Elder Service Needs Study Report

Central California Area Social Services Consortium (CCASSC)

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I. Introduction

A significant change is taking place with U.S. demographics due to the increase in elders who are over 60. The number over 65 and above will double to 80 million by the middle of the 21st century (U.S. Bureau of the Census, 1999). In the majority of Central California counties, the percentage of the population 65 and older is below the state average of 10.6% (Rand California, 2003). However, California's 65 and older population is expected to almost double in the next 40 years, with the highest increase projected in the 85 and older age cohort (CalSWEC, 2005, Scharlach, Torres-Gil & Kaskie, 2001). This has clear implications for workforce preparation. Also, a drop in the Central California population, aged 25-44 from 31.6% to 29% has implications for weakening of the economic base that supports needed services to elders (Diringer, Curtis, McKinney & Deveau, 2004).

Torres-Gil and Puccinelli (1999) point out that the baby boomer effect will hit in 2010, when those 55 years and older will represent one fourth of the U.S. population, one in seven will be 65 years and older, there will be greater longevity, and the profile of elders will reflect more diversity. These data also suggest that baby boomers will be healthier than current elder cohorts, live longer, and will have more years of managing chronic illnesses. The authors also suggest the longevity could also lead to greater intergenerational tensions.

Bellos and Ruffolo (1999) point out that the increased heterogeneity in elders will be reflected in not only differences related to health, but also in level of activity, functioning

level of education, resources and mental decline, and benefits. Greater attention will need to be given to differences in age, gender, race, ethnicity, and income in relation to the aging process. For example, Stanford & Dubois (as cited in Bellos & Ruffolo) point out that although women of all backgrounds live longer than men, different patterns regarding living alone or living with family are showing up among white, African American, Hispanic and Asian women.

Findings that men develop more disorders that lead to death and women develop more chronic illnesses that lead to impairment (Taeuber, 1992) have strong implications for losses related to bereavement and loss of functioning that women will face as they age. As a way to address the increased longevity, changing demographics, and increased need for services, Torres-Gil and Puccinelli propose that programs for the new aging include involving the family, viewing elders as a resource and preparing the younger generation for aging.

This research study on the Service Needs of Elders in Central California was funded by Central California Area Social Services Consortium (CCASSC), whose membership includes social services directors from Fresno, Kern, Kings, Madera, Merced, San Joaquin, San Luis Obispo, Santa Barbara, Stanislaus and Tulare Counties. and representatives from California State Universities, Bakersfield, Fresno and Stanislaus. This report will first present relevant literature on the needs of elders and service delivery issues before presenting the research methodology utilized in data gathering with directors and/or their designees, stakeholders and consumers in the Central California region represented by the Central California Area Social Services Consortium (CCASSC). This will be followed by presenting the main findings across all ten

participating CCASSC counties and Mariposa County, who was included in this study because of their geographic proximity to the region. These findings will be discussed in relation to the literature review. Best Practice Models will then be discussed and followed with recommendations that reflect best practice model concepts in relation to the findings. Appendices include findings by county, informed consent documents, summaries of best practice models, and a listing of websites that provide resources for program development for services to elders.

II. Literature Review

The literature review will discuss service concerns related to unique considerations with elders such as abuse, poverty and stigma, service delivery considerations and specialized service delivery areas such as mental health and health care. Assessment considerations, skills needed for working with elders and the need for gerontology training for all health and human services and for health professionals will also be explored. Finally, resources and competencies developed by the Council Social Work Education (CSWE) and National Association of Social Workers (NASW) for addressing the need for training will be presented.

Abuse

Four common categories of abuse are: physical, neglect, psychological and financial (Meeks-Sjostrom, 2004) which include neglect, outright violence, fraud or exploitation (Nelson, 2005). Financial abuse alone is expected to increase due to four factors: 1) mere growth of elder population, 2) elders own greater share of wealth, good credit 3) vulnerability increase with age in mental, physical and social domains, and 4) increasing resourcefulness of predators in accessing financial assets (Kemp & Mosqueda, 2005). The authors suggest that factors that are potentially instrumental in creating abusive situations due to the vulnerability of elders include 1) medical, pharmacological, psychological and social problems, 2) exploitive relationship with friend or family, for example where financial transactions are kept in secrecy from elder or there is a lack of professional assessment of elder's capacity and assets, 3) transfer of assets where the benefits for the elder are not proportionate to the value or do not reflect the elders wishes,

4) provision of basic options in business transactions such as the right to change one's mind, and 5) lack of consideration for the effects of the business transactions on the beneficiaries or in relation to the public welfare system.

Elders' isolation could be related to an abusive situation and vulnerability can make it more difficult for them to disclose due to a fear of retaliation (Quinn & Tomita, 1986), and older women in abusive situations often find themselves receiving in home services compared to younger women who more often are referred to shelters or support groups (Wilke &Vinton, 2002). Also, because older women may have more difficulty identifying intimate partner violence due to "embarrassment, commitment to the perpetrator, and not recognizing the relationship as abusive" (Zink, Jacobson, Regan, & Pabst, 2004, p. 900) it is important for practitioners to recognize signs of abuse and have skills in engaging the elder in the discussion and make needed referrals. Social work assistance is needed in screening for abuse, conducting assessment and providing expert evaluations for the justice system (Kemp & Mosqueda, 2005).

Poverty and Ethnicity

Adjustments to aging and related mental health issues can be complicated by lack of resources related to poverty, inadequate housing, isolation, discrimination, lack of access to health care, and other resources lack of adequate insurance, and age discrimination (Clark, 2003). Although the view is held that low income and ethnic elders often have strong family and social networks, there is evidence that mobility and acculturation have weakened traditional support (Markides & Mindel, 1987). Also while there is an increasing number who go into poverty or greater debt as a result of reduced income, there is also a significant amount of elders, who are identified as "tweeners",

meaning near poor, not eligible for assistance yet do not have sufficient resources to cover basic expenses (Smeeding, 1990).

Stigma and Ageism

A person-environment approach to practice with elders must take into account the effects of stigma and ageism on how elders view themselves, feelings about receiving assistance and how stereotypes can influence service delivery. Nelson (2005) suggests that the reality that elders are often viewed as depressing, untreatable and are approached with anticipation of frustration or irritation due to their cognitive and physical limitations need to be recognized. He also points out how categorization of elders is based on assumptions about human development as resting on a goal orientation (Hagestad & Uhlenberg, 2005), rather than a process orientation that highlights identity development and accommodation in older age (Sneed & Whitbourne, 2005). Elders beliefs that they are less useful and therefore less deserving feeds into a perception that quality of life isn't as important in old age (Zuniga, 1999). These beliefs are sometimes held by practitioners and can be manifested through overaccomodation through words as in the tone that is taken or in talking down to elders as if they didn't understand. Although unintentional, this phenomenon can have the effect of infantilizing elders and thus needs to be recognized so that respect for elders is promoted and preserved. These types of life experiences can create situations where elders come to accept the ascribed role and the loss of self esteem associated with lack of productivity in the workplace.

Effective practice requires enhancing sensitivity that includes recognizing and dealing with negative stereotypes as well as heterogeneity among elders, developing

awareness of effects of experiences within different historical periods, and having knowledge of development in older adults (Erikson, Erikson, & Kivnick, 1986). Some research suggests that the problem may not be ageism but rather healthism in that there is evidence that clinicians rate prognosis of older clients worse than younger clients who present with the same problems (James, & Haley, 1995).

Services for Elders

Literature on service delivery principles that are valuable in work with elders focus on working within family system, partnering with consumers and their families, and assessment of unique needs found in aging. The inclusion of a multigenerational practice framework that addresses the needs and requirements of each generation and the interdependence between generations promotes connections between generations (Fredriksen-Goldsen, 2005).

Home visits with caregivers can assist caregivers in managing difficult behaviors of dementia clients, with ongoing contact provided through phone calls, and assistance in managing physical and mental illnesses (Vitaliano, Katon, & Unutzer, 2004). Ideally services to elders are culturally competent and along with case management, family work, and advocacy (ombudsmen, community coalitions, larger system change), crisis intervention, adult protective services, should also include transportation and housing assistance. Adult day care (health, social and related support services), adult foster care services, and respite services for caregivers are particularly helpful in maintaining elders in the community (Bellos & Ruffulo, 1999).

Spitzer, Neuman, and Holden (2004) suggest that services for assisted living residents and their families should include: 1) Assessment of psychosocial, overall

adjustment, need for support services, and strategies to maintain independence, 2) Psychoeducation for resident and family regarding assisted living philosophy, range of care, resident and family responsibilities as well as available resources, intervention regime, staff functions and purpose, 3) Counseling for adjustment to placement and ongoing support, 4) Crisis intervention (bereavement, new diagnoses, progression of dementia, new to medications, 5) End of life planning including wishes, self-determination, and 6) Student training.

Other specialized services such as palliative, mental health, crisis intervention and health care are needed. Palliative care can address pain management of patients, monitoring their medical issues, and advanced care choices, as well as caregivers bereavement support (Yurk, Morgan, Franey, Stebner, & Lansky, 2002). A clear theme in the gerontology literature is the notion that mental health services are essential because the elderly are more vulnerable to affective disorders due to isolation, and loss related to changes in physical mobility and work capacity as well as bereavement (Zuniga, 1999).

Human services can have a significant role in supporting elders in dealing with health care needs. Satariano (2006) suggests that social services can assist elders in recognizing the role of biological, behavioral, social and environmental factors that are associated with maintenance of healthy functioning and that health can be maintained in spite of high risk profiles. Such an approach would examine what cultural and spiritual (i.e., religious) resources can be utilized in these efforts towards healthy aging. Zuniga (1999) proposes that pharmacology is significant for social workers to understand and assist elders with specifically in relation to understanding differences in how substances

are metabolized by different ethnic groups, assisting elders in understanding how medications work, and to fit medical regimes into their daily activities.

Satariano (2006) points out that the stages of change concept (Prochaska, & DiClemente, 1983) can provide a means to understand the process that elders go through in moving towards accepting new regimens in their life and making the necessary adjustments. This concept is helpful in that it addresses the role of timing and various factors that must come together for change to occur.

Assessment

Comprehensive assessment of elders is particularly imperative because some behaviors arising from disorders, such as substance abuse, difficulties sleeping or changes in eating patterns possibly related to depression, could be mistaken as part of the aging process (Delon, & Wenston, 1989; Knight, 1983).

Assessment of activities of daily living (ADL) and instrumental activities of daily living (IADL) explores basic as well as more complex functioning. A focus on activities related to "basic self care such as eating, mobility, using the toilet and bladder functioning, dressing, and bathing", and those more difficult activities such as "cooking, cleaning, doing laundry, paying bills and managing finances, driving, housework, and home maintenance are both essential" (Richardson, & Barusch, 2006, p.71). The authors promote an Integrated Gerontology Practice Model that examines actions, biological factors, cognitions, environment and feelings as well as demographics, such as age, gender, and relationship status.

Ortiz and Langer (2002) suggest that assessment of spirituality and religion in elders is a basis for strength based assessment and acknowledges clients' needs and

personal resources. Such an assessment can engage elders in examining their beliefs about sources of power and meaning in their lives and end of life considerations. The authors suggest that these assessments could address: 1) shared beliefs that bring comfort, 2) presence of family or friends, interdependence that gives strength for living, 3) spiritual sources that provide strength to overcome obstacles, and 4) beliefs that give life meaning or purpose. Similarly, Cohen, Greene, Lee, Gonzalez, and Evans (2006) propose a strength based assessment to examine resiliency characteristics that can include: 1) policies, power relations and economic conditions with which elders have dealt, 2) sociocultural factors that influence the meaning of aging, 3) interpersonal dynamics relating to family and friends and activities such as advocacy, supporting others, leisure activities, and 4) psychological factors regarding aspirations and achievement of goals that provide a sense of efficacy and dignity.

Skills Needed for Services

Naito-Chan, Damron-Rodriguez and Simmons's (2004) study with consumers and employers of social workers is provocative and suggestive of areas for skill development. They found that older adults did not understand the role of social workers and were most interested in advocacy services and that caregivers did not understand the role of social workers, and were most concerned about getting information and resources (e.g., transportation, in home support). Also they found that most employers were concerned about the ability of social workers to conduct a comprehensive assessment, including a mental status assessment in order to identify the presence of dementia, and/or a chronic disease and how they might effect functioning. Knowledge about categories of medication, how they work and possible effects were also identified as important for

social workers to be informed about. These researchers found that employers view self awareness in practitioners, in part, as an ability to utilize supervision effectively and address the needs of families. The skills that were identified as the most important included: 1) access and availability in finding resources, 2) advocacy, be an ombudsman; help deal with bureaucracy, 3) assessment, 4) case management, 5) cultural competency, 6) emotional support, and 7) collaboration with other professions.

