a way that could be passed on as a legacy,” Kay Campbell, a Burness consultant, said. But she said challenges remained. “The program was very hard to articulate. It’s a complex message.”

Burness Communications:

- **Organized a national summit, “Workable Solutions to Long-Term Care Challenges,” in conjunction with the program’s annual meeting.** The event, held October 29, 2009, in Washington, drew some 155 national, state and community leaders, including:
  
  - Representatives from aging, health policy and civic organizations, such as Families USA, the National Council on Aging and the National League of Cities
  
  - Individuals from government agencies and Capitol Hill, including representatives of the Veterans Administration and the Senate Special Committee on Aging
  
  - Foundations and area universities, including Atlantic Philanthropies and the University of Maryland’s Center for Aging Studies

  A live webcast of the summit drew an additional 64 virtual “attendees.”

- **Helped the national program office draft and produce Community Partnerships for Older Adults: Local Solutions for National Long Term Care Challenges, which debuted at the Summit.** It is a “leave-behind to educate others about how to do this in your community and to build awareness of this unique effort,” said Campbell.

See the [National Program Office Bibliography](#) for other communications products.

**EVALUATION FINDINGS**

The Mathematica team had originally planned to evaluate the changes occurring in local long-term-care systems as a result of the partnership activities, but their many different approaches made measuring outcomes challenging.

“There are many creative and exciting ways to work collaboratively to improve the long-term-care system,” Lead Evaluator Cheh said. “However, despite the potential for creativity, the partnership model may not always result in measureable outcomes.”

---

14 A video of the conference was available online.

15 Phyllis Bailey did most of the interviewing for this publication.
Partnerships often do not have the consistency and mandate that you have with other organizations.”

As a result, said Cheh, many of the original evaluation strategies did not pan out. Ultimately, Mathematica tracked changes in the partnership communities, where feasible, but also examined the characteristics of the partnerships—their leadership, their operating structures and lessons learned from their strategies.

Key findings, based on published reports and interviews with Mathematica evaluators, are summarized below. See Appendix 6 for a summary of evaluation reports and the Evaluation Bibliography for links to the publications.

**Measureable Changes in the Communities**

- **While awareness and use of community-based services increased in the communities where partnerships were located, there was a slightly greater increase in the proportion of vulnerable adults who tried but could not access services.** The finding suggests a continuing need to develop creative approaches to help older adults age in place.\(^\text{16}\)

- **Policy-makers were unable to link changes in state policy to partnership activities, but at the local level, the link was more apparent.** Because so many competing factors and players influence the development of state policy, it was difficult both to see a direct link between advocacy and outcomes. However, local policy-makers did recognize the contributions of the three partnerships that worked to influence community-level policies.\(^\text{17}\)

- **Most grantees had difficulty using the media to increase awareness of aging issues.** Citywide media campaigns were largely beyond grantees’ reach and the return on investment in resources to influence coverage by local newspapers appeared to be minimal. However, while media discussions of long-term-care issues declined nationally, there was an increase in media items about long-term-care providers and community living for older adults in program communities.\(^\text{18}\)

\(^{16}\) *Community Partnerships for Older Adults Effect of CPFOA Partnerships on Vulnerable Adults’ Ability To Age in Place: Findings from the Second Community Survey of Older Adults*, Kim Jung and Valerie Cheh, September 2010.


\(^{18}\) *Spreading the Word About Aging and Long-Term Care: Community Partnerships’ Efforts to Influence the Media*, Angela Gerolamo and Valerie Cheh, February 2007.
Partnerships as a Workable Strategy for Community Change

Among the findings from the evaluation studies examining various aspects of the partnership model:

- **Partnerships are not necessarily the best way to implement a project.** While the planning phase of the project did require a coalition, nearly half of all the grantees’ tactics during implementation could have been used by individual organizations.\(^{19}\)

- **In a study of how partnership governance structures and processes influenced the outcomes of seven community partnerships, the evaluators concluded that better structures lead to better outcomes.**\(^ {20}\) Among the other findings:
  
  — The extent to which leadership team members were aligned on their priorities was related to community impact, but not to other outcomes.
  
  — Leadership teams in which many members were involved in communication perceived greater organizational benefits (such as developing collaborative knowledge) than did teams that had few members involved.
  
  — Leadership teams with either a shared or centralized governing style tended to have greater community impact, compared to those with a blend of styles.\(^ {21}\)

- **In a survey of seven leadership teams, the evaluators found that slightly more than half the leaders were held in high esteem.** Leaders held in high esteem were those identified by others on the team as having good ideas, being involved in productive relationships and playing important roles.

However, that finding masked substantial variation across teams. For example, only 26 percent of the leaders on one team were held in high esteem in 2007, compared to 94 percent on another. Among other findings:

  — All types of leaders were held in high esteem. However, those who represented organizations that focused on aging issues were most likely to be held in high esteem, especially after the partnerships had begun implementing their projects.
  
  — A very large proportion of the leaders from the applicant agency were held in high esteem, compared to leaders from other partnership organizations. This difference suggested that the applicant agency had significant influence over the partnership.

\(^{19}\) *The Community Partnerships for Older Adults Program Cross Site Report*, Valerie Cheh, Bridget Lavin, Beth Stevens and William Black, December 2005.

\(^{20}\) Components of structure in this context include goals, how large the partnership is, the types of organizations involved and the number of workgroups. Process refers to the activities and governance of the partnership.

— Leaders who were not as highly esteemed were more likely to leave the leadership team, which imposed a cost in time and resources.\(^{22}\)

**SIGNIFICANCE OF THE PROGRAM**

RWJF Senior Program Officer Lowe noted that the program called attention to long-term-care innovations in communities across the country. She also emphasized the broader value of partnerships, which demonstrate “that what’s good for older adults in the way of community or local policy is good for everybody in the community.

