Photography by Bradley Stookey

Bridging Elder Care Networks
Community Plan 2006-2010

A roadmap highlighting the realities for seniors in Northeast Florida, the community learning process and the future direction for Bridging Elder Care Networks

Life: Act 2®

A NEW APPROACH TO THE SECOND HALF OF LIFE

A Northeast Florida Community Partnership Led by United Way

Community Partnerships for Older Adults
A National Program of the Robert Wood Johnson Foundation

United Way
of Northeast Florida

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Blue Cross and Blue Shield of Florida

OUR MISSION

To develop and implement an accessible, efficient, and integrated health care and long-term care system for seniors in Northeast Florida

OUR VISION

Northeast Florida will be a place where all citizens are knowledgeable about the issues and concerns facing older adults in our community and seniors are perceived as valuable, contributing members.

Letter to the community

Life: Act 2®
A NEW APPROACH TO THE SECOND HALF OF LIFE
A Northeast Florida Community Partnership Led by United Way

On behalf of United Way of Northeast Florida (UWNEFL) and Life: Act 2 Bridging Elder Care Networks (BECN) Task Force we are excited to present our four-year *Community Plan, 2006-2010*. During the last eighteen months more than five hundred elders, forty-two providers of services, five major hospital leaders and staff and community volunteers have partnered together to share information and develop this plan. This comprehensive plan, which when implemented, will improve long-term care and supportive service systems in Northeast Florida.

In November, 2004, United Way of Northeast Florida received a competitive Robert Wood Johnson Foundation Community Partnerships for Older Adults development grant award of $150,000 to develop a more coordinated long-term care and health system. With this funding, BECN has completed a comprehensive plan that will assist adults age sixty and older to remain longer in their homes. Older patients will have shorter in-patient stays as a result of improved linkages between health and social services providers. Hospital specific system changes will occur that will improve the delivery of services to older adults. Older persons in our five-county area who receive services from the region's health systems will benefit from personnel trained in geriatric protocols. The community, particularly older adults and their caregivers, will have better knowledge of how to access health and long-term care information. On May 1, 2006, United Way of Northeast Florida was awarded a $750,000 grant from the Robert Wood Johnson Foundation, Community Partnerships for Older Adults to implement this Community Plan.

The following document summarizes our plan for the next four years. Please journey with us and become well-informed about the issues and concerns facing elders in Northeast Florida. We look forward to your support and commitment to make this truly a community-driven strategic plan.

Best regards,

Walt Bussells, Chair
Life: Act 2
Bridging Elder Care Networks

Mark LeMaire, Director
Life: Act 2
United Way of Northeast Florida

Life: Act 2 Organizational Partners

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The Cathedral Foundation
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St. Vincent's
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University of North Florida
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Salvation Army Sr. Center
Clay County Council on Aging
Lutheran Social Services
Jacksonville Community Council, Inc. (JCCI)
Willman Consulting, Inc.
Margaret Lynn Duggar & Associates, Inc.
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Senior Volunteers
Palm Valley Community Center
Wiley Sr. Center
Housing Partnership, Jax
Westside Sr. Center
Macclenny Sr. Center
Nassau County Council on Aging
Singleton Sr. Center
Moncreif Sr. Center
Maxville Sr. Center
Beaches Sr. Center
Council on Elder Affairs
CARES

Note to the reader: The following is a guide to the acronyms used in this document:

Activities of Daily Living (ADL)
Advocacy and Transitional Care Management (ATCM)
Area Agency on Aging (AAA)
Aging Resource Center (ARC)
Bridging Elder Care Networks (BECN)
Community Partnerships for Older Adults (CPFOA)
Comprehensive Assessment Review and Evaluation Services (CARES)
Continuing Education Units (CEUs)
Florida Department of Elder Affairs (DOEA)
Extended Care Information Network (ECIN)
Healthcare Systems Network (HSN)
Healthy Communities Access Program (HCAP)
Multigenerational Early Literacy Collaboration (MELC)
Northeast Florida Information Network (NEFIN)
Robert Wood Johnson Foundation (RWJF)
United Way of Northeast Florida (UWNEFL)
University of North Florida (UNF)

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Executive Summary

Seniors 60 years and older are living longer more active lives. By 2010, it is projected our five-county area of Northeast Florida will have 238,964 persons age 60 and older, a 31 percent increase over 2005. Approximately 9 percent of this population will be over age 85. In fact, the fastest growing age group among seniors is 84 years and older.

In July of 1999, United Way of Northeast Florida (UWNEFL) initiated a community planning process to identify a major area to become its Targeted Community Initiative for the next fifteen years. This planning process involved more than eighty community members representing many diverse interests from five surrounding areas of Baker, Clay, Duval, St. Johns and Nassau counties of Northeast Florida. In November, 2001, a recommendation was made to United Way's Board of Trustees that aging become a major priority for the Initiative. The Trustees unanimously adopted this recommendation and UWNEFL became the first United Way in the country to adopt aging as a priority. Out of this initiative marked the beginning of a Life: Act 2 Partnership Council and Bridging Elder Care Networks (BECN).