Lack of Preparation by Health Care and Human Services Professionals

A major theme in the literature is the recognition that as the baby boomers are approaching 65 that professional communities are not prepared to respond to the increased need in services in a systematic and informed way (CSWE, 2001). Although there is recognition of the need to increase gerontology curriculum and training, there is substantial documentation that few social work programs offer gerontology content (Schlarlach, Damron-Rodriguez, Robinson, & Feldman, 2000).

In response to this need, the CSWE and the Hartford Foundation, have funded a significant amount of curriculum development and research substantial efforts that has led to the development of gerontology competencies. These aging competencies address values and ethics, diversity, populations at risk as well as the core areas of human behavior and the social environment, policy, practice, and research. Below are the links to the foundational skill competencies, bibliography and the Aging Report:

- CSWE/SAGE Competencies
  http://depts.washington.edu/geroctr/Curriculum3/Competencies/CalSWECCompetencies.doc

- Foundations Competencies: http://depts.washington.edu/geroctr/Curriculum3/Competencies/FdnComp.doc
- CSWE bibliography http://depts.washington.edu/geroctr/Curriculum3/Competencies/CompBiblio.doc
- CSWE/Sage Aging Report: http://depts.washington.edu/geroctr/Curriculum3/Competencies/CSWESAGE_SWNationalCompetenciesSurveyandReport.doc

Rosen, Zlotnik and Singer (2002) point out that some of the most often identified competencies needed by all social workers include: 1) assess one's own values and biases regarding aging death and dying, 2) accept, respect, and recognize the right and need of older adults to make their own choices and decisions about their lives within the context of the law and safety concerns, 3) understand normal physical, psychological, an social changes in later life, 4) respect and address, cultural, spiritual, and ethnic needs and beliefs of older adults and family members, and 5) understand the influence of aging on family dynamics. As the authors point out, these competencies are helpful in that they identify ethical and professional boundary issues that commonly arise in work with older adults and their caregivers, such as client self-determination, end of life decisions, family conflicts, and guardianship.

Both the Council on Social Work Education, through the GeroEd center funded through the Hartford Foundation and the NASW continue to develop initiatives in addressing the need for gerontology curriculum and resources. In April 2006, the NASW Board of Directors approved three certificate programs that are now available. These include Certified Social Worker in Gerontology (BSW level), Certified Social Worker in

Gerontology (MSW level), and Certified Advanced Clinical Social Worker in Gerontology (Advanced Clinical level).

III. Methodology

The research efforts were directed by the co-principal investigators, Dr. Betty Garcia and Dolores Siegel (CSU, Fresno), and in coordination with Dr. Margaret Tynan (CSU, Stanislaus), Dr. Rose McCleary (CSU, Bakersfield), and Dr. Gigi Nordquist (CSU, East Bay). Dr. Garcia and Ms. Siegel co-conducted the directors and stakeholders phone conferences, as well as co-conducted all but the Kern County consumer focus group. Dr. Tynan participated in the organizing and co-conducting the phone conferences with the directors, co-conducted the Kern County consumer focus group and organized the several Focus Groups. Drs. McCleary and Nordquist assisted in organizing the stakeholders phone conferences and several consumer focus groups.

Participants

Qualitative data gathering occurred in three stages with a phone conference with each CCASSC director and/or designee (n=11), a phone conference with stakeholders (n=11), and focus groups with consumers (n=8). Stakeholders for the phone conferences were identified through stakeholder lists provided by the directors and/or designees in the individual phone conference. Consumers for the focus groups were recruited through the use of flyers that were posted in senior centers and other agencies that serve elders. The director and stakeholder phone conferences were 1 to 1 ½ hours long and the focus groups were slated for 1 l/2 hours.

Stakeholder participants were from a broad range of public and non-profit elder services agencies. Stakeholder phone conferences ranged in size from 2 to 5 members. Consumer groups were held in eight of the eleven counties; organization of the Kings and Tulare county focus groups were unsuccessful, did not occur and no consumers came to the San Luis Obispo meeting (See Table 1). The San Luis Obispo group was arranged in a local hospital conference room; there was no information on the centrality or accessibility of the medial setting as a site for the focus group. Consumer focus groups were conducted with n=50 participants, ranged in size from 2 to 13, represented a cross section of diversity, included 6 members younger than 60, 7 individuals who were disabled, and were 68% (n=34) female and 32% (n=16) male (See Table 2).

TABLE 1: Consumer Focus Group by County

County	***City***	***Number of Participants n=***
Fresno	Fresno	6
Kern	Arvin	8
Kings	Focus Group Not Conducted	0
Madera	Madera/Chowchilla also represented	6
Mariposa	Mariposa	13
Merced	Merced/Atwater also represented	7
San Joaquin	Stockton	2
San Luis Obispo	San Luis Obispo (No Shows)	0
Santa Barbara	Orcutt	3
Stanislaus	Modesto	5
Tulare	Focus Group Not Conducted	0

This was a purposive snowball sample and therefore is a non-representative sample. This is due in part, to the consumer selection methods used by different counties. As the data will show, agencies struggle with transportation issues, accessing elders and "getting the word out" about services and activities. Several counties notified seniors who frequent the senior centers and some focus groups were planned around the lunch hour so that those who come for lunch could be invited to participate. These efforts were extremely helpful in obtaining consumer participation, however, those attending were more mobile, involved in older adult issues, and well versed. There were several other limitations to this study regarding consumer participation. They include; 1) the inability to access consumers residing in more remote or rural areas, 2) the inability to access those with mobility difficulties, and 3) transportation difficulties faced by consumers and agencies. In addition, although research materials (i.e., flyers advertising focus groups, focus group questions and informed consents) were developed in Hmong and Spanish languages, there were insufficient resources to recruit and conduct the consumer focus groups in languages other than English. Three focus groups (Kern, Merced, Madera) included Hmong and/or Spanish language translators for several of the participants.

It would be beneficial for future research studies to focus efforts on reaching those older adults in this more remote sub-population that were not part of this study.

TABLE 2: Demographics

Age	**n**	**Ethnicity**	**n**
<50	1	White Ethnic	29
50-60	5	Hispanic/Latino	11
60-70	12	African-American	3
70-80	17	Asian	4
>80	7	Native American	1
		Assyrian American	1
		Greek American	1

Instruments

Participants received copies of the survey questions and informed consent prior to the phone conference and/or focus group meeting. See Appendices B-D for copies of the Informed Consent Forms that were utilized for the phone conferences with directors/designees and stakeholders and in focus groups with consumers.

Procedure

In the first stage of data gathering, directors and their staff were asked to identify potential stakeholders for the stakeholder phone conferences. Contact was made with the identified stakeholder agencies and phone conferences were organized to include approximately 5 to 7 members. At the end of the stakeholder phone conference, researchers asked stakeholders about possible ways to reach consumers in order to publicize the consumer focus group in their region. Flyers were posted at recommended settings, and community based locations were identified that consumers could easily reach. Staffs at senior centers were consulted regarding optimum times for elders to

participate in groups; also senior center staffs were helpful in coordinating sign up lists for the consumer focus groups. Efforts were made to assure that beverages and snacks were available at the consumer focus groups. Focus group participants were provided with a $10 Target card as a benefit for participating in the group.

Research protocol, questions, and informed consent forms were reviewed and approved by Human Subject Committees at CSU, Fresno, Stanislaus and Bakersfield. At the beginning of each data gathering session, participants were asked for permission to tape record the session. Consumers reviewed and signed the Informed Consent at the beginning of the focus group and were provided with a personal copy of the Informed Consent in case they had further questions of t

he researchers after the focus group.

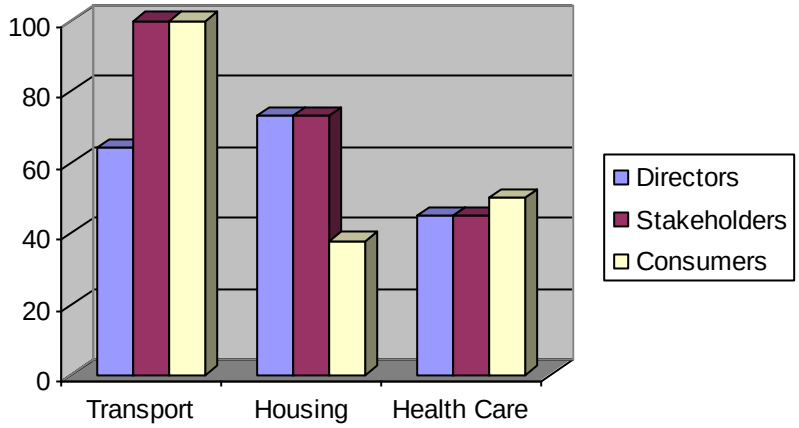
IV. Findings

This section presents main findings across all counties. Questions utilized for data gathering will be identified, along with the cohort that responded to the question. The findings by specific county are found in Appendix A.

1. "*What do you consider to be the 5-7 biggest service needs and concerns of the older adult (over 60) population in your region?* Answered by County Social Service Directors, Stakeholders and Consumers.

All agreed respectively, that transportation 64%, 100%, and 100%; affordable housing 73%, 73%, 38%; and health care 45%, 45%, 50% were significant service needs of older adults (See Chart 1).

Chart 1
Percent Response to Common Service Needs



Many concerns emerged regarding transportation needs. Directors and stakeholders reported difficulties arranging transportation to and from Senior Centers, to other available services, and to medical appointments. Consumers cited multiple problems with transportation. Consumers in several counties reported that transportation to their destination was not problematic, but return trips were. Accounts of no one returning to pick them up and waiting up to three hours to return home were common. Oftentimes elders had to wait outdoors in the weather elements with groceries that were likely to spoil. They also stated that neither door to door assistance nor accommodation for ambulatory equipment (wheel chairs, scooters) was regularly available on public transportation buses. Finally, non-English speaking elders found it difficult at best to navigate the public transit system.

Older adults agreed that there is not enough affordable housing to meet the need. The lack of management oversight for older adult apartment complexes was also identified. One consumer stated, "…the Baptist Church operates apartments where I've lived for a year, they've had eleven maintenance men and we've had 3 managers and

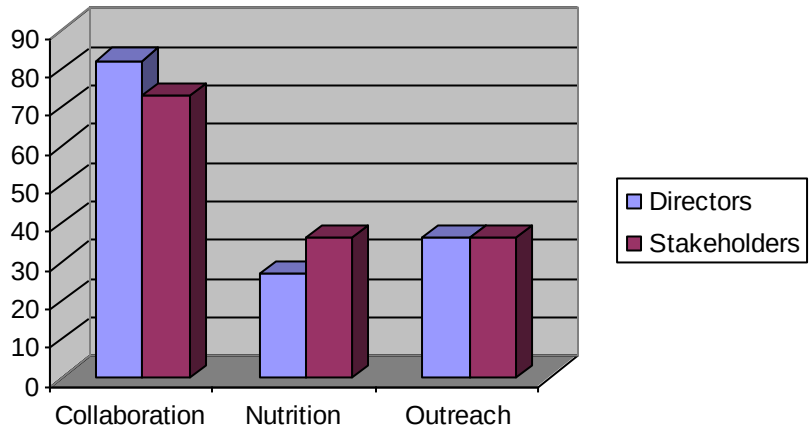
nothing is kept up. The Salvation Army owns the Ventura senior housing project where I lived before and it was much better."

Directors (64%) also identified mental health services as a service need. In particular, needs for in-home mental health assessment and service were reported. Stakeholders (73%) reported that access to services was a significant need. Finally, 50% of consumers identified needs for both medical resources/specialists and outreach information. Consumers stated that in cases where medical specialists (dialysis, cancer treatments), were not locally available, traveling long distances was necessary to get their specialized health care needs met. Limited transportation for this purpose caused further hardship.

2. *"What is currently working well in the service delivery system to this population"?* Answered by Directors and Stakeholders (See Chart 2).

The majority of respondents reported that collaboration among service providers was working well. Those in smaller counties cited that being a smaller county contributed to this phenomenon. They said that knowing each other and oftentimes, knowing the older adult promoted effective collaborative efforts. A common statement was that, "We are doing the best with what we have." Nutrition programs and outreach to elders were also identified. Many counties described the value of collaborative multidisciplinary teams in coordinating service delivery.

Chart 2
Percent Response to Services Working Well



3. "*What services are available to meet the needs of older adults?*" Answered by Directors and Consumers.

Most directors (67%) reported that the Multipurpose Senior Service Program (MSSP) served some senior needs, while fifty percent of consumers stated that both Senior Centers and In Home Supportive Services (IHSS) met some of their needs.

Directors also cited Area Agencies on Aging (AAA) (55%), the Ombudsman Program (45%) and Catholic Charities (27%) as additional available services meeting senior needs. Services provided by Catholic Charities varied by county. For example, Catholic Charities provides a senior companion program in Madera County while in Stanislaus County, they provide house cleaning and the Ombudsman program. Consumers (38%) cited both Meals on Wheels and transportation as meeting needs. It was the general opinion that these services were pieced together and that while available, these services were inadequate due to limited funding.