“It became very clear that the partnerships were not just the voices of older adults and the organizations that served the older adults. Where possible, they could bring together others on certain issues. For example, if there was an ordinance for creating open space or a park, that was as important for people working with frail older adults as it was for people with children.”

Bailey agreed about the importance of partnerships, which she said “brought civil discourse back to the communities. In a lot of communities that we gave grants to, people were used to being in their stove pipe and there really was not a lot of incentive to get out. Partnerships created that neutral table, where the bottom-line expectation was that you talk to each other, you do it with courtesy, and you do it understanding that it serves all of your interests.

“You can actually end up doing some pretty amazing things like attracting new resources, or making the ones you have go a lot farther in a scarce environment.”

**LESSONS LEARNED**

These lessons are gleaned from the national program office’s Summative Report to RWJF and evaluation reports; and interviews with RWJF staff, the national program office staff and representatives of the community partnerships.

**Community Partnerships**

*Fostering Collaboration*

1. **Partnerships take time to develop and need to be continually nurtured.**
   Partnership building is a long-term process yet the grantee communities tended to operate within a culture focused on short-term needs and economic emergencies.

---

\(^{22}\) *Who Are the Influential Leaders in Partnerships—and Do They Stay?* Valerie Cheh and Todd Honeycutt, February 2010.
“Those relationships have to grow and they have to be tested to create trust,” said Senior Information Officer Phyllis Bailey.

Working on tangible projects can help. “If your theme is collaboration—getting people to work together across the silos of their agencies—you have to have projects to work on,” said Arlene Kershaw, head of the Manchester, N.H., partnership. “You can’t break down silos by talking, you have to do it by working on projects together and finding those similar reasons to do it.”

As an example, Kershaw cited the partnership’s effort to clean the yards of seniors. “The success was not that we cleaned 200 senior yards,” she said. “The success was getting multiple agencies to figure out how to leverage their resources and put together a system where every fall you are cleaning the yards of frail seniors.”

2. **Identify the core elements of a community partnership early on.** “We did not identify the core elements until the seventh year of the grant,” reported the national program office to RWJF. Only then did it become “much easier to articulate the essence of the community partnership work, and what partners were being asked to commit to.”

The national program office also wrote that the difficulty defining the program also made it difficult for communications firms hired by RWJF to “undertake long-term, consistent, or wide-scale enough efforts to support the many lessons and progress of the program for the purpose of creating sustainability.”

3. **If you expect policy change and sustainability from a partnership effort, leadership and resources need to be devoted to them from the start.** According to the national program office, the program was seen as one of community capacity-building, with policy change and sustainability as secondary priorities. “Without explicit leadership and resources dedicated to the second and third priorities, these important efforts languished,” the national program office reported to RWJF.

4. **Sustaining community partnerships requires strong lead organizations.** “Every site that had a strong organization behind it—whether it was the Easter Seals in Manchester, N.H., or the United Way in Jacksonville, Fla., or a very large strong nonprofit, such as an Agency on Aging Services, or the county-run Department of Aging—did better,” Lowe said. “It is about infrastructure and it is about leadership and it is about vision.”

5. **Find ways to explain the concept of community partnerships.** The concept of community partnership is more abstract than the more easily quantifiable “units of service” or other aspects of direct service that are used to build a sense of results, return on investment or credibility. According to a report to RWJF from the national program office, difficulty articulating the concept sometimes hampered communication and attempts to build local and national support, although many grantees grew more articulate about the power of working together over time.
6. Celebrating success and articulating results builds a sense of accomplishment and feeds the energy to continue. To sustain interest in a partnership over time, it also helps to periodically reflect on where it has been and where it is going.

Every six months or so, the Jacksonville, Fla., partnership held a “pause and reflect” session, the partnership’s former director Mark LeMaire reported. “We take time with our core staff and volunteers to step back and say, ‘How are we doing? Who haven’t we seen in a long time? How are we doing on our metrics? Any opportunities we are not paying attention to?’ It sounds like a simple thing, but it helps us stay on track.”

7. Do not be blindsided by naysayers. “There are a few people in the community who don’t understand what we do,” said Rita Barreras, head of the Maui Partnership. “They don’t agree with collaboration, they question you, they wonder what you are doing. Be aware that you are always going to have that. It’s too bad, but that happens in life.”

8. Keep older adults and people from the community involved in a meaningful way. People stay engaged and invested when their voices are heard. Populations that are typically not included in strategic conversations were initially cynical and then excited about being included, the national program office reported.

As the Houston Partnership noted in a report to RWJF: “There are many ways to engage older adults and family caregivers in the partnership’s work. The opportunity for success with funders, providers and policy-makers is greatly enhanced when the partnership’s goals and strategies are grounded by input, feedback and priority-setting by consumers.”

9. Turf issues are hard to break down and typically must be dealt with more than once. A number of partnerships described turf issues with their Area Agency on Aging, which did not always support partnerships that included representatives outside the aging field. “The turf issues didn’t come up just one time,” Senior Information Officer Bailey said. “They came up over and over and over and you had to address them. In some places, the Area Agency on Aging became a leader or a key partner; in other places, they were like a thorn in their side.”

The Houston partnership, for example, reported that efforts to integrate their work with the agency “were often met with resistance, inaction or a lack of interest,” but that persistence and compromise paid off. In cities where Area Agencies on Aging were the host organization (Atlanta, San Francisco, Milwaukee and Culpeper, Va.), the leaders reported that the partnership “broadened our approach and how we operate.”

10. Take a positive approach when dealing with policy-makers, rather than shaming them. “We didn’t go to the state and say, ‘We need more money from Medicaid, and shame on you for not doing this,’” New Hampshire’s Kershaw said.
“We said, ‘We want you to be everything you should be. That is your charge. But we are not going to wait around when there is so much work to be done. We are going to pull ourselves up by the bootstraps as a local community and work on this as your partner and not just expect you to fund everything.’ I think that gave us an enormous amount of credibility.”