In November 2004, UWNEFL was one of eleven organizations out of over four hundred applicants chosen to receive a competitive grant award of $150,000 from Robert Wood Johnson Foundation to develop their plan and strategies. Eighteen months of exploring the five-county region's existing resources, conducting community assessments and surveys, establishing a consortium of key stakeholders, and interviewing more than five-hundred seniors has yielded a four-year strategic plan. BECN has placed UWNEFL on the cutting edge of identifying and developing innovative system changes to long-term care and health systems that will better accommodate elders. Key findings suggest:

- Many seniors do not know how to access health and social services
- Gaps occur in follow-up and transitional services for many seniors discharged from the hospital
- Seniors in the community were not knowledgeable about 2-1-1 information referral number or the Elder Helpline
- Geriatric education initiatives are not always available to providers and hospital staff
- Transportation for some seniors was difficult
- Seniors are concerned about the high cost of prescription drugs and frequently have to decide between eating and purchasing medications

The Community Plan, 2006-2010, will assist seniors, caregivers and families by the implementation of a system redesign that will offer more effective communication between health and long-term care systems and enhance services to older persons. Residents of all ages will be informed about 2-1-1 referral service for non-emergency services and access to the Elder Helpline. Older persons will benefit from personnel better trained in geriatrics. Older persons will have shorter in-patient stays at hospitals as a result of better coordination and improved linkages between health and long-term care service systems. Moreover, elders will experience more successful post-hospital outcomes as a result of improved discharge planning and accessible post-transitional services.

Priority goals for the next four years will be:

- To decrease the number of days older adults unnecessarily stay in a hospital due to the unavailability of, or ineligibility for, long-term care or independent living support services;

- Increase the knowledge of the community as a whole, but particularly older adults and/or their caregivers, on how to access health and long-term care information and services;

- Increase the percentage of paraprofessionals and professionals working with older adults who have advanced knowledge and/or training in gerontology and aging related issues;

- Implementation of hospital-specific system changes that will improve the delivery of health services to older adult patients.

Other initiatives included in implementation are: establishing an Advocacy Transitional Care Management Team (ATCM) consisting of an Elder Care Advocate and a team of volunteers to assist elders discharged from the hospital with connection to transitional services; distribution of a Take One Card with helpful senior resource phone numbers; and distribution of a tool kit for seniors on discharge from a health facility.

Critical issues concerning transportation for seniors and the high cost of medications are highlighted in the strategic plan, but because of funding limitations will be addressed through other community initiatives.

On May 1, 2006, United Way of Northeast Florida was awarded a $750,000 implementation grant. Funding to implement this community plan to date has been provided by the Robert Wood Johnson Foundation & Community Partnerships for Older Adults, United Way of Northeast Florida and Blue Cross and Blue Shield of Florida.

Background

United Way of Northeast Florida (UWNEFL) has led the challenge to bring together for-profit and nonprofit entities to discuss the current and future state of seniors in our community. Life: Act 2, a collaborative partnership began in July, 1999, when UWNEFL initiated a community planning process that resulted in selecting aging as a community focus for the next fifteen years. The Life: Act 2 Partnership Council was formed with membership dedicated to bringing about a "culture shift" that would inform the Northeast Florida community on the aspects of aging, including knowledge of health and long-term care services and how to access them. Moreover, through the efforts of the Life: Act 2 Partnership Council, Bridging Elder Care Network Task Force (BECN), Cultural Shift Committee, Multigenerational Early Literacy Collaboration (MELC), and Partner Grants Committee has been established to further the vision of having a community well informed about, and inclusive of, older citizens.

Photography by Bradley Stookey

In 2003, Life: Act 2 commissioned the University of North Florida Center for Aging Research to conduct a needs assessment of adults 65 and older in the five county area UWNEFL serves. In November 2004, Life: Act 2 was one of eleven communities selected from a field of over 400 applicants to receive a Robert Wood Johnson Foundation development grant for $150,000.

Following the receipt of the grant, the Life: Act 2 Partnership Council commissioned Bridging Elder Care Networks (BECN). BECN was formally launched in March 2005 with the establishment of a diversified Task Force, chaired by Walt Bussells, former Chairman of the United Way Board of Trustees. The Task Force comprises 23 seniors, volunteers, caregivers, executive directors from various Councils on Aging, nursing home executives, hospital and corporate executives and an elder law attorney.

BECN focused on the following goals during the development phase:

1. Build a Task Force capacity that will coordinate the development of a system change model between health and long-term care systems that will lead to a more accessible, coordinated and responsive system

2. Develop a cross network Systems Change Model that links long-term care and healthcare services

3. Build a community driven strategic plan to implement the new systems change model

4. Build capacity to increase awareness in the community about the availability of long-term care and health system services.

The Life: Act 2 BECN project was designed around an eighteen-month planning process involving data research and a large number of workshops and focus groups with hospital executives and staff, providers of services to seniors, and seniors themselves. Moreover, hospitals have agreed to and completed a hospital self-assessment survey in regard to their facility being elder-friendly.

In addition to the results of the focus groups, self-assessments and informal surveys, the BECN Task Force used as a base the results of the 2003, Life: Act 2 Needs Assessment Survey conducted by University of North Florida Center for Aging Research, and the 2002 "AdvantAge Initiative" conducted by the Visiting Nurse Society of New York's Center for Home Care Policy and Research to guide their work.