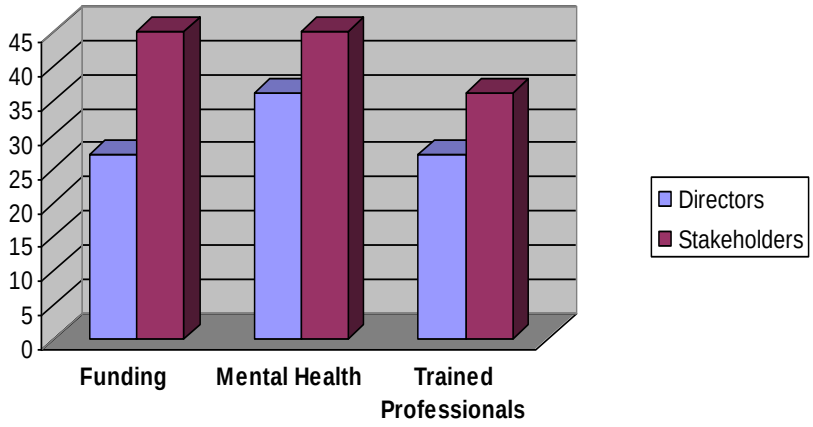
4. "*What gaps do you see between the current service delivery system and the population needs?*" Answered by Directors, Stakeholders and Consumers.

All agreed that transportation was a service gap suggesting that although existing transportation services met needs, there are many shortcomings, such as long wait periods and lack of door to door service, that remain problematic. Most consumers (75%) saw this as a major gap in services, followed by stakeholders (36%) and directors (27%).

Consumers (38%) also identified pharmacy resources and medications as a significant gap. Several concerns surfaced around pharmacy and medication service gaps. Medication home delivery was identified by many consumers as a gap. This gap, in part, could be due to the significant transportation needs of older adults. If they could travel to the pharmacy, medication home delivery may not be seen as such a gap. The limited number of pharmacies was also noted, particularly in rural and mountain areas. Finally, some consumers stated that when selecting a drug plan through MediCare Part D, one needed to be certain that their local pharmacy could accommodate the drug plan selected.

Stakeholders (45%) identified consumer knowledge of services as a gap. Many stakeholders reported struggles with "getting the word out about services" to elders, particularly those in more remote areas. Locating seniors for distribution of printed materials proved difficult. An example of this was in Mariposa County where the largest consumer focus group convened. This group appeared well informed and articulate, however when one of the researchers shared a brochure describing local services, the majority of those present had never seen this information. Chart 3 illustrates additional service gaps identified by directors and stakeholders.

Chart 3
Percent Response to Additional Gaps in Services



Funding was seen as a significant gap by nearly one-third of directors and almost one-half of stakeholders. One director stated, "Funding is a disincentive, we work to keep people at home and the savings from not being placed in long-term care creates a saving for the state not the county". Another put it this way, "We have the pieces, but not the power".

Stakeholders agreed with directors that mental health was a service gap. There was consensus that mental health service needed to be delivered to consumers on an in-home basis. One stakeholder described that, "Depression is a huge issue, seniors may not have the ability to tell the doctor their concerns and may have multiple doctors looking at one thing, prescribing medication. Doctors don't communicate and seniors don't know what [medications] they are taking or why".

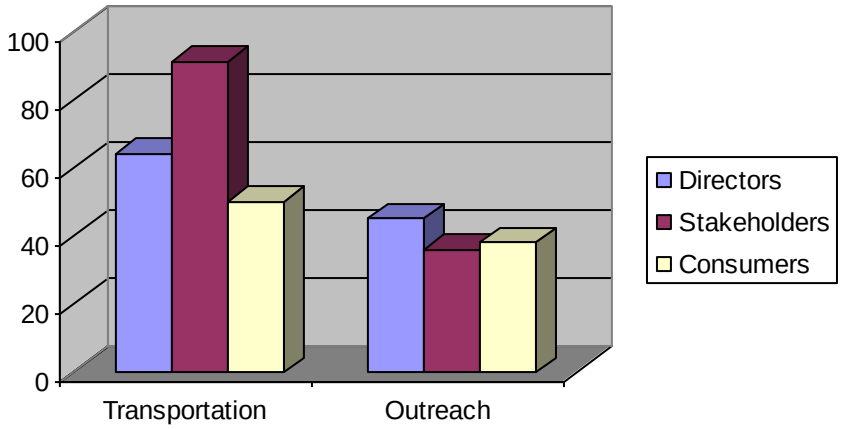
Lack of trained professionals was seen as a service gap. It was agreed that curriculum on providing services to older adults was needed across disciplines such as in social work education and in the health care professions (e.g., physicians, nurses, pharmacists). One stakeholder illustrated this grim reality with the following comment;

"Seniors are sent to the ER from a long-term care facility and are put off in a corner until they [ER staff] can deal with everybody else…a lot of time they are not checked on and they haven't eaten or had their medication. They may be there 36-48 hours and when they are triaged, they may be told, "Well you are old, what do you expect?"

5.*"What issues related to consumer access to care do you see as needing to be addressed?"* Answered by Directors, Stakeholders and Consumers.

Again, all agreed that transportation and outreach were significant issues that needed to be addressed on behalf of older adults. (See Chart 4)

Chart 4
Percent Response to Issues Related to Consumer Access



There was much discussion by each of the cohorts about what made older adult service education and outreach an access issue. Generally, all agreed that is was quite difficult to identify the most effective means of reaching older adults. Problems were identified with keeping resource manuals updated. One stakeholder commented, "On one hand, we need to increase awareness that there's available help, on the other hand those needing free assistance, there's not much left because waiting lists have begun." Locating elders in remote and rural areas was viewed as problematic.

Consumers discussed concerns related to media barriers. For example, in one county a former free newspaper was no longer available, and many elder consumers cannot afford to subscribe to the newspaper. Several newspapers have discontinued sections dedicated to older adult information dissemination and relevant issues. One mountain community saw the need for a radio station. Consumers also complained about being directed to information on the internet. Many do not own a computer or know how to use one. Phone menus were also described as difficult to navigate. Many seniors preferred speaking to a person on the telephone about their questions.

Table 3 identifies additional issues identified by each of the cohorts regarding access. There was frequent discussion about the stigma, elders feel about asking for help. There is a sense of pride in the current generation of seniors where many will do without before they will reach out for help. Many directors, stakeholders and seniors anticipated that this phenomenon will change as the baby boomers reach older adulthood. There was speculation that this next generation of seniors would not only expect services to be available to them, but demand them as well.

Table 3
Additional Response to Issues Related to Consumer Access

Consumers	
Funding	63%
Directors & Stakeholders	
Cultural Issues	36%
Stakeholders	
Computer Illiteracy	27%

MediCare Part D	27%
Stigma, Asking for Help	27%

6. ***"When you consider the multiple levels of program development such as line staff training, supervision, administrative leadership, organizational leadership, policy, organizational mission, what type of changes do you think are needed to transform and improve service delivery to older adults?"*** Answered by Directors and Stakeholders.

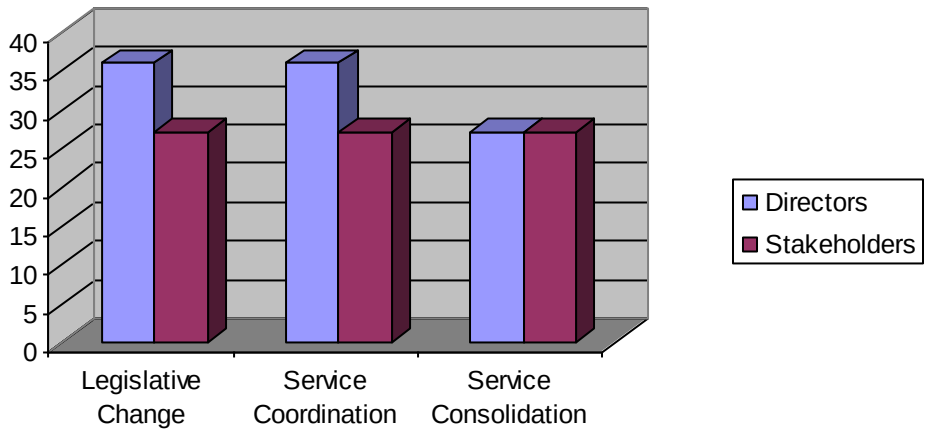
The majority of respondents (73%) saw professional staff training as most important to transforming service delivery. Most agreed with the statements that "issues of aging and what is normal aging needs to be incorporated into all curricula" and "you need to learn about aging from seniors themselves". Themes of ageism also emerged in this discussion. Some felt that for those getting their MSW, more emphasis is placed on working with children and families and that social workers need to get gerontology training that has the comprehensiveness and depth comparable to the Title IV-E Child Welfare curriculum.

Forty-five percent of stakeholders and 36% of directors also agreed that changes were needed in funding and resources to transform services. Concerns were voiced about restrictions on funding streams and the inability to blend funding for needed services. One example of these concerns was described in the following statement, "Program planning needs to integrate transportation (budget for it) into the service delivery. The public sector doesn't deal with transportation; it is all coordinated through the non-profit and private sector". One director stated, "Funding directives are outdated, elder abuse funding is now offered through Adult Protective Services, this is redundant", suggesting

more organizational planning is needed regarding having well coordinated service delivery programs for elders.

Directors and stakeholders also reported needed changes in legislation, service coordination and service consolidation (See Chart 5).

Chart 5
Percent Response to Changes Needed to Transform Services to Older Adults

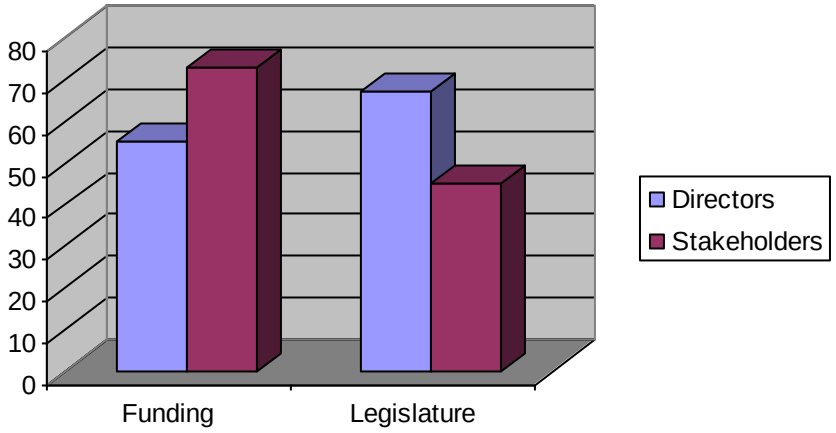


Legislative term limits were considered problematic. Many felt that it took time to inform legislative leaders about the needs of older adults and that term limits created the need to repeat this process with each new term. Another key concern is best described in the following comment; "There's a disconnect at the state and federal level, federal policy and the state level needs to put aside turf issues between the California Department of Aging and the California Department of Social Services and Mental Health. There's no coordination. There will be no system of care until this is worked out".

7. "*What obstacles they perceived in implementing these needed changes?"* Answered by Directors and Stakeholders.

Both funding and the legislature were seen as the biggest obstacles facing them (See Chart 6).

Chart 6
Percent Response to Perceived Obstacle to Changes



A major theme about legislation and funding was summarized in this comment; "Politicians have put off addressing senior needs way too long". There was agreement that there has been overall neglect of senior issues and needs and that funding is considered on a year to year basis, depending on the politics of the legislature. There was great concern expressed that in the past two years, Governor Schwarzenegger has tried to terminate the IHSS program.

One stakeholder stated that, "If there was a coalition where we could be together as stakeholders with the Governor, he could [organize] a commission. Key senior issues could be kept at the forefront despite change in governors. Because by the time we start making a difference, the next governor is elected who has different ideas". This again, raised the concerns of maintaining the awareness of older adult issues among key leaders in light of term limits. Table 4 highlights additional obstacles identified by respondents.

Table 4
Additional Obstacles Identified

Directors	
Regulations attached to funding	67%
Outreach and Education	27%
Stakeholders	
Ageism	55%
Staff Limitations	36%
Transportation	36%

8. ***"If needed resources were provided to best serve older adults, what would be different?"*** Answered by Directors, Stakeholders and Consumers.

No overwhelming consensus emerged in response to this question. Some directors however, did report the need for a One Stop Shop (27%) to meet service needs of older adults. Those counties that do have a One Stop Shop approach to service delivery, reported its effectiveness in meeting service needs.

Table 5 illustrates that transportation was again seen as a needed resource. Stakeholders recognized the need for happier, healthier seniors. They also identified consumer knowledge of available services for older adults. Consumers raised several funding issues. Most agreed there was not enough funding for existing services and for service staff needs. Others specified needed funding for transportation and gas costs for volunteers. Still others spoke of funding issues regarding program eligibility restrictions.