**Partnership Management**

11. **Reduce and focus the number of priorities and strategies for action.** With so many groups and interests at the table, many partnerships struggled with “mission creep.” In a report to RWJF, the Boston partnership noted: “If we were creating a community-wide plan again, we would examine the number of workgroups and narrow our focus. It was challenging to have so many goal areas and we found that we couldn’t do all that we wanted in the time that we had.”

12. **Run the partnership as if it were an organization.** Several partnerships noted the need for a formal structure with governance tools, such as memoranda of understanding. A joint decision-making and consensus-building process is also crucial. Partnerships need to communicate well, using many tools, including blogs, email and meetings, so participants are up to date and can be ambassadors for the partnership. (Barreras/Maui Partnership, National Program Office Report to RWJF)

13. **Keeping a partnership focused, organized and productive requires paid staff.** The partnerships uniformly reported the importance of having staff to handle administrative tasks related to such things as group process, project management and communications. “To have a community system operate similarly to an organization, you have got to have staff,” said Barreras of the Maui partnership.

Bill Haskell, project director of the San Francisco partnership, concurred: “You can organize all the workgroups you want, but if it doesn’t have the staff that follows through with the minutes, meets with the co-chairs, develops the agenda for the next meeting and follows up on unresolved issues, nothing gets done.”

14. **Manage meetings efficiently so participants feel the time is well spent.** That means having a clear agenda, starting and ending on time, and respecting people’s contributions.

“There is a lot of work we put in, before during and after a meeting to make sure that we are getting the most of our members,” said LeMaire of the Jacksonville, Fla., partnership. “It is hard when you get busy to pay attention to all of that. But because we have paid attention, and still do, people want to show up at the table.”

**Fiscal and Leadership Challenges**

15. **Seek opportunities to turn an economic crisis to advantage.** Budget cutbacks, staff reductions and intensified competition for fewer resources at a time of increased demand threatened the viability of the local community structures created by the
grantees. This was especially problematic in communities with weak infrastructure and a lack of civic engagement.

But economic stress also encouraged collaboration in some communities. “It was understood that working in partnership could make resources go farther and help the community keep their eyes on the larger picture/vision,” the national program office reported to RWJF. “New opportunities arose in advocacy ‘to help people pull together above the fray.’”

16. **Because partnerships are never static, there is an ongoing need to build leadership capacity.** Nearly every partnership site experienced disruptive changes in staff and leadership as a result of turnover, illness and other transitions. In some cases, the lead or host organization changed altogether.

   “Leadership shifts make or break the work,” said Program Co-Director Bly.

   “You need to be growing capacity constantly,” said Bailey. “Sometimes new strengths emerged.”

17. **Work on sustainability from day one.** A number of the partnerships struggled with how to sustain their work after RWJF funding ended. The Boston partnership, which ceased operation after the grant period, reported: “If we had it to do over again, we would recruit organizations/others with deep pockets, become a 501(c)(3) within the first two implementation years, and hire a staff member to focus on fundraising from the beginning.”

**Evaluation**

18. **The social network analysis methodology developed and used in the evaluation should be replicated.** Social network analysis pays attention to the structure of the relationships between people as well as the attributes of those people. The evaluators believe that this method can be used to help understand how organizations work and can affect change. (Evaluation Final Report)

19. **Use the evaluation process to give grantees information that they can use immediately.** The Mathematica evaluation team invited the partnerships to add questions specific to their own communities to the first survey. “If baseline information is being gathered,” Program Co-Director Bolda said, “permit the individual grantee to participate in that and benefit from that, instead of simply looking at it as an overall program evaluation tool. You get more bang for the buck. In that instance, it was an incredibly valuable resource.”

---

23 Social network analysis is used to map and measure human and organizational relationships, both visually and mathematically. This approach views relationships in terms of nodes and ties—nodes are the individual actors in networks; ties are the relationships between the actors. See the Mathematica Issue Brief “Making Connections: Using Social Network Analysis for Program Evaluation” by Todd Honeycutt. November 2009. Available [online](#).
20. **Give regular feedback to grantees about what the evaluation is discovering.** At annual meetings, Mathematica presented what they had learned to the partnership leaders. Not all partnerships were interested, but many “were very enthralled with anything Mathematica could share with them,” said Bolda.

**AFTERWARD**

Fourteen of the 16 Community Partnerships sites that received implementation funds continued some level of activity at least through the summer of 2010. However, with the close of the national program office, the activities and funding structures of most of the partnerships did not continue to be closely tracked.

Atlanta, Milwaukee and San Francisco embedded their partnerships into their lead agencies. For example, the Aging Atlanta Partnership has been integrated into the Area Agency on Aging; the Partnership for Community-Based Care & Support in San Francisco now serves on the coordinating council that guides the city’s long-term-care strategy. Other partnerships operated with local funding or staff support from partner organizations.

The partnerships in Boston, El Paso, Texas, and Port Angeles, Wash., ceased operating at the end of the grant period.

**Ongoing Collaboration**

Thirteen of the partnership communities continue to share information and collaborate through a “Staying Connected” group.24 “The purpose is to continue the practice of the ‘teaching and learning model,’ where the communities can share resources, ideas and projects with each other,” said Nancy Giunta, who worked with the San Francisco partnership, as a consultant with the national program office and has helped to facilitate Staying Connected.

The group has adopted a preliminary statement of purpose and has a fiscal agent through which member organizations contribute funds for the facilitator. Members have met twice, in conjunction with the 2009 and 2010 annual conferences of the American Society on Aging/National Council on Aging.