A compilation of all the research indicates several broad areas of critical need:

- Education for both consumers and practitioners on elder care and available community resources
- Enhanced communication and collaboration between health and long-term care systems
- The high cost of prescription medications
- Transportation for seniors

BECN members, consultants, UWNEFL staff, UWNEFL leadership and volunteers studied the compilation of data and research to draft preliminary strategies. In September, 2004, a community workshop was hosted and attended by a cross-section of the community including elders and providers of services to discuss the findings of the research and to make recommendations for needed systems changes. The result of this combined work was the development of four priority goals as the guiding force for the implementation and strategic planning phase of the BECN initiative. Those four goals are:

GOAL I. Decrease the number of days older adults unnecessarily stay in a hospital due to the unavailability of, or ineligibility for, long-term care or independent living support services.

GOAL II. Increase the knowledge of the community as a whole, but particularly older adults and/or their caregivers, on how to access health and long-term care information and services.

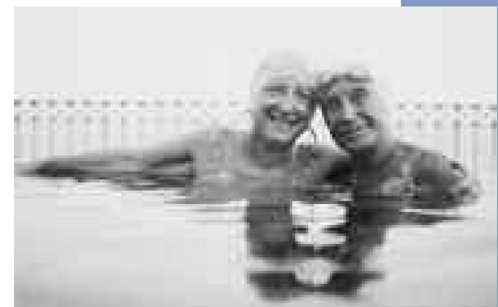
GOAL III. Increase the percentage of paraprofessionals and professionals working with older adults who have advanced knowledge and/or training in gerontology and aging related issues.

GOAL IV. Implement hospital-specific system changes that will improve the delivery of health services to older adult patients.

The development of these goals sets forth the framework contained in this strategic plan with defined priorities and major strategies to achieve these goals.

"There is a highly cohesive set of opinions in Northeast Florida about the barriers elders face in receiving streamlined services and care. There is also a high degree of agreement on what interventions must take place to enable the elders of Northeast Florida to easily access and obtain these services. It will not be an easy task to overcome these barriers, but the partnerships are already formed and the commitments among these partners are solid. With careful execution, the goals and objectives of this strategic plan will be met".

Community Report, October, 2005



Photograph by Marcelo Mokrejs

Community Description

Life: Act 2, Bridging Elder Care Networks initiative covers a five-county area in Northeast Florida and comprises Baker, Clay, Duval, Nassau and St. Johns counties.

Table 1 describes the five-county area of Northeast Florida in regard to population, age, Activities of Daily Living (ADL), needs profile and Alzheimer's cases.

Demographic information (2004) from the Florida Department of Elder Affairs (DOEA) shows the total 60-plus population of the five counties is 187,472, which represents 15.2 percent of the total population (1,230,371). Three of the five counties have higher percentages of persons with two or more disabilities (2000 Census) than the state average (15 percent). Newly-available data from DOEA reveals the levels of need for persons over age 60, calculated based on a special tabulation by the U.S. Bureau of the Census, 2000. The statewide average percentage of "Very High Needs" is 2.9 percent.

Social and Long-term Care Services

Social and long-term care services are provided in each county, primarily by community-based, not-for-profit agencies.

Table 1: 2004 Figures - Northeast Florida
Source: State of Florida Department of Elder Affairs

County (Total Population)	60+ Population	2+ ADL's 65+ Population	Very High Needs Population	High Needs Population	Moderate Needs Population	Est. Cases Alzheimer's 65+
Baker (24,028)	3,282 (13.7%)	698 (21%)	-0-	19.5%	51.7%	266
Clay (156,654)	22,949 (14.6%)	3,479 (15%)	2.4%	-0-	31.1%	2,075
Duval (845,856)	119,725 (14.2%)	21,179 (18%)	5.2%	5.9%	35.2%	12,284
Nassau (63,846)	11,587 (18.1%)	1,853 (16%)	3.4%	4.1%	32.7%	939
St. Johns (139,987)	29,929 (21.4%)	3,508 (12%)	-0-	2.6%	15%	3,016
Five County Total (1,230,371)	187,472 (15.2%)	30,717 (22.2%)	N/A	N/A	N/A	18,580

In Duval, the largest area county, local government is also a major provider. These providers are well established and offer cost-effective services. They have solid relationships with elected officials and utilize many volunteers. They are highly accountable and open to innovation. Each county receives Older Americans Act funds, along with state Community Care for the Elderly funds, Medicaid waivers for home and community-based services and state funds for services to persons with Alzheimer's disease and their caregivers.

Community Based Services

Community-based service providers continue to struggle with limited funds from state and federal governments, which have increased these funds only minimally over the past few years. Most increases in community-based funding from the state, while still limited, have been through the Medicaid waiver program, which targets lower income and most frail (nursing home eligible) older persons. Waiting lists for community-based services exemplify this problem. The state funded program for in-home services, Community Care for the Elderly, currently serves 590 clients in the five counties, while 1,234 clients are on the waiting list as of October 2005. In addition, the Medicaid waiver program for similar types of in-home services is serving 656 clients and has 256 persons on the waiting list. The Assisted Living for the Elderly waiver is only available in four of the five counties.

Gender, Race and Financial Status

The following Tables, 1, 2 and 3, outline persons age 60 and older in the Northeast Florida five-county area by gender, race and financial level.