Table 5
Additional Resources Needed to Meet Needs of Older Adults

Stakeholders		Consumers	
Healthier, happier seniors	45%	Funding	63%
Education on services	36%	Transportation	50%
Transportation	36%	Volunteer gas costs	38%
Community services to reduce institutional care	36%	Media resources	38%
		IHSS staff resources	38%

Information was sought about preparation of the older adult service workforce. Consumers were asked to rank on a scale of 1 to 5 (1=not prepared, 5= very prepared), professional staff preparedness to deliver services to older adults. Responses clustered into three categories; Senior Center staff, geriatric health care staff and IHSS staff and providers (See Table 6). Preparation of Senior Center staff ranked high among those who responded. The same held true for at least five consumers regarding IHSS social work staff Although not a representative sample, some consumers found that IHSS providers were ill prepared to provide services. Some respondents stated that providers were unreliable due to not showing up. In such cases, there was no plan in operation for substitute providers to render needed services. One consumer related a situation where a provider did not complete all of the required services but still expected to be paid for the full number of authorized hours for service. Opinions about health care staff were split with 38% finding them well prepared and 44% regarding them as ill prepared.

Table 6
Professional Staff Preparedness to Deliver Services to Older Adults

Type of Staff Identified by Consumers	Scores
Senior Center staff (n=11)	91% ranked $\geq$ 4
Geriatric health care staff (n=16)	38% ranked $\geq$ 4 18% ranked = 3 44% ranked $\leq$ 2
IHSS administrative staff (n=2) IHSS providers (n=5)	100% ranked = 5 60% ranked $\leq$ 1

V. Discussion and Implications for Practice

Findings from the data provide invaluable information about what services are available to older adults and what services are working well. The data also identify service needs and gaps, needed service delivery changes and obstacles to those changes. Finally, the data provide some significant insight into current and future workforce preparation for service delivery to elder consumers. The topics addressed in the literature review covered many topics raised by participants in the study related to abuse, poverty and ethnicity, stigma and ageism, services for elders, assessment, and needed professional skills. The literature review provides a potential guide for the enhancement of existing services and the development of new, innovative programs.

Three main themes or groupings of feedback stand out in the data analysis. These three groupings are: 1) themes in the main findings (e.g., transportation, housing, access to services), 2) strengths in current services, and 3) barriers to change in service delivery. The following will discuss the findings in these three groupings and relate these to the literature review, with a focus on practice implications.

Themes in the Main Findings

The overall findings emphasized transportation, housing, health care, access to services, greater outreach to increase knowledge of services, gerontology training for health and humans services (health care, social services, mental health, etc.) professionals, pharmacology services, mental health services and shortages of services (i.e., need for satellite, mobile units). Although not discussed in this literature review, there is a large body of research and writing on the unique needs of elder rural residents that supports the concerns raised in this study, such as transportation, isolation, and problems in access to services. Specific findings in this study point to problems regarding inordinate long waits for transportation, a need for provision of midday transportation from senior centers to home in cases of medical necessity, a dire need for door to door assistance, and need for better accommodation of wheel chairs on public transportation. The literature also focused on health care issues such as palliative care, pain management, support for elders making informed choices, and assisting elders in recognizing the interaction of biological, behavioral, and social factors in maintaining healthy functioning.

The literature on skills needed by social workers (Naito-Chan, Damron-Rodriguez & Simons, 2004) contributes a useful summary of the array of interventions whose implementation can promote systematic attention to the concerns identified above. Specifically, social worker preparation is needed in assessing elders needs and levels of functioning, taking an advocacy role as well as being informed about needed resources, demonstration of cultural competency in engaging with various senior communities and individuals, and collaboration with other human service and health professionals. Assessment will be discussed in more detail later.

The Central California's rural character and the associated greater risk for isolation of elders creates several significant concerns regarding assessment of an individual's mobility, need for transportation, door to door assistance, provision of midday transportation from senior centers to homes, and monitoring for needed assistance. The remoteness and isolation of many seniors makes it even more important for cultural competency to address the concern that low income seniors of all backgrounds do not participate in senior centers and that primarily white ethnic seniors frequent the centers. For example, advocacy efforts could be directed to develop programs identified by stakeholders to provide enhanced monitoring of elders functioning by including mail delivery staff, yard workers, and other staff who might notice changes in the routine patterns of elders.

Strengths in Current Services

There were clear themes that collaboration between agencies and on teams and the presence of a strong infrastructure of pertinent services are in place, working well and a source of pride for those administrators and stakeholders. In addition an underlying theme in consumers focus groups was that needed services were in place, however needed enhancement because they are not sufficiently meeting elder's needs. For example, much information on resources for elders has been pulled together into brochures, however, oftentimes this is not fully utilized due to the need for further effort at dissemination and publicizing.

The strength in collaborative efforts and organization of services provides an opportunity to pursue efforts at increasing the level of professional preparedness in gerontology within social work and with other professionals (e.g., health care). The

existence of strong collaborative networks increases the likelihood that serious and committed dialogue can explore the challenges in supporting, developing and implementing gerontology training of professionals. This will be addressed in more detail in the next section. Likewise, existing collaborative networks and service delivery systems can be the initiators, as discussed in the literature, of partnerships with educational institutions for the purpose of gerontology training of the future human services workforce.

Barriers to Change

Several themes regarding barriers to change were evident in the findings. These included limitations posed by funding streams, lack of professionals trained in gerontology or cultural competency, difficulties of many elders in accessing and utilizing computer technology as well as message menus on the telephone, need for broader coalitional advocacy, and the lack of sufficient one stop shops.

Recent efforts by CSWE and the NASW in the development of aging competencies, certificate programs in aging, and web courses offer a plethora of resources for training in gerontology and supporting local, in-service efforts with current professional staff. The California Social Work Education Center (CalSWEC), through a statewide effort, developed aging competencies that built upon the work of CSWE. These competencies have been approved are being adopted by the graduate social work programs in the State. Rosen, Zlotnik and Singer's (2002) observation about the most identified competencies needed by social workers can offer a preliminary framework for assessing staff needs. These competencies included self awareness via assessment of one's own values and biases towards death and dying, respectfulness of elders' rights to

make their own choices, the aging process, and appreciating cultural and spiritual needs and beliefs of elders and their families. Many of these competencies are most likely valued by social work practitioners, however, supports and resources needed by staff to develop and practice these competencies require examination.

The need for social workers to understand the normal aging process was addressed in several ways in the literature review that supports findings on the need for training in gerontology. One theme was a strong need for effective assessment of Alzheimer's, dementia, and anxiety. Another theme was the need to distinguish behavior arising from factors other than aging, such as addiction (e.g., intoxication) or side effects of medication. Services that support the coping and adaptations of elders to aging described by participants can also gain from incorporating services to address the losses and separation dealt with by elders. These service needs raise questions about the preparedness of staff to provide these services and the supports that they require to provide effective services.

Funding barriers require advocacy that on both local and state levels. The collaborative networks in place and new ones developed to address marginalized elder constituents can strategize together in advocacy efforts to address needed change.

The next section will discuss Best Practice Models and follow with recommendations from the findings in relation to the models.

VI. Best Practice Models for Services to Older Adults

There is no one approach to best practice that fits every situation. Best practice models are built on principles that need to be adapted to fit a particular need, situation, or community. According to Ham, Goins and Brown (2003), there are seven key principles of best practice for service delivery. They are:

1. New or novel program/service introduced to population that meets an identified need,
2. Benchmarking,
3. Programs that blend funding streams in new ways to sustain the program/service,
4. New and integrative staffing coalitions formed across agency lines,
5. New coalitions among agencies, which have not worked together before (usually prompted by #3 and #4),
6. Client/patient focus,
7. Replicability

To be successful in a rural setting, programs need to include the consumer, their caregivers and family. It is also critical to incorporate community, social, cultural and organizational systems, using resources indigenous to the community, such as churches, neighbors and other community members (Ham, Goins, & Brown, 2003). Consideration must be given to accessibility, affordability, acceptability, appropriateness, awareness, sustainability (Ham, Goins, & Brown (2003). A coordinating or advisory panel is also valuable to the development, implementation and evaluation of program innovations.

Programs implementing best practice models fell into two general categories. The first category was those that were seamless system of care models, such as the Older Adult System of Care (OASOC) model that addresses mental health needs in California. The second category was those in smaller scale, such as a supplemental transportation program for seniors in southern California in the city of Riverside.

Two seamless system of care models were the OASOC Demonstration Project in California and the Illinois long term care transformation model.

Seamless System of Care Models

The California Mental Health Directors Association designed a framework for an integrated Older Adult System of Care (OASOC) that would be; 1) fully funded, 2) culturally and linguistically competent, 3) age appropriate, and 4) gender sensitive (California Mental Health Directors Association, rev. 2005) Its purpose in part, was to recognize the shifting demographics in California that includes the largest elder population in the country, particularly as baby boomers enter older adulthood.

The OASOC framework is designed as a seamless system of services for older adults with mental health issues. In developing this design it was recognized that a fully funded system would require priority for significant funding increases from state and local governments, particularly for outreach to ethnic and other underserved populations.

The OASOC develops collaborative relationships between county public mental health systems in cooperation with older adults and their families. These partnerships include both non-profit and private community service providers and grassroots

entities. Its goal is to achieve quality of life and independence as defined by the elder in partnership with their natural relationships such as family and community in his or her life (California Mental Health Directors Association, 2005).

The California OASOC Demonstration Project conducted four demonstration projects in Humboldt, San Francisco, Stanislaus and Tuolumne counties. The projects focused on three areas; 1) implementation of system of care components, 2) service to older adult target population, 3) achievement of positive consumer outcomes.

The purpose of these projects was to promote the development and piloting of comprehensive, coordinated systems of care that were consumer-focused (California Department of Mental Health. (2004). The projects were successful in improving access, reducing service barriers, and serving multiple needs through multi-agency, comprehensive integrated care.

Key issues emerged during these projects. There was a prevalence of transition age adults requiring services similar to those of older adults. It was important to identify barriers that were unique to each county, such as the stigma of asking for mental health services, transportation and limited availability or visibility of services. Services were tailored to community needs and consumers. Service access was improved by bringing services to consumers through mobile units and co-location of services. The development of multi-disciplinary advisory coalitions that included voice of consumers was significant to the success of the projects (California Department of Mental Health, 2004).

A second seamless system of care model is in Illinois. This model, in compliance with the Older Adult Service Act, (P.A. 093-1031) is a long term care transformation model to convert the Illinois comprehensive service system from funding a largely facility-based service delivery system to a largely home-based and community-based system. Service restructuring is intended to encompass the provision of housing, health, financial, and supportive older adult services.

This model focuses on three main areas: 1) identifying service needs that are non-existent or under funded, 2) restructuring the existing older adult service system in order to increase senior's ability to remain active in their communities, 3) encouraging nursing home operators to convert beds to assisted living and home and community-based services (Illinois Department on Aging, 2006)

Key components of the service transformation are: financing, coordinated point of entry system, comprehensive care coordination, expanded home and community-based service options, workforce improvement, nursing home conversion, and increased opportunities for consumer choice and control over their care and LTC reform (Illinois Department on Aging, 2006).

Implementation of this model is based on the development of a "case coordination unit" that is holistic and client-focused. Customized care plans are based on a comprehensive assessment with the client in their home to identify strengths and care and service needs to help the older adult and family members make informed decisions (Illinois Department on Aging, 2006).

Models of Best Practice Models for Specific Service Needs

Transportation

The ability to access health care, social services and recreational activities will have a significant impact on the length of time older adults can remain independently in their home.

Supplemental Transportation Programs for Seniors (STP's) began in the 1980's with the involvement of the Administration on Aging through National Eldercare Institute (Ham, et al. (2003). These programs were designed to help meet the special mobility needs of those 85 and over. STP's addressed those needs through clustering errands, transportation escorts, door-through-door service and other methods of personal support (Ham, et al. (2003).

The "5 A's of Senior Transportation, developed by the Beverly Foundation in 2001 include; availability, accessibility, acceptability, affordability and adaptability (http://www.seniordrivers.org/STPs/fiveAs.cfm). Models of best practice for transportation should incorporate these factors into their design. The following community based programs demonstrate models of best practice.

The first program is T.R.I.P (Transportation Reimbursement and Information Project) which is in Riverside, CA. It is a non-profit program that provides volunteer drivers and escorts. A "friends helping friends" approach that is empowerment based is used. The older adults recruit their own drivers. The program provides mileage reimbursement to the passengers who then give the reimbursement to their drivers (http://www.livingpartnership.org/Transportation.htm).

Jefferson County Service Organization of Oskaloosa, Kansas is a non-profit agency that is the sole transportation provider of longer-distance rides to medical appointments. Drivers are retired and since the appointments involve long distances, the driver can stay with the passenger. Assistance with scheduling medical appointments, shopping and carrying groceries or packages is also provided (Ham, et. al. (2003).