**Other RWJF-Funded Efforts**

In April 2008 the Institute of Medicine (IOM) issued a report, *Retooling for an Aging America: Building the Health Care Workforce*, which calls for fundamental reform in the way that care is delivered to older adults and puts forth a plan to help ensure that the size

---

24 The group keeps in touch through a [blog](#) that has links to each of the 13 partnerships’ websites.
and skill level of the health care workforce is sufficient to handle the needs of a new generation of older Americans.

The report was the product of a 15-month RWJF-funded effort by the IOM’s Committee on the Future Health Care Workforce for Older Americans. See the report online.

Prepared by: Kelsey Menehan
Reviewed by: Karyn Feiden and Molly McKaughan
Program Officer: Jane Isaacs Lowe
Evaluation Officer: Brenda Henry
Grant ID#: CSL
Program area: Vulnerable Populations

25 Grant ID# 57803. See Program Results Report.
**APPENDIX 1**

**National Advisory Committee**

**Carol Austin, PhD, MSW**  
Professor  
University of Calgary School of Social Work  
Calgary, Alberta, Canada

**Barbara Bowers, PhD, RN**  
Professor  
University of Wisconsin-Madison School of Nursing  
Madison, Wis.

**Cynthia Henderson, MD**  
Administrator  
Cook County Hospital  
Chicago, Ill.

**Jeffrey Henderson, MD, MPH**  
President and CEO  
Black Hills Center for American Indian Health  
Rapid City, S.D.

**Barbara Hirshorn, PhD**  
Affiliate Faculty Member  
Institute for Families in Society  
University of South Carolina  
Columbia, S.C.

**David Ishida**  
Regional Administrator  
U.S. Department of Health and Human Services  
Administration on Aging  
San Francisco, Calif.

**Bob Logan**  
Director of Medicare Community-Based Enrollment  
National Association for Area Agencies on Aging  
Washington, D.C.

**Larry O'Donnell (retired)**  
Ridgewood, N.J.

**Rosa Ramirez, MPA, MSA**  
Gerontology Consultant  
Victorville, Calif.

**Donna Regenstreif, PhD (retired)**  
Jensen Beach, Fla.

**Herb Sanderson**  
Director  
Arkansas Department of Health and Human Services  
Division of Aging and Adult Services  
Little Rock, Ark.

**Little Rock, Ark. Fox Wetle, PhD**  
Chair, Associate Dean of Medicine  
Public Health and Public Policy  
Brown University  
Providence, R.I.

**Nancy Whitelaw, PhD**  
Consultant to National Council on Aging  
Adjunct Investigator at Henry Ford Health System  
Royal Oak, Mich.
APPENDIX 2

Eligibility Requirements to Participate in Community Partnerships for Older Adults

As described in the call for proposals, released in 2003:

- Each participating community must have an existing partnership of key groups and individuals that may include social service and health care organizations, not-for-profit and public agencies, private businesses, community leaders, elected officials, tribal leaders, caregivers and older adults.

- An applicant must demonstrate that a core group of community leaders has been working together as a partnership for at least two years. A single agency’s advisory board does not constitute a community partnership for the purposes of this program.

- An eligible community is defined as a geographic area with at least 10,000 residents who are age 60 or older. Such geographic areas might include all or part of a major city or large county, or multiple contiguous counties. An applicant community’s geographic area may not be defined as “statewide.” Exceptions to these criteria will be made for rural communities, and for Native American Indian and Alaska Native tribal communities.

- Applications will not be accepted from universities, hospital-based health systems, professional associations, state agencies and for-profit entities. However, these organizations are encouraged to participate in community partnerships. Exceptions will be made for rural communities.

APPENDIX 3

Project List

Juneau, Alaska

Central Council of the Tlingit and Haida Indian Tribes of Alaska
Developing a case management system of coordinated long-term care for Native American elders
ID# 52261 (November 2004–July 2006) $150,000

    Project Director
    Francine E. Jones
    (800) 344-1432, ext. 7162
    fjones@ccthita.org
**Magnolia, Ark.**

Area Agency on Aging of Southwest Arkansas  
Community-based long-term health care  
ID# 046189 (Aug. 2002–April 2004) $147,900

**Project Director**  
David Sneed  
870-234-7410  
aaaswa@magnolia-net.com

**Fremont, Calif.**

City of Fremont  
Creating a coordinated system of services for a culturally diverse population of frail elderly  
ID# 52259 (November 2004–April 2006) $150,000

**Project Director**  
Mary Anne Mendall, MSW  
(510) 574-2062  
mamendall@ci.fremont.ca.us

ID# 57503 (May 2006–April 2011) $750,000

**Project Director**  
Karen Grimsich  
(510) 574-2062  
kgrimsich@ci.fremont.ca.us  
**Partnership website:** [http://tceconline.org](http://tceconline.org)

**Riverside, Calif.**

Riverside County Office on Aging  
Developing a comprehensive, community-oriented system-of-care model  

**Project Director**  
Michelle Rainer  
(909) 697-4697  
aging.mrainer@co.riverside.ca.us
**San Francisco, Calif.**

City and County of San Francisco Department of Aging and Adult Services

Community-wide strategic plan of long-term health care

ID# 46191 (August 2002–January 2004) $150,000

ID# 50345 (February 2004–July 2008) $750,000

**Project Director**

Bill Haskell

(415) 355-6782

bill.haskell@sfgov.org

**Partnership website:** [http://www.sfhsa.org](http://www.sfhsa.org)

---

**Jacksonville, Fla.**

United Way of Northeast Florida

Developing a coordinated and accessible long-term care system for older adults

ID# 52260 (November 2004–April 2006) $150,000

ID# 57500 (May 2006–April 2010) $750,000

**Project Director**

Mark LeMaire

(904) 390-3200

markl@uwnefl.org

**Partnership website:** [https://www.unitedwaynefl.org](https://www.unitedwaynefl.org)

---

**Atlanta, Ga.**

Atlanta Regional Commission

Improving the long-term care system in Atlanta

ID# 46364 (August 2002–January 2004) $150,000

**Project Director**

Cheryll Schramm

(404) 463-3220

cschramm@atlantaregional.com

ID# 050343 (February 2004–January 2009) $750,000

**Project Director**

Beth Stalvey

(404) 463-3224

bstalvey@atlantaregional.com
**Partnership website:** [http://www.atlantaregional.com/aging-resources](http://www.atlantaregional.com/aging-resources)