Table 1: Persons Ages 60+ by Sex, NE Florida, 2004

County	Percent Female	Percent Male
Baker	54%	46%
Clay	54%	46%
Duval	58%	42%
Nassau	54%	46%
St. Johns	55%	46%

Table 2: Persons Ages 60+ by Race, NE Florida, 2004

County	Percent Black	Percent Hispanic	Percent Other	Percent White
Baker	8%	.6%	.6%	90%
Clay	4%	2%	2%	92%
Duval	20%	2%	3%	75%
Nassau	6%	1%	1%	92%
St. Johns	4%	1%	1%	94%

Table 3: Persons Ages 60+ by Poverty Level, NE Florida, 2004

County	# Below Poverty Level	# 125% Below PL	Total # 125% Below PL
Baker	282	420	702
Clay	1,422	2,174	3,596
Duval	12,702	18,087	30,789
Nassau	920	1,416	2,336
St. Johns	1,634	2,306	3,940
Northeast FL	16,960	24,403	41,363

Tables 1-3 Source: Florida Department of Elder Affairs

The Bridging Elder Care Networks Community Partnership gathered information from a cross-section of the community throughout the eighteen-month development grant phase. Methods used to gather this information were needs assessment surveys, senior and provider focus groups, hospital workshops, hospital self-assessments, senior home-bound surveys, a hospital tracking document, one-on-one meetings and research.

AdvantAge Initiative

A community study, AdvantAge Initiative, was conducted in 2001 by the Visiting Nurses Society of New York Center for Home Care Policy and Research through a Robert Wood Johnson Foundation Grant. This initiative was used as a base for the development grant proposal. This study concentrated on how a senior community perceives indicators for an elderly-friendly community.

University of North Florida Needs Assessment

In 2003, UWNEFL commissioned a Life: Act 2 Needs Assessment Survey conducted by the University of North Florida Center for Aging Research to ascertain any gaps or overlaps in health and long-term care services and systems. The survey targeted older consumers, service providers and key leaders in a five-county region. This Needs Assessment was used as a base for the writing of the 2004 development proposal submitted to Robert Wood Johnson Foundation.

Senior Focus Groups

Twelve senior focus groups were held in a five-county area of Northeast Florida, Duval, Clay, St. Johns, Nassau, and Baker Counties during 2005. More than four hundred seniors participated, including caregivers and directors of senior centers. After an initial presentation about the project, seniors were asked certain discussion questions. In addition, a health and long-term care "BINGO" card was designed to encourage full participation among the senior groups.

Provider Focus Groups

During 2005, one-on-one meetings were conducted with providers, as well as a large focus group with representation from forty-two providers including nursing homes, assisted living facilities, adult day care, home health agencies, medical equipment providers, faith-based providers, Alzheimer's Association and Area Agency on Aging. A facilitator directed the discussion topics.

Hospital Workshops

May through August of 2005, five hospital workshops were conducted with more than fifty key staff attending. Participating hospitals included Baptist Medical Center (included participants from Baptist Beaches and Baptist Nassau), St. Vincent's Medical Center, Saint Luke's/Mayo, Shands Hospital

and Brooks Rehabilitation Hospital. A facilitator conducted the workshop and had discussion on various topics that pertain to elder care within their institution.

Hospital Self- Assessment

During the month of August, 2005, hospitals agreed to do a "hospital self-assessment" designed by the Bridging Elder Care Networks team that targeted how "elder-friendly" their institution was. One hospital took the self-assessment further by developing a task force within their institution to continue to look at elder needs.

Senior Home-Bound Survey

Senior volunteers and case managers from Urban Jacksonville, an organization that provides services and meals to seniors, (seventy-two percent who are at or below poverty level) were trained to share with home-bound seniors about our project and to elicit feedback from a population often forgotten when gathering information.

Hospital Tracking Survey

An informal survey was compiled to track a senior profile that could capture the number of seniors that may need transitional assistance after discharge from the hospital. Training of discharge planners in two hospitals was completed and compilation of findings is ongoing. Hospitals tracked the number of patients that fit this profile for approximately three weeks. This will give an indicator on how many seniors per month our ATCM team may need to assist and connect to transitional services.

One-on-One Meetings

Individual meetings were conducted from December, 2004 through November, 2005 with directors of senior day care centers, providers of services, Comprehensive Assessment Review and Evaluation Services (CARES) team, City of Jacksonville's Director of Adult Services, Catholic Charities and Lutheran Social Service Directors, Bowman ServicePoint technical directors, Jax Care Executive Director, hospital directors and 2-1-1 Director.

Research

Research was conducted on a possible high-tech data exchange system between providers and hospitals. Best practice models included 2-1-1, Bowman ServicePoint, Metsys, ECIN, and Jax Care. This research was initiated to determine the feasibility of creating an electronic data exchange system (system change model) that would afford a more timely way to notify a provider of a senior patient who, on discharge from a hospital, would need services and follow-up. Patients would consent to the exchange of health information between health and service providers, resulting in services and follow-up immediately after discharge.

Life: Act 2's BECN used the AdvantAge survey (persons aged 65+, 2001) and the 2003 Life: Act 2 Needs Assessment survey conducted by the University of North Florida (UNF) Center for Aging Research as a base for analysis of the information gathered from the community. The survey information is remarkably consistent with the community input. Common themes include the need for new strategies for informing older persons about social and health services and how to access them.