The Independent Transportation Network (ITN) of Portland, ME is a non-profit local transportation program that serves both urban and rural elders and visually impaired. It began as a graduate student project at Edmund S. Muskie School of Public Service. The program provides both owned and volunteer vehicles with paid and volunteer staff. The unique aspect of the program is that it builds capacity for voluntary revenue from those who benefit from elders having mobility, such as family members, merchants, churches or assisted living programs. Revenue is generated in the form of gift certificates from family members or contracts with assisted living facilities and churches (http://www.itnamerica.org/search_news.asp)

Housing

The ability to remain independent in one's home as they enter older adulthood is a critical component of the quality of life for elders. Several programs that address this need, include the Program of All-Inclusive Care for the Elderly (PACE). PACE is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA). It features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The program is based on a system of acute and long term care services

developed by On Lok Senior Health Services in San Francisco, California. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package enables them to live at home while receiving services instead of being institutionalized. Capitated financing allows providers to deliver all of the services that participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems (http://www.cms.hhs.gov/pace/). Preventive, primary and acute medical services and LTC, culturally and ethnically sensitive in program, menu, language provision, owns 26 vans for transporting and meal delivery. (http://www.cms.hhs.gov/pace/, http://www.onlok.org/)

Glacier Circle Senior Community, located in Davis, CO., is a resident led senior community development within a larger planned neighborhood. This is one three planned co-housing projects across the country (http://abrahampaiss.com/ElderCohousing/GlacierCircle.htm).

Home Sharing is a structured means to match homeowners with those who need shelter in a cooperative arrangement that benefits both people. Unrelated adults share a home that one owns. It appears to best work when both are of similar age, gender and they both can provide an important contribution to the success of the "match" (Ham, et. al., 2003)

Share-A-Home is a model where a group of unrelated older adults contribute to the rental or purchase of a large home and hire a manager to provide personal and domestic services. Each home is self-sufficient and independent. However it is

unclear what regulatory categories this model may fit and it is unlikely the public funds could be used to start up such a model (Streib, Folts & Hiker, 1984).

Health Care

Access to health care is a major problem facing elders in rural settings. New approaches in the use of technology can prove valuable in addressing this need.

Telemedicine and interactive televideo (ITV) are methods that can be used to provide two-way transmission of video and audio pictures. ITV and internet access can serve to reach those in distant and remote areas to receive needed services, consultation, educational programs and other information. This technology can also help monitor the frail elderly and disabled.

The Asheville Project is a model being implemented in Asheville, N.C. It is provided for current and retired city employees in effort to control health cost. The model expands health professional's roles. The project pays pharmacists to serve as "coach" or consultant on things such as diabetes, diet, exercise, medication, stress reduction. Patients attend a health class and meet the pharmacist monthly in return for receiving free medications and supplies associated with their disease. A complete description of this project can be found in the referenced pdf file (http://www.pharmacytimes.com/files/articlefiles/TheAshevilleProject.pdf).

VII. Recommendations

The data results and best practice models have important implications for practice in service delivery to older adults across the central region. Services to older adults:

- Should be based on need rather than age, and
- Earlier intervention can delay the onset of serious concerns such as, health care or housing needs.
- Extending services to transition age adults, or those in their 50's, would serve as a means of prevention and intervention at an earlier stage. This may be a useful strategy in accommodating the anticipated growth in older adult service needs with the advent of baby boomers entering older adulthood.

Although no standard outcome measures were identified nationwide, quality of life and independence were often cited as objectives in service delivery to older adults. Consideration of the independence, mobility and quality of life for elders as benchmarks in service delivery may be warranted. Preservation of dignity and cultural competence must also be integrated into services. The data serve to inform directors and stakeholders on county service needs and gaps as well as what is working successfully. This information can form the foundation on which to both implement and create best practice in service delivery to this client population.

It is recommended that such models build on what is presently working well. Most counties have multi-disciplinary advisory panels and strong collaborative networks. As seen in best practice models, the membership of these panels and networks needs to

expand and include representation from consumers, caregivers, family members, local and regional leaders and government officials, health care and mental health care providers and perhaps, churches. Comprehensive panels such as these can lend valuable input into increasing and promoting public awareness and support of older adults and their needs in an effort to combat ageism. They can also build support for increased flexible funding. As was noted, the shift of priority funding is critical to the transformation of service delivery. This funding can then begin to support service needs and gaps as well as outreach to underserved and un-served populations.

The study results identified services that are working well. We recommend that:

- The strengths of these services be assessed in order to improve and expand them; both nutrition programs and outreach were thought to be working well, however needed improvements were also identified.
- The transformation of service delivery should be based on these strengths in order to identify means of integration.
- Input from older adults, their caregivers and family members will help to understand the aging experience and what is needed in order to best provide support and assistance to them.
- Services need to be more accessible. Study results illustrate both the utility and effectiveness of a service system model that integrates co-location, satellite sites and or mobile units to better reach older adults.

Workforce development is a key factor in the successful implementation of services to older adults and in redesigning delivery systems.

- Both formal and informal members of the workforce are needed in addition to those who serve on an employed or volunteer basis.
- An organized approach to recruitment, training and retention of the workforce is needed that includes training and understanding of rural aging needs and issues related to gerontology.
- Partnerships should be established with colleges, universities and other educational institutions to address educational needs for workforce development.
- Community organizing efforts are recommended to order to "grow your own" workforce who can understand, serve and support their older adults.

These recommendations suggest approaches for improvement and expansion of service delivery to older adults in the Central California region. Key features found in these recommendations are:

- Expansion of existing advisory panels and collaborative networks,
- Build on the strengths of existing services for improvement
- Build a lobbying force for the increase and shifting of priority funding
- Involve consumers and their families in program and workforce development.
- Promote public awareness of older adult issues, specifically in outreach to older adults in their 50's. This recommendation was discussed in the context of 1) the need for health providers to prepare for the upcoming large cohort of boomers and concern about being overwhelmed, 2) the extraordinary lack of gerontological training in all health professions (e.g.,

medical, social service, mental health), 3) recognition of a need to determine strategies for intervention (e.g., individual, community, organization), and 4) growing evidence that positive images of aging can result in more long term health into aging (Kolata, 2006).

This will be a dynamic, ongoing process that will require periodic assessment of progress as well as forecasting emerging challenges facing those serving older adults.

References

Bellos, N. & Ruffolo, M. (1999). Aging: Services. *Encyclopedia of social work*. pp. 165-173.

Buckwalter, K.C. & Davis, L.L. (2002). Elder Caregiving in Rural Communities, National Family Caregiver Support Program Issue Brief. Available at www.aoa.gov/carenetwork.

CalSWEC (February, 2005). *Aging Initiative Progress Report.* P. 5. Berkeley, CA: Author.

California Department of Mental Health. (2004). *Analysis of the Older Adult System of Care Demonstration Project*.

California Association of Homes and Services for the Aging (CAHSA). (2005). *Innovative Aging Services & Housing Models Summary*

California Mental Health Directors Association. (rev. 2005). *Older Adult System of Care Framework.*

Clark, E. (2003). The future of social work practice. In *Encyclopedia of social work. Supplement 2003.* (19th ed.). National Association of Social Workers

Cohen, H., Greene, R., Lee, Y. Gonzalez, J. & Evans, M. (2006). Older adults who overcame oppression. *Families in Society: The Journal of Contemporary Social Services, 87*(1), 35-42.

Council on Social Work Education/SAGE-SW (2001). *A blueprint for the new millennium*. Funded by the John A. Hartford Foundation of New York City.

Delon,, M. & Wenston, S. (1989). An integrated theoretical guide to intervention with depressed elderly clients. *Journal of Gerontological Social Work, 14,* 131-146.

Diringer, J., Curtis, K. McKinney, C. & Deveau, D. (2004). *Health in the heartland : The crisis continues.* Retrieved 6/29/06, from http://www.csufresno.edu/ccchhs/pubs/HIH/Health_in_the_Heartland_2004.pdf

Emmons, K. (2000). Health problems in a social context. In L. F. Berkman & I. Kawachi *(Eds.). *Social epidemiology.* New York: Oxford University Press, 242-266

Erikson, E., Erikson, J. & Kivnick, H. (1986). Vital involvement in old age. New York: W.W. Norton.

Fredriksen-Goldsen, K. (2005). Multigenerational health, development, and equality. *The Gerontologist, 45*(1), 125-130.

Hagestad, G. & Uhlenberg, P. (2005). The social separation of old and young: The root of ageism. *The Journal of Social Issues, 61*(2), 343-360.

Ham, Goins, & Brown. (2003). "Best Practice in Service Delivery to the Rural Elderly." West Virginia Center on Aging, www.hsc.wvu.edu/coa/

Housing Assistance Council (2001). Federal Programs and Local Organizations: Meeting the Housing Needs of Rural Seniors. Available at: www.pha-resources.org/sec/docs/agngnplac/hacrursn.asp

Illinois Department on Aging. (2006). *Older Adult Services Act (P.A. 093-1031). Report to the General Assembly.*

James, J. & Haley, W. (1995). Age and health bias in practicing clinical psychologists. *Psychology and Aging, 10*(4), 610-616.

Kemp, B. & Mosqueda, L. (2005). Elder financial abuse: An evaluation framework and supporting evidence. *Journal of American Geriatric Society, 53,* 1123-1127.

Kolata, G. (October 6, 2006). Old but Not Frail: A Matter of Heart and Head. *New York Times, A1, A22.*

Kerschner, H. & Aizenberg, R. (1999). *The 5 A's of senior friendly transportation: Focus group report*. Pasadena, CA: The Beverly foundation

Kerschner, H. & Aizenberg, R. (2001). *Supplemental transportation programs for seniors.* Pasadena, CA: The Beverly Foundation.

Knight, B. (1983). Assessing a mobile outreach team. In M.S. Smyer & M. Gatz (Eds.). *Mental health and aging; Programs and evaluations.* . 23-50. Beverly Hills, CA: Sage Publications.

Knight, B. (1986). Psychotherapy with older adults. Beverly Hills, CA: Sage Publications.

Markides, K.S. & Mindel, C.H. (1987). Aging and ethnicity. Newbury Park, CA: Sage Publications.

Meeks-Sjostrom, D. (2004). A comparison of three measures of elder abuse. Journal of Nursing Scholarship, 36(3), 247- 250.

Naito-Chan, E. Damron-Rodriguez, J. & Simons. W. (2004). Identifying competencies for geriatric social work practice. *Journal of Gerontological Social Work, 43*(4), 59-79.

National Advisory Committee on Rural Health. (2001). Medicare Reform: A rural perspective. Report to the Secretary, U.S. Department of Health and Human Services. http://ruralhealth.hrsa,gov/policy/nacpubs.html.

Nelson, T. (2005). Ageism: Prejudice against our feared future self. *Journal of Social Issues, 61*(2), 207-221.

Ortiz, L. & Langer, J. (2002). Assessment of spirituality and religion in later life: Acknowledging clients' needs and personal resources. *Journal of Gerontological Social Work, 37*(2), 5-21.

Prochaska, & DiClemente, 1983Stages and processes of self change of smoking: Toward an integrative model. *Journal of Consulting and Clinical Psychology, 51*(3), 390-395.

Quinn, M.J. & Tomita, S.K. (1986). *Elder abuse and neglect: Causes, diagnosis, and intervention strategies.* New York: Springer.

Rand California (2003). Population and demographic statistics: Population estimates [Data files] retrieved 6/29/06 from http://ca.rand.org/stats/popdemo/

Richardson, V. & Barusch, A.. (2006). *Gerontological practice for the twenty-first century*. New York: Columbia University.

Rogers, A. & Delewski, C. (2004). Elders with serious and persistent mental illness (SPMI). Assessing needs, resources, and service utilization. *Journal of Gerontological Social Work,43*(1), 19-36.

Satariano, W. (2006). *Epidemiology of aging: An ecological approach.* Boston: Jones and Bartlett Publishers.

Schlarlach, A. , Damron-Rodriguez, J. Robinson, B. & Feldman, R. (2000). Educating social workers for an aging society: A vision for the 21st century. *Journal of Social Work Education, 36*(3), 521-538.

Scharlach A., Torres-Gil F., Kaskie B. *Strategic planning framework for an aging*

population. California Policy Research Center, University of California. CPRC Brief No. 1 (May 2001).

Smeeding, T. (1990). Economic status of the elderly. In R.H. Binstock & L.K. George (Eds.), *Handbook of aging and the social sciences.* 362-382. San Diego: Academic Press.

Sneed, J. & Whitbourne, S. (2005). Models of the aging self. *The Journal of Social Issues, 61*(2), 375-388.

Spitzer, W., Neuman, K. & Holden, G. (2004). The coming of age for assisted living care: New options for senior housing and social work practice. *Social Work in Health Care, 38*(3), 21-45.

Streib, G.F., Folts, W.E., & Hilker, M.A. (1984). *Old homes—new families: Shared living for the elderly*. New York: Columbia University Press.

Taeuber, C.M. (1992). *Sixty-five plus in America: Current populations reports, special studies.* Washington, D.C. U.S. Bureau of the Census.