**Kahului, Hawaii**

**Hale Makua**
Strategic planning initiative for long-term care for Maui residents
ID# 46366 (August 2002–January 2004) $150,000

**Project Director**
Anthony J. Krieg
(808) 877-2761
tonyk@halemakua.com

ID# 50346 (February 2004–May 2008) $750,000

**Project Director**
Rita Barreras, MUA
808-877-2761
info@mauilongtermcare.org

**Partnership website:** [http://www.halemakua.org/long-term-care](http://www.halemakua.org/long-term-care)

**Coeur d' Alene, Idaho**

**North Idaho College**
Creating systems change to improve long-term care and supportive services for the elderly
ID# 52255 (November 2004–April 2006) $149,390

**Project Director**
Pearl Bouchard
(208) 667-3179
pbouchard@agingadultsvcs.org

**Oak Park, Ill.**

**AgeOptions**
Creating an integrated collaborative long-term care system for suburban elderly
ID# 52263 (November 2004–April 2006) $150,000

**Project Director**
Erin Wright, MGS
(708) 383-0258
erin.wright@s3a.com
ID# 57497 (May 2006–April 2010) $750,000

**Project Director**
Kevin Grunke
(800) 699-9043
kgrunke@agingcareconnections.org

**Partnership website:** http://www.agingwellpartnership.org

**Boston, Mass.**

City of Boston Commission on Affairs of the Elderly
Consumer-focused, long-term care for the elderly
ID# 46365 (August 2002–January 2004) $149,826

**Project Director**
Robert Ormsby
(617) 635-3213
Robert.Ormsby@CI.Boston.MA.US

**Veronica B. Smith Multi-Service Senior Center**
Consumer-focused, long-term care for the elderly
ID# 50344 (February 2004 – July 2008) $750,000

**Project Director**
Emily Shea
617-426-5186
eshea@bostonolderadults.org

**Ann Arbor, Mich.**

Catholic Social Services of Washtenaw County
Establishing an elder-friendly community that promotes improved long-term care and independence
ID# 52257 (November 2004–April 2006) $150,000
ID# 57505 (May 2006–April 2011) $750,000

**Project Director**
Jill L. Kind
(734) 712-3625
jkind@csswashtenaw.org

**Partnership website:** http://blueprintforaging.org
Houghton, Mich.

Copper Country Community Mental Health Services Authority
Implementing the organization and delivery of long-term care and supportive services for older adults and caregivers
ID# 46184 (August 2002–April 2004) $148,000

Project Director
Susan Donnelly, PhD
(906) 482-4880
theinst@portup.com

Port Huron, Mich.

St. Clair County Community Mental Health Authority
Designing and piloting a next-generation senior service system
ID# 46185 (August 2002–April 2004) $150,000

Project Director
Amy Smith
(810) 985-8900
asmith@scccmh.org

Manchester, N.H.

Easter Seals New Hampshire
Redesigning community long-term care and supportive services for the frail elderly
ID# 52262 (November 2004–April 2006) $150,000
ID# 57504 (May 2006–April 2010) $750,000

Project Director
Arlene Kershaw, MSS
(603) 621-3558
akershaw@eastersealsnh.org

Partnership website: http://www.easterseals.com/nh/our-programs/senior-services

Binghamton, N.Y.

Broome County Office for the Aging
Comprehensive planning for long-term care and supportive services for seniors
ID# 46190 (August 2002–January 2004) $150,000

Project Director
Kathleen Bunnell
Waynesville, N.C.

Haywood County Council on Aging
Developing a comprehensive seamless continuum of care for older adults
ID# 52265 (November 2004–April 2006) $135,000

Project Director
Denise A. Mathis, MBA
(828) 452-2370

Mountain Projects
Developing a comprehensive continuum of care for older adults
ID# 57499 (May 2006 – April 2010) $750,000

Project Director
Victoria Young
(828) 452-1447
jeyoung@charter.net

El Paso, Texas

Rio Grande Council of Governments
Strategic planning and advocacy program for long-term care
ID# 46367 (August 2002 – January 2004) $149,421
ID# 50351 (February 2004 – January 2008) $750,000

Project Director
Adan Dominguez
(915) 533-0998, ext. 116
a.dominguez@riocog.org
**Houston, Texas**

Sheltering Arms  
Developing a strategic plan to improve long-term care and supportive services for elders and caregivers in Harris County  
ID# 46210 (August 2002–January 2004) $149,715  
ID# 50350 (February 2004–January 2008) $748,664  

**Project Director**  
Jane Bavineau  
(713) 685-6506  
jbavineau@shelteringarms.org  

**Partnership website:** [http://www.careforelders.org](http://www.careforelders.org)

**Charlottesville, Va.**

Jefferson Area Board for Aging  
Improving the coordination, quality, and accessibility of long-term care and supportive services for older adults  
ID# 52256 (November 2004–July 2006) $149,984  

**Project Director**  
April Holmes  
(434) 817-5236  
aholmes@jabacares.org

**Culpeper, Va.**

Rappahannock-Rapidan Community Services Board  
Developing local and regional community awareness and action to address long-term care issues of the elderly  
ID# 52258 (November 2004–April 2006) $150,000  

**Project Director**  
Sallie Morgan  
540-825-3100, ext 3437  
smorgan@rrcsb.org  
ID# 57501 (May 2006–April 2010) $750,000  