The AdvantAge telephone survey revealed that 40-60 percent of respondents indicated they did not know that certain community services were available. The AdvantAge findings are more problematic when the "don't know" responses are added, because the services actually do exist. This initiative recommended the following:

- Assistance services needed
- Medical screening and service referral
- Transportation
- Assistance with Activities of Daily Living
- Neighborhood programs to connect neighbors to neighbors

Likewise, a major finding of the UNF survey was that one of the biggest gaps in health and long-term care services is knowledge of and access to available services. This knowledge gap exists across all income and educational levels. Also, the need for information about health care and how to access it is as great as, if not greater than, the need for long-term care information. The assessment results indicated little, if any, duplication in services or service coordination. Close-ended responses indicated seniors did not have a general knowledge about the nature and type of health and community services that were available. "Lack of information" was a recurring theme. Quantitative analysis of narrative data identified primary needs such as better communication, more available information and adequate services. The data gathered from the research literature, individual interviews, focus groups and senior survey clearly identified communication and information, in-home support services and transportation as primary areas of need for seniors in the Northeast Florida area.

Providers, gathered in a focus group setting, indicated education is needed for seniors, caregivers and families on

available health and long-term care resources. In addition, providers reported waiting lists for transportation, a need for continued education in geriatric care and patient follow-up after a senior is discharged from the hospital. Although provisions for follow-up care after discharge should be readily available for Medicaid participants, many times it takes several months to start the services.

Photograph by Bradley Stookey

The most significant breakthrough was that health systems are very willing to work with BECN in new ventures as contributing partners. It was also discovered that many systems are struggling for and are open to "electronic approaches" to fix system problems like communication and coordination. Funding, however, was not always available for these innovative initiatives.

Older persons who attend senior centers and do not know where to get information directly about services ask the senior center director. When asked if no senior director was available for information, most seniors responded they would not know whom to call. Some seniors felt it appropriate to call 9-1-1 for a non-emergency. Many seniors did not know about the 2-1-1 referral number or Elder Helpline. Transportation emerged as a problem, as did the high cost of medications.

Input from frail elders (disabled, 72% at or below poverty level) was solicited by training volunteers and case managers with a community-based agency to administer the an informal needs survey to homebound individuals who are receiving services. The survey captured information from 164 respondents. Fifty-three percent (53%) did not know who to call for hospital information; seventy-four percent (74%) never heard of 2-1-1 referral service or Elder Helpline. Fifty-three percent (53%) did not think hospitals and social service agencies communicate well with each other.

Another strategy was to interview personnel face-to-face in four agencies that serve minority and ethnic populations. Although it had been identified as an issue, it was nonetheless surprising to learn that many professionals in health systems know very little about long-term care and many long-term care professionals know very little about health systems.

Five hospital workshops with health system leaders led to exciting and encouraging successes. At each session, top administrators attended and expressed support for the effort. Each session had broad, high-level representation from hospital departments such as pharmacy, education, discharge planning and emergency services. Baptist Health System, for example, also had personnel from several locations, so their input reached across counties.

A common theme often heard from hospital staff was in regard to an older person when discharged from the hospital where there is little or no follow-up. Most seniors within a hospital setting are not sure what services are available or how to obtain those services. Participants agreed there was little geriatric education available to them. Lack of transportation was sighted as a problem for some seniors and better communication between physicians, hospitals and long-term care facilities is needed. Workshop participants suggested some elderly who visit the emergency room often have no real emergency. Often they need resource information or are lonely and need to talk with someone. Moreover, elders who do not qualify for Medicaid and have little additional money to purchase home services when discharged may remain longer at the hospital or end up back in the hospital after going home.

Research of best practice models included 2-1-1, Bowman ServicePoint, Metsys, ECIN, and JaxCare. This research was initiated to determine the feasibility of creating an electronic data exchange system (system change model) that would afford a more timely way to notify a provider of a senior patient who, on discharge from a hospital, would need services and follow-up. Patients would consent to the exchange of health information between health and service providers, resulting in services and follow-up immediately after discharge. While hospitals and providers were open to this innovative system, findings revealed a prohibitive price tag for developing this system. Several hospitals utilized an Extended Care Information Network (ECIN) system and felt comfortable with that. Dialogue with

service providers suggested ECIN was too expensive for them to purchase. JaxCare has developed alliances with Life: Act 2 and BECN to pursue projects to further their shared goals of better healthcare access, coordination and quality. JaxCare embraced BECN's RWJF planning grant and incorporated it into an HCAP proposal that JaxCare submitted in June 2005. The two-year project, Health Services Network for the Elderly, was funded effective September 2005. Its purpose is to strengthen and expand Jacksonville's current integrated community healthcare safety net system in order to increase access, improve quality of care and coordination of services, and create a case management platform to facilitate continuity in the management of serious illnesses, disabilities and chronic conditions for the low-income, underinsured and uninsured elderly residents of Duval County.

Photograph by Bradley Stookey

A community workshop was held in October, 2005 with over forty participants spending the day reviewing data and information that had been gathered. A facilitator assigned three work groups that reviewed barriers identified by hospitals, providers and consumers. Compilation of the research, discussion and brainstorming indicated four areas of critical need in our community:

1. Education for consumers and practitioners
2. Communication and collaboration throughout the entire health and long-term care system
3. High cost of medications
4. Transportation

While all four critical needs are addressed in the community strategic plan, two of the four addressed in the implementation proposal submitted November 2, 2005 to the Robert Wood Johnson Foundation Community Partnership for Older Adults. They are education for consumers and practitioners and communication/collaboration throughout the entire health and long-term care system.