Torres-Gil, F. & Puccinelli, M. (1999). Aging: Public policy issues and trends. In *Encyclopedia of social work*. pp. 159-164. Washington, D.C.: NASW Press.

Toseland, R.W. (1999). Aging: Direct practice. In *Encyclopedia of social work*. (19th ed.). pp. 153-159. Washington, D.C.: National Association of Social Workers.

U.S. Census Bureau. (2002). Census 2000, Summary File 2. Available at: http://factfinder.census.gov

U.S. Census Bureau (1999). The older population in the United States: Population characteristics. Author: Washington, D.C.

Vitaliano, P., Katon, W. & Unutzer, J., (2004). Making the case for caregiver research in geriatric psychiatry. *American Journal of Geriatric Psychiatry, 13*(10), 834-843.

Whitaker, T., Weismiller, T., & Clark, E. (2006). *Assuring the sufficiency of a frontline workforce: A national study of licensed social workers. Special report: Social work services for older adults.* Washington, DC: National Association of Social Workers.

Wilke, D. & Vinton, L. (2003). Domestic violence and aging: Teaching about their intersection. *Journal of Social Work Education, 39*(2), 225-236.

Yurk, R. Morgan, D., Franey, S., Stebner, J. & Lansky, D. (2002). Understanding the continuum of palliative care for patients and their caregivers. *Journal of pain and symptom Management, 24*(5), 459-470.

Zink, T., Jacobson, J. , Regan, S. & Pabst, S. (2004). Hidden victims: The healthcare needs and experiences of older women in abusive relationships. *Journal of Women's Health, 13*(8), 898-908.

Zuniga, M. (1999) *Aging: Social work practice*. In *Encyclopedia of social work.* 173-183.

Zuniga, M. (1999). Aging: Social work practice. In *Encyclopedia of social work.* 173-183. Washington, D.C.: National Association of Social Workers.

APPENDIX A
Findings by County

Findings by county are presented in relation to three key questions that dealt with identification of major service needs, gaps in services, and issues that need to be addressed.

This section will present the responses from directors, stakeholders and consumers on three domains of data gathering, these were "What do you consider to be the 5-7 biggest service needs of older adults in your county?", "What service gaps exist in service delivery?", and "What issues need to be addressed?"

Question: "What do you consider to be the 5-7 biggest service needs of older adults in your county?" (Directors, stakeholders, and all consumers, except Kings, San Luis Obispo, Tulare Counties responded).

Fresno County

All three groups (director's office, stakeholders and consumers) shared in the identification of transportation, access to services and health care as priorities. However, in relation to health care, there was variation between the three groups in what they perceived as major healthcare issues. The directors identified "access" as its central concern in relation to affordable health care plan, home based mental health, interdisciplinary teams, providing culturally competent staff, whereas consumers focused on the need for medical resources meaning services such as effective discharge planning and health professionals who are trained in gerontology. They also spoke about the importance of information on nutrition, and the provision of fresh food and food that reflects diverse cultures in senior center settings. Stakeholders focused on the dilemma of elders needing door to door transportation assistance, and the problems with early

morning pickup and late afternoon return to home, leaving some seniors with having to take a taxi home midday due to lack of stamina or health issues (e.g., diabetes), at the personal cost of $30. Special interests were identified by the following:

- Directors specifically placed a high priority on low income housing, mental health services and program development related to prevention (i.e., working with young elders in preparation for aging) and services that promote health aging.
- Stakeholders discussed the development of a "marketing" orientation in doing outreach to elders regarding services
- Consumers discussed the necessity of having skilled, domestic help for home bound seniors and affordable housing.
- Both directors and stakeholders shared an interest in the necessity of providing home and community based services.
- Consumers were concerned with the effects of ageism regarding the unemployability of elders, and the importance of working with the under 60 group to prepare them for the aging process.

Kern County

All three groups were in agreement that transportation was the key concern. Consumers felt transportation problems were "huge" in relation to frequent stories of individuals having to wait 3 hours to get picked up, the lack of transportation services for wheelchair bound elders, the need for ramps to get onto public buses, and lack of transportation services on weekends. In addition:

- Directors discussed concerns regarding access to services and the provision of caregiver support.
- Stakeholders also identified affordable housing, provision of skilled domestic care for home bound seniors, need for outreach regarding health care services, and lack of interagency communication as important concerns. There was some emphasis on supporting independence of seniors, particularly through the provision of adult day and day health care centers.
- Consumers focused on their need for medical resources specifically focused on the need for advocates, social work assistance with paperwork related to medical services, and gerontological specialists (health care, social services).

Kings County

Directors and stakeholders were in agreement that prioritization is on transportation and providing affordable housing. Stakeholders specifically discussed the need for transportation for medical services.

- Directors also identified mental health services as important, concern with the loss of the companion program, and providing information on services suggesting the importance of outreach. Companion type programs were praised by others in other parts of the Central Valley.
- Stakeholders also focused on concerns regarding lack of communication between agencies and health issues in relation to affordable health care, prescription use among seniors and their frequent lack of understanding of the medications (effects, dosage, regime), lack of coordination among physicians.

Madera County

- All three groups agreed on transportation and access to services as being top priority needs. Directors were specifically concerned with the need for caregiver concerns, adult day health care, provision of mental health services and confusion for some consumers when some advertised services are available in Fresno, but not in Madera. All three groups emphasized the need to address the isolation of many elders, as well as the low income status of many, which effects their mobility and access, and the need for outreach.
- Stakeholders and the directors were in agreement on prioritizing the development of affordable housing.
- Stakeholders and consumers were both concerned with the need for a nutrition program that includes meal delivery for home bound seniors and provision of nutritious, fresh food in meal programs.
- The directors were very concerned about the geographic distances, isolation of seniors, and having a strong APS program.
- Stakeholders also focused on the need for skilled domestic help, the need for recreation and socialization for stimulation due to the isolation of many seniors and a strong APS program.
- Consumers pointed out transportation services need to be more comprehensive and timely for example with food shopping needs (e.g., refrigerated food).

Mariposa County

All three groups were in agreement that transportation and access to services are the major needs and emphasized the challenge of the isolation of seniors as a major

concern. Consumer's focused on the need for outreach and information provision. It was interesting to note that when the research staff pointed out the presence of a services brochure in the senior facility, very few of the elders knew about it. It was reminder that information can be developed; however, outreach is essential to assure that it is utilized.

- Directors and consumers both agreed that affordable housing is a priority.
- Directors also identified concerns regarding energy costs for elders and health care access, for example in regards to Alzheimer's patients having to get placed out of county. The need for a wide array of services was identified that included skilled nursing facilities, senior housing, geriatric nursing professionals, and adult day care.
- Stakeholders placed much emphasis on
    - How the strong sense of independence in elders living in the mountain makes it more difficult for them to accept the limitation of aging; isolation, lack of family support.
    - Difficulty that elders encounter with phone menus and the necessity of being able to speak with a person
    - Problems with Medicare Part D
    - Long waiting lists for long term care facilities
- Consumers focused on
    - The need for medical resources and the need for professionals trained in gerontology. Although the Fremont Hospital was touted as a needed resource there was much discussion about the need to go into the valley for specialized services (e.g., dialysis).

- The necessity of elders having a health care program before moving to Mariposa in that some health care programs (e.g., Kaiser), do not allow subscription to their health care, if the residence is in Mariposa.
- Other concerns included how ageism and stigma works against elders utilizing services, reduction of Sheriff's services, need for an 800 number for health questions or nursing advice in non-emergencies, need for transportation to medical appointments, and door to door assistance with transportation.

Merced County

There was no overriding agreement by the three cohorts regarding prioritization.

- Directors and stakeholders shared a focus on access to services.
- Stakeholders and consumers shared a focus on prioritizing transportation, affordable housing and providing nutritious food programs. Diabetic diets, freshness of food, and diverse cultures need to be considered in meal planning.
- Directors focused on:
  - Mental health
  - The challenge of a retirement community "coming over the hill" (i.e., moving in to retire); preparing for the baby boomers
  - Necessity of culturally competent staff. Interestingly, both the stakeholders brought up the issue of cultural competence from a different perspective which was the lack of integration of diverse cultures into the senior centers and the need to change this.

Consumers also talked about lack of a senior program for the Hmong community and the need for food in senior centers to reflect the diverse cultures in the region.

- Stakeholders focused on
    - Transportation needs
    - How low income seniors do not use senior center services
    - A need assistance of many seniors in understanding legal documents; concern regarding transfer of property
    - Dysfunction in the medical profession (records lost) and elders not being able to manage advocating for self
- Consumers focused primarily on
    - The need for medical resources and specialists (e.g., quality interaction with time for questions, gerontology training for professionals, need for a medical hotline, translation services)
    - The need for recreation and socialization services, particularly because of the isolation of many seniors
    - Adequate health care coverage
    - Provision of living skills
    - Transportation; need for translator on buses (e.g., Hmongs feel "afraid to call use bus, fear they will get lost")
    - Need for community center(s) that highlight diversity

San Joaquin County

The sole agreement across all three groups was on the priority of providing transportation. Consumers emphasized the need of services to be more comprehensive (e.g., one gave an example of seniors having long waits sitting on the sidewalk to get picked up by Para Transit, another described being dropped off but not picked up to return home) and problems with reliability of the bus service.

- Directors and stakeholders agreed on affordable housing as a priority.
- Stakeholders and consumers agreed on access to service and providing outreach information on services as important (e.g., using television).
- Directors focused on the need for mental health services, efforts at prevention and promoting healthy aging, as well as needing to plan for home services that baby boomers will need.
- Stakeholders focused on the need to have a strong nutrition and domestic care programs, financial abuse services and reaching out to underserved elder ethnic communities. They were also concerned about greater collaboration and full service partnerships with the community.
- Consumers were very concerned about the difficulties with the Para Transit mentioned above.

San Luis Obispo County

Directors and stakeholders focused on different service needs that, in fact, complement each other:

- Directors identified low income housing, mental health services (e.g., 24 hour shelter at discharge, crisis intervention, short term services), health care access

(e.g., for homeless) and prevention as well a promoting healthy aging (e.g., in 40's & 50's) as priorities. Directors also identified the need to address:

  - Comprehensive medical care needs, specialists in gerontology, long term care beds, hospital discharge planning services
  - A disconnect between medical professionals and community providers
  - Integration, collaboration between providers that serve seniors

- Stakeholders identified addressing caregiver respite services, abuse and isolation (e.g., loneliness, depression) of seniors, and the need for in home care as priorities.

Santa Barbara County

All three cohorts identified different service needs, that all have importance.

- Stakeholders and consumers agreed on transportation as a priority
- Directors focused on the need for low income housing, mental health services, and prevention services as well as promotion of healthy aging.
- Stakeholders focused on:
  - The challenge of the diversity of the three geographical county regions and related service needs,
  - Importance of involving and doing outreach with low income seniors who are not using senior centers and the need for care giver support, who oftentimes are also elderly
  - The reality that few residential care facilities take the SSI rate (1 out of 46), forcing elders to move north, often to the Santa Maria area.

    - Adequate services for old-old, but inadequate services for young-old seniors
    - Mental health services have not addressed dementia sufficiently
- Consumers focused on the need for skilled domestic help, particularly with groceries, care giving, and the need for skilled staff in health facilities.

Stanislaus County

Directors, stakeholders and consumers all agreed that housing (affordable) is the top priority.

- Directors emphasized that are too many gaps in home services
- Consumers focused on the need for:
    - Medical resources & specialists
    - Healthcare for younger elders; prevention
    - IHSS workers are not skilled, and this seems to be due to the low salary; language barrier
- Stakeholders and consumers shared priorities on transportation, particularly buses, and the need for domestic care that is skilled. Consumers emphasized;
    - Difficulties with Dial-a-ride in that seniors get picked up, but oftentimes do not get returned to their homes
    - Long (3 hour) waiting period for a pick up
    - Lack of space on buses for wheel chairs; there are only two
    - Lack of transportation services in outlying rural areas
- Directors and stakeholders emphasized the need for health care access and access to services.

Tulare County

Directors, stakeholders and consumers all agreed that transportation, access to services, health care access and health care are the biggest service needs.

- Directors were also concerned about the need for increased funding and outreach to all cultural groups.
- Stakeholders also focused on the need for
    - More affordable housing
    - Stronger nutrition program
    - Skilled domestic care that can assist with home maintenance tasks
    - Effects of inflation on low income
    - The Hot Springs area was particularly concerned about the lack of services (legal, nutrition, health, social) for seniors, particularly because 85% of the population (n=350) is over 60 years of age.

Question: "What services gaps exist that need to be addressed?"

(Directors, stakeholders and consumers addressed this question)

Fresno County

All three cohorts agreed that there are insufficient numbers of social workers, physicians, nurses, and pharmacists who are trained in gerontology, and insufficient funding for programs. Directors and stakeholders agreed there is a gap in services for Alzheimer's patients, particularly in regards to intake assessment of dementia.