**Project Director**  
Christine Miller  
(540) 829-6405  
cmiller@agingtogether.org


Partnership website: http://www.agingtogether.org

**Colchester, Vt.**

Visiting Nurse Association of Chittenden and Grand Isle Counties
Improving services for older adults in the Champlain region
ID# 46182 (August 2002–April 2004) $147,732

**Project Director**
Beverly Boget
(802) 860-4441
BOGET@vna-vermont.org

**Port Hadlock, Wash.**

Olympic Area Agency on Aging
Developing comprehensive aging and long-term care services for a rural elderly population
ID# 52264 (November 2004–April 2006) $146,085
ID# 57496 (May 2006–June 2007) $238,112

**Project Director**
Sheryl J. Lowe
(206) 683-1109
slow@jamestowntribe.org

Jamestown S'Klallam Tribe
Developing comprehensive aging and long-term-care services for a rural elderly population
ID# 62827 (July 2007 – October 2008) $204,505

**Project Director**
Iva Burks, MPH
(360) 417-2329
iburks@co.clallam.wa.us

**Milwaukee, Wis.**

Milwaukee County Department on Aging
Caring communities for people needing long-term care
ID# 46208 (August 2002–January 2004) $150,000
ID# 50348 (February 2004 January 2009) $750,000

**Project Director**
Stephanie Sue Stein
414-289-6876
sstein@milwonty.com

Partnership website:
http://county.milwaukee.gov/Aging7705/ConnectingCaringCommunities.htm

APPENDIX 4

National Technical Assistance Experts Fostering Cross-Project Sharing

Lisa Aleekih
Senior Vice President and Interim Practice Director
Federal Human Services Market
The Lewin Group
Falls Church, Va.

Elise Bolda, PhD
Co-Director
Community Partnerships for Older Adults
University of Southern Maine
Portland, Maine

Diane Braunstein
Director
Technical Assistance and Systems Change
Public Policy Division
Alzheimer's Association
Washington, D.C.

Karen Linkins
Director, Evaluation Team
The Lewin Group
Scottsdale, Ariz.

Debra J. Lipson
Senior Researcher
Mathematica Policy Research
Washington, D.C.

Mia Oberlink, MA
Project Director
AdvantAge Initiative
Visiting Nurse Service
New York, N.Y.

Beverly Patnaik
Community Partnerships for Older Adults
Burlington, N.C.

Susan Reinhard, PhD, RN
Senior Vice President
AARP Public Policy Institute
Washington, D.C.

Marisa Scale-Foley
Associate Director
Access to Benefits Coalition
Washington, D.C.

Nancy Whitelaw, MEd
Senior Vice President, Healthy Aging
National Council on the Aging
Adjunct Investigator, Henry Ford Health System
Royal Oak, Mich.
APPENDIX 5

Technical Assistance Consultants

Communications
Tamar Abrams, Communications Strategist
Abrams Communications
Washington, D.C.

Community and Program Development
Kathryn Lawler
Atlanta Regional Commission
Atlanta, Ga.

Evaluation
Eric Eisenstein, DBA
Assistant Professor of Medicine
Assistant Professor of Community and Family Medicine
Duke University
Durham, N.C.

Nancy Giunta
Assistant Professor
Hunter College School of Social Work
Faculty Fellow
Brookdale Center for Healthy Aging and Longevity
City University of New York
New York, N.Y.

Kelley Moseley, MBA, DrPH
Professor and Director
Health Care Administration Program
Texas Women’s University–Houston
Houston, Texas

Mina Silberberg, PhD
Assistant Professor of Community and Family Medicine
Duke University Medical Center
Durham, N.C.

Fundraising and Development
Susan Axelrod
Consultant
Rexford, N.Y.

Inclusion and Diversity
John Capitman, PhD
Executive Director
Central Valley Health Policy Institute
College of Health & Human Services
California State University–Fresno
Fresno, Calif.

Humberto Reynoso Vallejo, PhD
Assistant Professor of Human Behavior in the Social Environment and Social Welfare Policy
School of Social Work
Boston University
Boston, Mass.

Logic Models
Stacy Barnes, MGS
Director
Wisconsin Geriatric Education Center
Marquette University
Milwaukee, Wis.

Partnership Evolution
Mike Winer
Founder
4Results Together
Portland, Ore.

Strategic Planning
Walter Leutz, PhD
Associate Professor
Schneider Institute for Health Policy
Heller School for Social Policy and Management
Brandeis University
Waltham, Mass.

Kenneth A. Rethmeier, DrPH
President
The Rethmeier Group
Bermuda Run, N.C.

A logic model describes the steps and flow of an activity, program or policy.
Using Survey Data and Strategic Planning

Mia Oberlink, MA
Project Director
AdvantAge Initiative
Visiting Nurse Service
New York, N.Y.

Phillip Stafford, PhD
Director
Evergreen Institute on Elder Environments
University of Indiana
Bloomington, Ind.

Work Plans

Gary Meyer
Baseline Research
Whitefish Bay, Wis.

APPENDIX 6

Evaluation Report Summaries

“Trends in Long-Term Care: Shoring Up the Infrastructure for Long-Term Care: What Do Vulnerable Adults Know About Their Options?”

The evaluators surveyed some 400 adults age 50 and over in each of the 13 active Community Partnerships communities.27 Their study shows that many adults who are likely to need long-term-care information in the next few years have substantial gaps in their knowledge. Communities seeking to bridge these gaps are likely to face challenges, particularly since this population turns to a wide range of sources for information.

Some of the strategies that the individual partnerships were implementing to improve awareness among vulnerable adults about long-term-care issues include:

- Developing and promoting the use of a telephone helpline
- Conducting a media campaign
- Conducting a door-to-door outreach campaign to reach isolated older adults
- Improving communication and collaboration among long-term-care service providers and senior services organizations to promote a “no wrong door” approach, allowing seniors to enter the long-term-care system through multiple channels

The Community Partnerships for Older Adults Program Cross Site Report, Valerie Cheh, Bridget Lavin, Beth Stevens and William Black, December 2005.