Critical Issue: Communication and collaboration throughout the entire health and long-term care system

A need exists to build a stronger bridge to closing gaps that at-risk older adults experience between hospitalization and independence or long-term care. Information collected suggests some older adults with chronic conditions return to the hospital due to difficulties of navigating and accessing follow-up care after discharge for services such as home-delivered meals, housekeeping, caregiver respite care, and medical transportation. In listening to the hospitals, discharge planners shared that once seniors transitioned back home, the experience of navigating the long-term care system was challenging. In addition, hospitals and providers pointed to the need for follow-up/ after-care for seniors once they return home. If it were possible to reduce the time an older adult is unnecessarily hospitalized, it would be possible to encourage a greater independence for seniors and reduce the cost hospitals incur when an older adult must stay in the hospital beyond their time of need.

Community Response: Create a pilot program with one hospital and a defined segment of the elder population to test a model. The model is based on an elder care advocate that would focus on elders who have no other support system, who are not getting services through the community or any funded program. They have no family or caregiver, and are totally alone. The connection between the elder and the elder care advocate begins at hospitalization. The elder care advocate would walk the elder through the system, stay in touch with them throughout the process, and link them with all needed after care services, using all resources in the community like 2-1-1 and the new Aging Resource Center concept. The Aging Resource Center would offer screening for possible funded program services and triage for other needed services. The elder care advocate would stay in touch with the elder throughout all these processes and for 30 days after hospitalization to make sure the elder is getting everything they need. The elder care advocate will have a close working relationship with the hospital admissions and discharge offices and with the Aging Resource Center. These relationships will allow the elder care advocate to be aware if the elder re-enters the hospital, and allows them to begin their services for that person again.

Another suggestion was to organize a corps of trained and screened volunteers who would inform our community on services for elders, targeting retirees as members of this corps. The Life: Act 2 committee could launch the corps with its own interested committee members. Volunteers would be recruited through articles in area papers. The Life: Act 2 Partnership Council could secure trainers to educate the volunteer corps on how to get the message out. The message to seniors is there is a lifeline available if you need it and volunteers are helping people connect the dots. Additionally, the message can be delivered by using "tool kits" in doctors' offices (previously discussed) as well as in hospitals and senior centers. Speakers from this volunteer corps can present to churches, civic groups, and individuals in order to spread the word. We suggest that United Way and the upcoming Aging Resource Centers sponsor this volunteer corps.

Community Report, October, 2005

Critical Issue: Education for Consumers and Practitioners

Based on our conversations and research, there is a need for a broad-based educational campaign on how to access services both for elders/caregivers, as well as medical and non-medical personnel. Elders and caregivers deserve access to consumer information on all services available and an easy guide on how to navigate the system to obtain those services. In addition, a geriatric and gerontology education process should be developed that motivates physicians and other medical professionals to study the field of aging and to become highly proficient in that field.

Community Response: Create a neighborhood-based educational campaign to identify elderly adults in need of support. The tag line for the promotional campaign could be "For When We Need It." Use the existing Neighborhood Program run by the City as the mechanism through which to implement this campaign. In addition, a comprehensive public information campaign that targets elders, caregivers, physicians, advanced registered nurse practitioners, physician assistants,

pharmacists, and all professionals in the social services arena. The campaign would inform these groups of the 2-1-1 information acquisition and referral services, as well as the link to the Aging Resource Center and Elder Helpline. Many hospitals already know where to turn for CEU's but a stronger emphasis on training in geriatrics is needed. Continual geriatric and gerontology educational offerings for medical practitioners and supportive professions that result in a cadre of highly trained individuals in these fields can provide elders with much needed specialized care. Additionally, obtain the commitment of healthcare employers to adopt policies that will sustain a workforce skilled in and sensitive to geriatrics, including raising the level of geriatric/gerontology training acquired in the first year of employment of healthcare professionals who work with older adults. Analyze the need for certification from hospitals. Explore how we could develop a partnership with UNF to help expand this knowledge base.

Through existing aging curriculum found within the Hartford Foundation and other groups, convene area employers (retailers, bankers, physicians, etc.) to stage "brown-bag" conversations that will help create a broader culture shift around aging.

Community Report, October, 2005

Critical Issue:

The High Cost of Medications

New data analyzed by the AARP Public Policy Institute show that over the 12-month period ending March 2005, manufacturers raised the price they charge for 195 brand-name drugs most commonly used by older Americans, on average, by more than 6 percent (6.6 percent). By contrast, over the same period, manufacturers raised the list price of 75 most commonly used generic drugs, on average, by less than 1 (0.7) percent. The general inflation rate, as measured by the Consumer Price Index (CPI), averaged 3 percent during the same period. "Seventy percent of the population over age 50 is currently having problems paying for prescription drugs. Some of these are wonder drugs, but they can't realize their potential if people can't afford to buy them." (AARP, 2006)

Based on our conversations with the community the cost of medications was a hotly debated issue. Although the new Medicare prescription drug coverage is

available for seniors eligible for Medicare regardless of income, resources, health status or current prescription expenses, seniors we talked to in focus groups held only a small hope that this program would work for them. Seniors did not understand the program and had little assistance in navigating the system to learn more about the requirements. Seniors had a compelling argument about the new program; it was mandatory and a penalty waged if they did not sign up during a certain time, however, if the state and local authorities cannot explain the program with any clarity, why should seniors be penalized? This left some seniors angry and confused. Many seniors pointed out they take more than one medication, sometimes four or five prescriptions. Pharmacies in Florida have rallied on the side of seniors during this transitional time for Medicare to help seniors obtain their prescriptions and fill in the gap. The pharmaceutical industry offers some discounts and rebate programs for low-income elders as well. The AdvantAge 2002 Community Survey conducted in Jacksonville reported one in six elder participants, 65+, said there was a time during a past year that they did not have enough money to fill a prescription for medicine.