- Directors also expressed concern about the following gaps:

    - An intake structure in place that addresses diabetes, dementia and Alzheimer's
    - User friendly services
    - Health care and social services professionals trained in gerontology (including pharmacists)
- Gaps identified by stakeholders included: insufficient linguistic competency in service delivery, and a lack of comprehensive, integrative services
    - Training for professionals on different facilities for elders and regulations by which they are governed
    - Conservatorship consulting and services
    - Isolation of elders
    - Companion programs
- Gaps identified by consumers included having a life long learning center; sufficient transportation, and companion services, also insufficient services for adult learning as in adult schools (e.g., courses on finances, health, enrichment)
    - More community resources, such as, use of churches for services
    - Companion services; families most often are at a distance

Kern County

The greatest service gap identified by all three groups is transportation

Also:

- Directors were concerned with service gaps relating to the great geographic distances with which elders must deal and the absence of sufficient outreach to culturally diverse elders (access issues).

- Gaps that stakeholders were concerned about included;
    - Lack of emergency responsiveness to elders; oftentimes elders must wait long periods in emergency rooms or their medication and nutrition needs are not assessed while they wait
    - Lack of information between agencies about services; fragmented services
- Gaps consumers addressed related to lack of bus space for wheelchairs, insufficient amount of advocacy for elders, and lack of sufficient outreach, particularly bilingual outreach (e.g., senior centers available and not used by all groups).

Kings County

Directors and stakeholders identified differences in service gaps. Directors focused on a training gap for law enforcement on working with elders, as well as respite care for care givers. Stakeholders focused on the baby boomers as a "tsunami", the difference with the young-old, vs. old-old (old-old more accepting of available services) and the absence of services and staff in place to prepare for the baby boomer increase.

Madera County

The one major gap that all three groups agreed upon was the need for greater resources. Directors and stakeholders identified funding as a major gap, whereas consumers identified medical resources.

- Directors identified gaps in addressing the confusion in services between Fresno and Madera, and the gap in having needed approaches to serve diverse groups (e.g., mountains, valley differences).

- Stakeholders identified gaps in funding, inconsistency in the Ombudsman program, and the absence of sufficient mental health programs.
- Consumers focused on the absence of services that could assist elder needs such as delivery of medication.
- The Director's office and consumers agreed on a gap in transportation services.

Mariposa County

There was no agreement across the three groups on the largest gaps in services.

- Directors identified gaps in intake and assessment with Alzheimer's and dementia.
- Stakeholders identified gaps in staff shortages, specifically in difficulty attracting staff due to low salaries.
- Consumers identified gaps in
    - Transportation services,
    - Medication delivery,
    - Sufficient volunteers for senior services
    - Using media more in order to advertise available services

Merced County

Directors and stakeholders agreed that linguistic competency in all service providers is a major gap. In addition:

- Directors identified gaps in
    - Medical services, such as having sufficient prescription coverage
    - Importance of reaching isolated, hard to reach seniors

- Stakeholders identified gaps in elders being informed about their medications and regimen, professionals being informed, and mental health services.

San Joaquin County

All three agreed on transportation as the largest service gap. Also:

- Directors identified
    - Affordable housing
    - Funding flexibility that would allow moving institutional care funding resources to home care funding
- Stakeholders identified linguistic competency, identifying home bound seniors that "no one knows about" and transporting large elder equipment, such as scooters.

San Luis Obispo County

Directors identified the challenge of access due to the geographic layout as a major gap. Stakeholders identified:

- Adequate funding
- Knowledge of services (professionals and elders)
- Linguistically competent service delivery
- Trained geriatric professionals in all fields
- Services in the evening (i.e., "middle of the night")
- Need for oversight of care facilities
- Senior "safety beds" when elder is not ready to return home

Santa Barbara County

Directors and stakeholders agreed on gaps in mental health services and in sufficient professional training in gerontology. Also:

- Directors identified a gap in intake and assessment of Alzheimer's dementia and affordable housing.
- Stakeholders identified gaps in funding and in baby boomer services.
- Consumers in this focus group were very high functioning and mobile.

Stanislaus County

All three groups identified different gaps.

- Directors identified a funding disincentive that keeps people at home, saves long term care costs; creates savings for the state, but not the county.
- Stakeholders identified funding and knowledge of services.
- Consumers identified gaps in transportation. They pointed out that the independence and pride that many elders feel needs to get addressed because it leads to not asking for help and remaining in home rather than assisted living when it is direly needed. Also, they identified the gap in preparing the young-old for aging, for example by focusing on health practices.

Tulare County

- Directors and stakeholders each identified different gaps.
- Directors focused on mental health services, access to outlying rural areas and transportation as major service gaps. Concern was expressed regarding the shortage and distribution of physicians, the status of the rural hospital ("under siege"), and lack of power to make effective changes.

- Stakeholders focused on a gap in services for baby boomers.

Question: "What issues need to be addressed to improve access or meet the needs of elders?" (Answered directors, stakeholders and consumers)

Fresno County

All three cohorts agreed that a key issue to be addressed is transportation. Consumers pointed out the need for transportation at night, when many elders cannot drive and may need transportation to ER. In addition

- Directors emphasized the need to address making services available to those in outlying rural areas as well as access to social services and health care, treatment for dementia.
- Stakeholders identified cultural competency, public education on services, gerontology trained staff, and the need for emergency personnel to have access to information that is protected by HIPPA as key issues. There was concern about the lack of gerontology training for physicians regarding appropriate types of facilities for specific levels of elder functioning.
- Consumers identified
    - Lack of sufficient initiative by the local newspaper on community affairs relevant to senior issues (media barriers)
    - Needs of pre-seniors (e.g., coverage for wheelchair & not eligible)
    - Lack of adequate funding for programs as key issues.
    - Funding for programs

Kern County

Directors and the stakeholders identified different types of issues to address.

- Directors identified adequate staffing to address cultural differences among elders and assuring access to services for those in outlying rural areas as key issues.
- Stakeholders identified transportation, public education on services to elders, lack of computer literacy, and the challenge of Medicare D as key issues.

Kings County

Directors and stakeholders agreed that transportation is a key issue. Stakeholders were concerned about the need for transportation due to disability among elders or needing services and living in outlying rural areas. Also:

- Directors identified access (daycare and meal programs) and outreach to seniors as important. There was also concern that some seniors see elder services only for those who are low income.
- Stakeholders emphasize the stigma as a key issue that must be addressed. Also they identified:
    - Need to address denial of aging and need for daycare or other services and the image that receiving services means asking for "charity"; an attitude of not wanting to be seen as "needy".
    - There was concern that
        - many elders limit their food purchases in order to pay for medication;
        - some of these elders do not meet the income criteria for eligibility, however, also don't have enough income to cover their expenses

        - possible abuse by children that is not reported because elders feel they will be abandoned

Madera County

There was no agreement across the three cohorts.

- Directors identified issues that included the cost of transportation services for rural outlying areas, language barriers, difficulties that elders encounter in accessing services in Fresno (unfamiliar).
- Stakeholders saw the need for advocates for elders as a major issue, because elders do not speak out for themselves, particularly those who are seriously ill.
- Consumers identified several issues that included
    - Need for greater funding for programs
    - Assistance with groceries, trips, events for socializing and intellectual stimulation as well as having pets; acknowledged the therapeutic value of elders to have pets, yet inability to care for them alone
- Directors and stakeholders agreed on transportation as a key issue.

Mariposa County

All three cohorts agreed on transportation as a key issue to be addressed. Stakeholders were particularly concerned that the need for transportation is growing. In addition:

- Stakeholders identified public education on services, and lack of dialysis facilities. They were also concerned about the challenge of reaching elders with limited access to leaving their homes.

- Consumers identified insufficient funding, media barriers, and lack of sufficient number of pharmacies for competitive prices. There was some interest in generating volunteer programs with local youth to work with elders.
- Directors pointed out how aging is harder in mountain areas due to isolation, lack of services, challenge of Medicare D, and lack of transportation.

Merced County

Directors and stakeholders agreed that transportation was a key issue. Also:

- Directors identified access and outreach, as well as staff to deal with cultural diversity as key issues. Interest in developing symbols for bus lines that are understood by all cultures and addressing the westernized approach to medical services.
- Stakeholders identified lack of physician awareness of services and insularity of government offices as issues.
- Consumers identified funding, the need for culturally competent staff as well as interpreters, and integrated senior centers that reflect all valley cultures as key issues.

San Joaquin County

Directors and stakeholders agreed on transportation and cultural competency as key issues to be addressed. Language and cultural competency, affordability of services, and knowledge of services were all discussed in relation to accessibility. Consumers identified funding and the use of newspapers to reach elders and provide information on activities and services.

San Luis Obispo County

- Directors identified access to services and outreach as key issues. Also identified were:
    - Need for a mechanism to update information on availability of services, eligibility; the trained staff to maintain this vehicle for information
    - Create one stop shop
    - Create integrated service delivery to include public services, community based services and health care agencies
- Stakeholders identified transportation and cultural competency as issues. This group was very concerned about the challenge of reaching elders in outlying areas who are isolated.

Santa Barbara County

Directors and stakeholders agreed on transportation as a key issue. Also

- Stakeholders identified lack of computer literacy, Medicare D, and the stigma of asking for help as issues to address.
- Consumers identified lack of adequate funding as an issue. Professionals who take initiative to "check into what is going on", who "care about other people" and higher wages for IHSS caregivers (e.g., greater skilled involvement) emerged as a theme. There was some emphasis on the need to de-stigmatize asking for assistance, particularly among the older seniors.

Stanislaus County

- Directors identified end of life education, services by plan rather than in crisis, the need to have an integrative assessment, and trained professionals as key issues.
- Stakeholders identified public education of services, addressing lack of computer literacy and Medicare D as issues. They agreed that many systems are in place, but are not used because they are difficult to navigate.
- Consumers identified transportation has the main concern.

Tulare County

Directors and stakeholders agreed on transportation, cultural competency with diverse elders as the main issues. Access to services was raised as a main issue in that some residents in remote areas occasionally also take an "urban" address in order to become eligible for services

Stakeholders identified a need for mobile, satellite services, the dilemma of middle income seniors in relation to eligibility of services and elders conflicts about "ask for help" due to cultural values, pride, the work ethic as issues that must be addressed.

APPENDIX B

Older Adult Services System of Care
Informed Consent Form
County Directors

You are invited to participate in the following research project that is being conducted to provide data that will identify service needs for the older adult population. You will be asked to participate in a telephone survey that focuses on strengths and weaknesses of current services to older adults, gaps in existing services, and identification of stakeholders who might help in further identifying resource issues. The telephone interview will take approximately 60 minutes of your time.

It is understood that your participation in this phone interview is voluntary, and that you will not gain any benefit from participating. If at any time you wish not to participate in this study, please let the interviewers know. You may stop the interview at any time, for any reason, with no penalty.

It is hoped that the data collected in this study will improve the comprehensiveness and quality of services for older adults in the Central California Region. In addition, data may be used for publication in a journal and/or presented at a conference. There will be no identifying information that would identify your responses, particularly in the use of quotes. Any use of quotes from your interview will be presented with confidentiality and anonymity. If desired, you are invited to review the quotes that may be used in a publication. All records will be kept with strictest confidence. Only the project researchers will have access to this information or the data. Any personal information collected will be stored in a locked file cabinet in the primary investigator's office.

If you have any questions about this research study or have questions regarding your rights as a research subject, please contact:

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I agree to a tape recording of the phone interview and understand that I can request that the tape recording be turned off at any point in the interview, without penalty. I also understand that if I become uncomfortable during the interview that the interview can stop and additional time will be made available to discuss the thoughts about the discomfort, and that the researchers are available to debrief after the interview. All tapes will be destroyed upon completion of this research project.

I affirm that I have read and understood this form, and I agree to participate in the telephone interview and give permission to allow the data to be used for program development, publication and presentations at professional conferences and meetings. I understand that I will be given a copy of this consent form and the completed report.

Signature _____ Date _____

bjg/ds

APPENDIX C

Older Adult Services System of Care
Stakeholders Informed Consent Form

You are invited to participate in the following research project that is being conducted to provide data that will identify service needs for the older adult population in the Central California Region. You will be asked to participate in a telephone survey that focuses on strengths and weaknesses of current services to older adults, gaps in existing services, and identification of stakeholders who might help in further identifying resource issues. The telephone interview will take approximately 60 minutes of your time. In some situations with your consent, this telephone survey may be arranged as part of a group survey or conference call. Prior to such an arrangement, you will be contacted to inquire about your interest and/or willingness to participate in a conference call. If you prefer to participate in an individual telephone interview instead, we will respect your preference and accommodate your request.

It is understood that your participation in this phone interview is voluntary, and that you will not gain any benefit from participating. If at any time you wish not to participate in this study, please let the interviewers know. You may stop the interview at any time, for any reason, with no penalty.