RWJF hoped that partnerships would be a good mechanism for achieving community-level improvements in the long-term-care system. Relatively little evidence exists,

27 The average survey response rate was 63 percent across all 13 sites and ranged from 53 percent to 71 percent in individual communities. Mathematica oversampled vulnerable adults to enhance the precision of its estimates.
however, to indicate whether funding partnerships is more efficient than funding single agencies working toward the same goals.

To examine whether the grantees were using tactics that require the work of a coalition, the evaluators developed a typology: (1) tactics that a coalition needs to implement; (2) tactics that one organization could easily implement; and (3) hybrid tactics, which either a coalition or a single organization could implement.

The analysis showed that about half of the tactics the grantees used required a coalition and all of the grantees used at least some tactics suitable for either coalitions or single organizations.

The evaluators noted:

“The current program presents a paradox. The planning phase of the project requires a coalition. But a coalition may not be the best way to implement the individual project tactics. We found that nearly half of all the grantee tactics could be used by individual organizations. Because of this situation, the Foundation may wish to consider changing its management approach to community partnership programs or changing the design of such programs.”

Are the Partnerships Affecting Policy in Their States and Communities?
Bridget Lavin, Valerie Cheh and Beth Stevens, May 2006.

This paper describes some trends in long-term-care legislation in the seven states where the second cohort of partnerships worked, and discusses whether and how partnerships have tried to affect state and local policy. The evaluators focused not only on legislative policy changes, but also on changes made within agencies, such as administrative or regulatory changes—all of which can improve the long-term-care system.

Although the partnerships tried to influence policy at the state level, policy-makers were unable to attribute changes in policy to their activities, primarily because so many competing factors and players influence outcomes. At the local level, however, the voice of the partnerships is more likely to be heard. Local policy-makers recognized the three partnerships that undertook activities to influence community-level policies as having informed the decision-making process.

The Community Partnerships for Older Adults Program Cross Site Report: Improving the Connectedness of Long-Term Care Providers, Final Report, Beth Stevens, Bridget Lavin and Valerie Cheh, July 2006.

This report analyzes data from one of the three major components of the evaluation: an implementation analysis that documents the strategies taken by different program sites to reach their goals. It also explores the barriers and challenges to implementation.
Evaluation staff collected baseline information in early 2004, interviewing members of each of the eight partnerships that received implementation grants, they then returned to the same sites in 2007 to discuss the progress and effects of their grants. The descriptions of tactics served as a source of ideas for other communities interested in improving their local, community-based long-term-care systems.

**Spreading the Word About Aging and Long-Term Care: Community Partnerships’ Efforts to Influence the Media, Angela Gerolamo and Valerie Cheh, February 2007.**

This Issue Brief describes ways that grantee partnerships tried to influence the media and to identify the trends in the number of media items and topics that were reported in the grantee communities. Key findings are:

- Most grantees had difficulty increasing awareness of aging issues through media outlets.
- Citywide media campaigns were largely beyond grantees’ reach.
- Spending resources to influence local newspapers offers a minimal return on investment.
- Media discussions of long-term-care issues declined nationally. Despite the increase in the number of older adults nationally, newspapers printed fewer articles about them or about long-term care over time.
- Despite an overall decline in printed media items, there were more media items in program communities about long-term-care providers and community living for older adults.

**Everyone’s At the Table, What’s Next? CPFOA Leadership Teams in Their First Year of Implementation,28 Todd Honeycutt, Kim Jung and Judith Wooldridge, June 2008.**

During their first year of grant implementation, the eight leadership teams varied widely in their composition, priorities and relationships. The evaluators observed four key themes:

- All partnerships had an array of individuals and organizations at the leadership table, although the organizations were primarily nonprofit groups; medical, health care, aging or funding organizations; and government agencies.
- Partnerships with more integrated leadership structures (that is, with more contact and greater regard among team members) were more likely than those with less integrated

---

28 CPFOA is the program’s acronym and is often used in publication titles.
leadership structures to perceive greater effectiveness in achieving the partnership’s priorities. Whether this will translate into actual effectiveness is not yet known.

- Project staff members were important to leadership functioning in all sites.
- Although the partnerships varied in their agreement on priorities among their goals and activities, that variance was not related to their perceived effectiveness.

*Collaboration With Non-Traditional Providers Expands the Scope of CPFOA Work, Beth Stevens and Kim Jung, July 2008.*

Based on telephone interviews with the project director from each partnership in the summer of 2007, the evaluators identified these key factors to facilitate productive collaborations between partnerships and nontraditional providers:

- A mutual interest in aging establishes a common ground for collaboration. Several partnerships successfully engaged nontraditional providers by demonstrating how older adults fit into their own mission or business.
- Someone within the nontraditional provider’s organization taking the role of champion helped partnerships complete their joint activities despite challenges.
- Support from political leaders or elected officials helped galvanize broader community support for partnership activities.
- When partnerships take advantage of outreach and connections and become known as a central source for expertise or knowledge, nontraditional providers seek them out.
- Understanding the language and challenges of the nontraditional provider’s business can help partnerships identify differences that may lead to misunderstandings or unrealistic expectations on both sides.

*Trends in Long Term Care: Databases Strengthen Long-Term Care Partnerships,*” Issue Brief, Ann Bagchi and Jung Kim, October 2008.

This brief focuses on three community partnerships—Aging Atlanta’s Care Options, El Paso’s Successful Aging Through Long-Term Strategic Alliances, and the San Francisco Partnership for Community-Based Care & Support—that developed databases as part of their efforts to improve the long-term-care system.