> "Social Security checks are going for medications and not for food"
>
> *- Clay County Senior*

Community Response: Due to the fast growing number of seniors over the next ten years, access to affordable health care and prescription drugs for seniors should be a priority. Any education awareness campaign locally and throughout the state should take into account the difficulty a senior has in navigating the system when it comes to finding affordable drugs and transitional Medicare Part D requirements. This is a critical issue voiced by our community, however, limited funding will slow immediate action. Advocacy and remedies will be found through partnerships and other community initiatives.

Critical Issue: Transportation

Seniors voiced their concern with transportation issues, especially when it came to trips to hospitals for medical appointments. While a van ride could be obtained for their appointment, seniors discussed having their medical appointments going beyond a certain time and having no van available for the trip back home (the van only picks seniors up

> “Getting around is a big issue here if you don’t drive”
>
> *- St. Johns County Senior*

at an appointed time). Traveling the five-county area, focus group participants thought Duval County had a better transit system that offered seniors 60 and older with a free senior transit card for free bus rides. Jacksonville Beaches offers seniors a "Dial-A-Ride" van for $2. Only one van is available and can hold up to twelve people. Seniors are encouraged to make van appointments far in advance due to the demand. St. Johns County appears to have little to offer in the area of a transit system for seniors. Seniors in the rural counties appeared to have less need for transportation services. Rural senior centers often provided van transportation for the seniors in their community, while friends, neighbors and relatives provided needed rides to grocery shopping and doctor's visits. Transportation for the Disadvantaged is available in all five counties. Persons are considered transportation-disadvantaged when physical or mental disability, income status, or age make them unable to transport themselves or to purchase transportation. Adult children who are caregivers have an increased challenge as well, with working full-time and providing transportation for their parent to and from medical appointments and hospital visits.

Community Response:

With the number of older adults growing rapidly in our five-county region, increased transportation options must be discussed with community wide recognition of the challenge along with local/ state advocacy to promote change. Enhanced coordination of affordable, reliable and accessible transportation needs and mobilization of public and private transportation opportunities should be a community priority. BECN will advocate for reliable transportation for seniors and research other funding to keep this issue in view of the community.

Strategic Plan

The Community Strategic Plan 2006-2010 is the result of an eighteen-month planning process and is focused on improving the quality of life for older adults. The Life: Act 2, Bridging Elder Care Networks will focus on stronger communication and coordination among both long-term and health-care partners. By helping systems to become more senior-friendly, we can impact a senior's quality of life. The bottom line is we want seniors to experience a greater level of relevant, coordinated care and a stronger opportunity to live in their homes with great dignity. We envision: residents of all ages will be informed about 2-1-1 referral service for non-emergency services and a connection to the Elder Helpline. Older persons will benefit from personnel better trained in understanding their needs. Older persons will have shorter in-patient stays at hospitals; thus increasing their chances of recovering quicker at home. Our work, which is outlined below, will be targeted at better coordination and improved linkages between health and long-term care service systems … so that seniors can find support when they need it most.

Goals and Objectives

The goals and objectives are an outcome of a collaborative team including: leadership, community, staff, volunteers, seniors and consultants, who studied a compilation of data and research to draft preliminary strategies. At a community meeting held in September of 2005, work groups synthesized information and data to narrow the scope of work and made recommendations for the needed systems change. The systems change model will be called Advocacy and Transitional Care Management (ATCM) system. The following are core goals, objectives and benchmarks that are part of a twenty page work plan. It is a beginning plan with benchmarks that will be revisited and revised each year over the next four years as required by the Grantor. Furthermore, continuing evaluation methodologies will be developed and data collected each year to capture reliable measurement after the ATCM system is actually up and running.

GOAL I. Decrease the number of days older adults unnecessarily stay in a hospital due to the unavailability of, or ineligibility for, long-term care or independent living support services

Benchmark: Number and percentage of days older adults are unnecessarily hospitalized

GOAL II. Increase the quality of health and long-term care service delivery to

Goal 1

SHORT TERM OBJECTIVES	IMPLEMENTATION OR COMPLETION DATE
Implement an Advocacy and Transitional Care Management (ATCM) systems model	July 30, 2006
Procure initial hospital to partner with in the ATCM systems change model	August 31, 2006
Procure long-term care (LTC) providers as partners in the ATCM systems change model	October 31, 2006
Expand United Way 2-1-1, 24 hour /7 days a week telephone information and referral service to accommodate a focus on independent living and long-term care community resources for older adults and their caregivers	January 26, 2007
Hire one Elder Care Advocate and one Administrative Specialist for the ATCM systems change model	January 26, 2007
Recruit and train a cadre of Senior Ambassador volunteers to assist and support the Elder Care Advocate in advocacy and transitional care management	April 31, 2007
Orientate Northeast Florida older long-term care (LTC) providers to the mission and capabilities of the ATCM systems change model	April 31, 2007
Implement the ATCM systems change model in the first hospital	May 1, 2007

older adults by paraprofessionals and professionals

Benchmark: Number of professionals and paraprofessionals with advanced knowledge or training in aging related issues