We hope that the data collected in this study will improve the comprehensiveness and quality of services for older adults in the Central California Region. In addition, data may be used for publication in a journal and/or presented at a conference There will be no identifying information that would identify your responses, particularly in the use of quotes. Any use of quotes from your interview will be presented with confidentiality and anonymity. If desired, you are invited to review the quotes that may be used in a

publication. All records will be kept with strictest confidence. Only the project researchers will have access to this information or the data. Any personal information collected will be stored in a locked file cabinet in the primary investigator's office.

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I agree to a tape recording of the phone interview and understand that I can request that the tape recording be turned off at any point in the interview, without penalty. I also understand that if I become uncomfortable during the interview that the interview can stop and additional time will be made available to discuss the thoughts about the discomfort, and that the researchers are available to debrief after the interview. All tapes will be destroyed upon completion of this research project.

I affirm that I have read and understood this form, and I agree to participate in the telephone interview and give permission to allow the data to be used for program development, publication and presentations at professional conferences and meetings. I understand that I will be given a copy of this consent form.

Signature _____ Date _____

bjg/ds

APPENDIX D

Older Adult Services System of Care
Consumers Informed Consent

You are invited to participate in the following research project that is being conducted to provide data that will identify service needs for the older adult population in the Central California Region. You will be asked to participate in a focus group that addresses your views on the strengths and weaknesses of current services to older adults, gaps in existing services, and current service needs. The focus group will take approximately 90 minutes.

It is understood that your participation in this focus group is voluntary, and that you will gain a $10.00 benefit after participating in this focus group. If at any time you wish not to participate in this study, please let the interviewers know. You may discontinue your participation at any time, for any reason, with no penalty.

It is hoped that the data collected in this study will improve the comprehensiveness and quality of services for older adults in the Central California Region. In addition, data may be used for publication in a journal and/or presented at a conference. There will be no identifying information that would identify your responses, particularly in the use of quotes. Any use of quotes from the focus group will be presented with confidentiality and anonymity. If desired, you are invited to review the quotes that may be used in a publication. All records will be kept with strictest confidence. Only the project researchers will have access to this information or the data. Any personal information collected will be stored in a locked file cabinet in the primary investigator's office.

If you have any questions about this research study or have questions regarding your rights as a research subject, please contact:

Co-Principal Investigators:
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and/or

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(209)667-3493

I agree to a tape recording of the focus group and understand that I can request that the tape recording be turned off at any point of the focus group, without penalty. I also understand that if I become uncomfortable during the focus group, that my participation can stop and additional time will be made available to discuss my thoughts about the discomfort, and that the researchers will be available to debrief after the focus group. All tapes will be destroyed upon completion of this research project.

I affirm that I have read and understood this form, and I agree to participate in the focus group and give permission to allow the data to be used for program development, publication and presentations at professional conferences and meetings. I understand that I will be given a copy of this consent form.

Signature _____ Date _____

bjg/drs

APPENDIX E

Best Practice Models

1. ***Longino, Jr., C.F. , Demographic and Resettlement Impacts on Rural Services.***
    - Elderly interstate migrants from metropolitan to non-metropolitan areas tend to be younger, married and white than are older migrants moving to metropolitan areas. When younger people move out the small towns have a higher proportion of older residents by default, resulting in these rural towns aging more quickly.
    - Older adults are more interested in lifestyle than jobs.
    - Rural retirement communities tend to be adjacent to metropolitan centers, getting best of both worlds. Migrants tend to be more affluent, younger, healthier than residents, which benefits the host community. Belief is that migrants will contribute more to the economic base of these communities through consumption and taxes paid than they consume.
2. ***Bull, C.N., Service Access and Barriers in Targeting Rural Elderly.***
    - Earned income trends reflect continuing transition from a manufacturing-based economy to a post-industrial service economy. This economic shift impacts the rural elderly, where there is increasing migration from rural communities to urban centers. This migration leads to increasing rural-urban disparities.
    - Less services are available to rural seniors; increased closing of rural hospitals. Increasing geographic remoteness and isolation combined with poverty and lower educational levels decreases advocacy capability. This population has less likelihood of becoming organized or developing political power to address needs.
    - Service eligibility should be based on “need” and not “age”

- Baby boomers are starting to enter retirement, who have been members of the workforce than previous generation. Expectations for service from both the public and private sector will increase.

3. Krout, J.A., Rural Elders: Meeting Their Needs.

- Rural elders, who live in various communities that have unique resources and problems, are diverse in their characteristics and their needs.
- They usually have limited access to a smaller and narrow range of services. These services face challenges of distance, low population density and remoteness.
- Successful programs incorporate community, social, cultural and organizational systems, using resources indigenous to the community, such as families, churches, neighbors
- Successful programs need to be tailored to the needs of their service population and specific needs of the community. They must consider; accessibility, affordability, acceptability, appropriateness, awareness, sustainability
- Research shows that to be effective and sustainable, the following components are important
    a. Caregiver education that involves PH nurse and church parishioners;
    b. Transportation, using paid volunteers and family;
    c. Partnerships between schools, hospitals, and nutrition programs to lower food cost;
    d. Multi-county housing coalitions that tap into federal dollars for home repair and modification, and;

e. Partnerships between nursing homes, senior centers and hospitals to build congregate housing.

4. Wagner, D. L. & Niles, K. J. Caregivers for Rural Elderly: Issues and Initiatives.

- While rural communities lack the infrastructure services found in more urban and metropolitan areas, they do have strong tradition and sense of community that allows both independence and relationship.

- Important elements for designing rural caregiver programs include involvement of those indigenous to the community, in-home or mobile services, non-family care giving, flexible hours and easy access.

- For most elders, family and friends provide care and support they need to remain living independently. In rural communities, they provide a significant need due to the lack of health care and community based services available that are typically found in more densely populated areas.

- Informal sources of support are critical to seniors remaining in their home independently. This support commonly provided by adult children may be unavailable to their absence in rural communities.

- 25% of all elderly in the country live in rural areas and their numbers are increasing (Buckwalter and Davis, 2002). Issues that affect caregiver's capacity to assist a relative or friend are; geographic distance, lack of knowledge about services or eligibility for them, stigma of asking for help (Buckwalter and Davis, 2002).

- Design factors of importance to rural caregivers:
    - Recognize diverse population characteristics, values culture
    - Involved local residents in process
    - Recognize physical and psychological barriers of distance
    - Importance of fictive kin, neighbors, friends in rural support systems that may contain few close relatives due to out-migration
    - Service and access hours need to be flexible to meet needs
    - Outreach and service design factors that do not stigmatize caregiver or recipient
    - Mobile options for assessment, service and support
- **R.U.R.A.L**. planning model (Buckwalter & Davis, 2002).

  R-Relevance to the needs of caregivers

  U-Unity with existing services and approaches

  R-Responsiveness to traditions of the community

  A-Access that ensures hours, location and outreach enhance access to services

  L-Local leadership included in the program and its outreach
- Models for caregivers to rural elderly;

a. *Education Models*: University campuses in partnership with local community conducts annual conferences

b. *Information and Training*: (Oklahoma developed "Caregivers Connection"), South Dakota's AgriAbility Project provides training for people willing to conduct local caregiver workshops (http://agriability.sdstate.edu/care1)

c. *Outreach Models*: Central Savannah River Area Rural Day Care Program offers mobile adult day care services, COPE, provides in-home respite, information and assistance to low-income and minority families of elders with dementia

d. *Consumer-Directed Programs*: Independence Choices Program (AK) being tested in other state, provides Medicaid recipient with cash and support in developing a care plan to meet their long-term care needs. Funds can be used to pay family members or unrelated personal assistance. In most cases, elder chooses not to have adult child for assistance. Promising in rural area because it is not agency dependent

5. Mueller, K.J. & McBride T. D. Defining Medicare Reform Criteria and Health Care Reform in Rural Areas.

- Medicare is perceived as a program with uncontrolled expenditures that will not be able to support increasing number of beneficiaries as "baby boomers" become eligible for services.

- Medicare, as designed in 1965, is outdated, not meeting the current needs of elders. Services do not include outpatient prescription medications, and preventive care services. Separates benefits for inpatient hospital services and ambulatory care (that is drastically on the rise).

- Rural context; 1) Medicare policy changes will have different impact in rural areas than in those more densely populated; a benefit for outpatient prescription drugs will be different for beneficiaries in larger communities with multiple pharmacists (both independent and national chains) that for those living in rural area served by few or no local pharmacists. 2) Some rural areas are losing health care services or are struggling to obtain needed services

- Public policy needs to follow 2 principles in recognizing disparities; 1) With any new initiative or reform, rural beneficiaries are no worse off than they already are, 2) Design policies reduce or eliminate disparities attributable to places where beneficiaries live

- Principles for Analysis of Medicare Reform should include; 1) equity of benefits of cost, 2) promote highest quality of care, 3) ensure all beneficiaries have comparable choice of care, 4) all have reasonable access to services, 5) inclusion of mechanisms for affordable costs

- How is access defined; local-distance via transportation-telecommunication?

6. Jenkins, C.L. Best Practices and Recent Trends in Health Care Administration in Rural Areas.

- Current concerns ins health care administration include; 1) maintaining financial viability, survival of existing health care organizations, recruitment and retainment of health care workers.

- Rural health care consists of acute care hospitals, and health care providers, physicians, skilled nursing facilities, home health agencies. Severely lacking at all levels (National Advisory Committee on Rural Health, 2001). Hospitals are primary health care source.

- Medicare payments per beneficiary are significantly lower in rural areas

- Initiatives:

    - CAH's --Critical Access Hospital designation through Medicare Rural Hospital Flexibility Program (Flex Program). Must meet qualifications that include licensure and operation as a not-for-profit and be located in state with existing rural health plan. Nebraska is national leader.

    - Education & Training Programs—Universities across the country are responding to the need to develop programs for education training to address needs of rural communities and elders, using rural hospitals and other service providers as Field Faculty

    - Professional Health Care Workforce Recruitment Programs

- Expanding Traditional Health Care Boundaries—technological communication via internet, video conferencing and remote patient consultation

- Expanding Health Professional's Roles—Asheville, N.C. Asheville Project for current and retired city employees in effort to control health cost. Pays pharmacists to serve as "coach" or consultant on things such as diabetes, diet, exercise, medication, stress reduction. Patients attend a health class and meet the pharmacist monthly in return for receiving free medications and supplies associated with their disease.

7. Plan of Action on Rural Aging (PARA): Policy Recommendations (Summary)

- PARA Project: 7 demonstration projects in rural counties of W.V. and OH focused on needs of transportation, caregiver support systems, housing , health promotion and wellness

- Successful programs have 4 major features of best practice models

  - New, innovative programs focused on clear, unmet needs

  - Integration of fiscal pkgs. and funding streams

  - New agency coalitions and partnerships developed that did not work together before

  - Development of evaluation outcome measures

- Rural aging policy needs to consider: 1) rural economic development policy, 2) standard definition of rural, 3) integrating fragmented Federal, state and local programs
- Economic policy that builds infrastructure and incentives to reverse out-migration of younger generation
- Health care and social service delivery needs to be more coordinated/ integrated. State and national level resources need to support local efforts.
- Education and Training of staff and professionals
- Attention to healthy, active aging
- Components of Successful Model Policies and Programs
    - Recruit, utilize & retain professionals who understand culture of rural elders
    - “ “ “ “ “ “ who incorporate prevention into practice
    - Integrate/coordinate services. So e.g., health care is provided in context of social and economic support
    - Develop & encourage svc. delivery mechanism & decision-making that are locally based and adapted to meet community needs
    - Support local innovation in increasing the effectiveness and efficiency of services in rural communities
    - Invest in developing reliable support systems i.e., transportation, housing, community infrastructure, & promotion of cost-effective home-based and community-based services and benefits
- Decision makers need to stimulate political will

- Promote awareness-raising activities around key issues affecting older people in rural and remote areas
- Feature key issues in debates at all govt. levels
- Increase participation and integration of older people in rural development policy
- Develop plan for action that includes key points of access, affordability, delivery, education & research, public campaign promoting active aging

APPENDIX F

Websites

http://abrahampaiss.com/ElderCohousing/GlacierCircle.htm

http://agriability.sdstate.edu/care1

www.aoa.gov/carenetwork/NFCSPConf01-Papers/systems-building.html

http://www.cms.hhs.gov/pace/

http://factfinder.census.gov

www.hsc.wvu.edu/coa/

http://www.itnamerica.org/search_news.asp#

http://www.livingpartnership.org/Transportation.htm

http://www.ncsl.org/programs/health/forum/olmstead/2003/03olmstd.pdf

http://www.nia.hih.gov/

http://www.onlok.org/

www.pha-resources.org/sec/docs/agngnplac/hacrursn.asp

http://www.pharmacytimes.com/files/articlefiles/TheAshevilleProject.pdf

http://ruralhealth.hrsa,gov/policy/nacpubs.html

http://www.seniordrivers.org/STPs/fiveAs.cfm

http://www.livingpartnership.org/Transportation.htm

www.umaine.edu/mainecenteronaging/mpcc.htm

http://www.whcoa.gov/