The sites offered the following insights about dealing with the challenges of database development:

- Clarify the purpose of the database and decide how the data will be used by different organizations before moving forward. Plan to incorporate the information into decisions about the necessary features and functions, which will affect development time and costs.
• Keep the database simple. Decide whether collecting and sharing client health information is necessary and limit the amount and type collected, when possible, to streamline development. Developers should be aware of existing systems in use by each organization and consider ways to build onto them, if possible.

• Involve potential users in the development process so that they can provide practical advice on features they need.

• Involve information technology professionals early on. They can translate agency needs into software specifications and ensure that new technology is appropriate to the setting in which it will be used.

• Draw on the experiences of others to avoid unnecessary and costly steps. San Francisco received advice and input from Atlanta, and El Paso consulted with San Francisco.

Community Partnerships for Older Adults Effect of CPFOA Partnerships on Vulnerable Adults’ Ability to Age in Place: Findings From the Second Community Survey of Older Adults, Kim Jung and Valerie Cheh, September 2010.

Mathematica conducted telephone surveys of vulnerable older adults29 in 2002 and again in 2008 to identify changes in knowledge and use of long-term-care services and to assess whether possibilities for aging in place have improved since the program began.30

The evaluation team concluded that while some progress had been made, new challenges had arisen and problems remain stubbornly persistent. While awareness and use of community-based services had increased in the communities where the program’s partnerships are located, there was a slightly greater increase in the proportion of vulnerable adults who tried to but could not access services.

While there is evidence of progress in the partnership communities, the demand for home- and community-based services will continue to increase, suggesting the continuing need to develop creative approaches to help older adults age in place.

Who Are the Influential Leaders in Partnerships—and Do They Stay? Valerie Cheh and Todd Honeycutt, February 2010.

The evaluators surveyed members of the seven leadership teams awarded implementation grants in the second round of funding. Overall, leaders in slightly more than half the

29 Vulnerable adults were defined as those who were 75 or older, or 60 to 74 and meeting one of the following criteria: (1) said they were in fair or poor health; (2) needed help bathing; (3) used a cane, walker, or wheelchair; (4) were afraid to be alone for more than two hours; or (5) had a chronic health problem such as diabetes, heart or lung problems, stroke, or kidney failure.

30 The surveys were conducted in the eight partnership communities: Atlanta (Fulton County), Georgia; Boston.; Broome County, N.Y.; El Paso, Texas; Houston (Harris County); Maui, Hawaii; Milwaukee; and San Francisco.
Community partnerships were held in high esteem (the category was used for leaders identified by many others on the team as having good ideas, being involved in productive relationships, and playing important roles).

However, that total masked substantial variation across teams. For example, only 26 percent of the leaders on one team were held in high esteem in 2007, compared to 94 percent on another.

Other findings:

- All types of leaders were held in high esteem. However, those who represented organizations that focused on aging issues were most likely to be held in high esteem, especially after the partnerships had begun implementing their projects.

- A very large proportion of the leaders that came from the applicant agency were held in high esteem, compared to leaders from other groups. This difference suggests that the applicant agency has influence over the partnership.

- Leaders who are not as highly esteemed were more likely to leave the leadership team, which imposes a cost in time and resources. Partnership members may want to identify ways to involve leaders so they are more integrated and avoid unnecessary leadership member turnover.

**Opposite Paths to the Same End: The Pathways of Interorganizational Partnership Structures and Processes to Outcomes, Todd Honeycutt, Valerie Cheh, Patrick Doreian, September 2010.**

This report examines how partnership structures and processes influenced the outcomes of seven community partnerships. The evaluators measured outcomes in four ways: the benefits that participants received, the effectiveness of the partnerships according to members, the effect of partnership activities on communities, and the sustainability of partnerships. The evaluation found that:

- All leadership teams tended to have the membership structure necessary to implement their activities, but those that had better structures—including appropriate representation and support from the community—tended to have better outcomes.

- The extent to which leadership team members were aligned on their priorities was related to community impact, but not to other outcomes.

- Leadership teams in which many members were involved in communication had higher levels of perceived organizational benefits than teams that had few members involved.

- Leadership teams in which communication was more centralized had activities with a larger effect on their communities than teams that had many leaders involved in communication.
• Leadership teams with a large number of leaders held in high esteem had higher ratings of perceived benefits than teams with fewer leaders held in high esteem.

• Leadership teams with either a shared or centralized governing style tended to have greater community impact, compared to those with a blend of styles.

• Leadership teams can have the right structure and process measures but still not have positive outcomes.

**NATIONAL PROGRAM OFFICE BIBLIOGRAPHY**

*(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)*

**Articles**

**Journal Articles**


**Reports**

**Reports and Monographs**


**Communications or Promotions**

**Promotions or Communications**

Grantee Website

www.partnershipsforolderadults.org (no longer available). The website for Community Partnerships for Older Adults contained descriptions and accomplishments of the 16 partnership sites; resources and tools for the partnerships to use in the areas of strategic planning, inclusion and diversity; fiscal strategies; communications; evaluation and partnership evolution. Community Partnerships for Older Adults, launched in 2002.

EVALUATION BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Reports

Evaluation Reports


**Issue Briefs**


**PROFILE LIST**

- Getting Ready for the Coming “Silver Tsunami” in Maui, Hawaii—a Grantee Profile of Rita Barreras
- Smoothing the Transition From Hospital to Community for Older Adults in Jacksonville, Fla.—a Grantee Profile of Mark LeMaire
- Older Adults Spearhead Grassroots Effort in Lyons Township, Ill., to Promote Age-Friendly Communities
- Bringing Community Supports to “Invisible” Frail Elders in Manchester, N.H.
- Bringing the Table to the Community in San Francisco
- Overcoming Scandal and Promoting Collaboration to Benefit Vulnerable Elders in Waynesville, N.C.