GOAL III. Increase the knowledge of the community as a whole, but particularly older adults and/or caregivers, on how to access health and long-term care information and services

Benchmark: Number of aging related calls to United Way's expanded 2-1-1 information and referral service from older adults, caregivers and general public

Goal 2

SHORT TERM OBJECTIVE	IMPLEMENTATION OR COMPLETION DATE
Establish or increase the number of aging-related education hours needed for graduation from targeted social service-related degrees	May 1, 2007

INTERMEDIATE OBJECTIVES	IMPLEMENTATION OR COMPLETION DATE
Increase the average annual enrollment of students in college degree or certification programs relating to the aging field	June 29, 2007 - August 31, 2007
Increase the number of continuing education units (CEUs) in aging-related topics for licensure or certification renewal for targeted professionals and paraprofessionals	August 1, 2007 - April 30, 2010

Goal 3

SHORT TERM OBJECTIVE	IMPLEMENTATION OR COMPLETION DATE
Implement a public information campaign targeting older adults and/or their caregivers, as well as the general public	May 1, 2006

LONG-TERM OBJECTIVE	IMPLEMENTATION OR COMPLETION DATE
Evaluate the success of the public information campaign	June 1, 2007 - April 30, 2010

GOAL IV. Implement hospital-specific system changes that will improve the delivery of health services to older adult patients

Benchmark: Number of elder-friendly changes within facility completed

Additional Goals and Objectives

GOAL V. Obtain resources sufficient for sustaining the activities of the Bridging Elder Care Networks Partnership- July 1, 2006-April 30, 2010

Benchmark: Continued BECN operations at the same or increased level, for a minimum of three years following the end of RWJF funding; percent of work cancelled due to budget shortfalls

Objective: Procure local public or private funding

Objective: Procure state and federal funding

Objective: Procure in-kind resources

GOAL VI. Build the capacity for the Bridging Elder Care Partnership (BECN)- May 1, 2006-April 30, 2010

Benchmark: Number and type of technical assistance received from the Grantor, Community Partnership for Older Adults (CPFOA) Robert Wood Johnson Foundation

Objective: Continue to seek out, receive, and respond to technical assistance from the Community Partnership for Older Adults (CPFOA)

Objective: Seek out, receive and respond to consultation and training from local, state and regional experts

Goal VII. Conduct an ongoing evaluation of the effectiveness of the ATCM systems change model-May 1, 2006-April 30, 2010

Benchmark: Written report of evaluation results

Objective: Develop an evaluation model

Objective: Implement evaluation

Goal 4

SHORT TERM OBJECTIVE	IMPLEMENTATION OR COMPLETION DATE
Implement hospital improvement plans	May 1, 2007

INTERMEDIATE OBJECTIVE	IMPLEMENTATION OR COMPLETION DATE
Monitor the implementation of each hospital's improvement plan	June 1, 2007 - April 30, 2010

In 2002, United Way of Northeast Florida committed to understanding the demographic imperative of an aging society. This involved studying current systems supporting seniors and their caregivers and developing innovative solutions system-wide that create conditions for successful aging and ensure the effective use of public and private resources. UWNEFL announced this commitment to more than 500 members of the community, assuring the community that UWNEFL would place aging issues at the top of its priority list for the next 15 years. UWNEFL leaders have evidenced this promise by dedicating their top leadership and significant resources including funding and organizational capacity, as well as future fundraising to this initiative. Blue Cross and Blue Shield of Florida, inspired by the sweeping nature of UWNEFL's commitment to solutions for seniors, invested a substantial amount of money. UWNEFL also secured a money grant from the Bank of America Foundation to fund an intergenerational book project.

Robert Wood Johnson Foundation has strengthened this initiative immeasurably by its investment and awarding UWNEFL a $150,000 development grant and a $750,000 implementation grant. UWNEFL leaders recognize that the goals of this proposal are bold and require long-term commitments. We have incorporated a specific goal, Goal V, in our implementation grant that will obtain resources sufficient for sustaining the activities of the Bridging Elder Care Networks Partnership. Our partnership is yielding significant progress in developing strategies for system-wide solutions supporting successful aging.

In addition, the UWNEFL Board of Directors has boldly pledged an additional amount of money of its constrained resources to continue this initiative beyond the four-year grant period. UWNEFL will directly sustain momentum by investing resources, continuing to engage skilled leadership, and exploring all collaborative opportunities. To complement its fund raising, BECN will continue to invest in community partnerships to achieve BECN goals through other organizations' development activities.

UWNEFL's greatest strengths as sponsor of Life: Act 2 and BECN are its position of respect in the community, the ability to convene and attract the community's most able leaders to embrace its initiatives and a proven track record of securing funding. UWNEFL pledges to support BECN with its extensive leadership, community influence and inspiration. We invite you to join us with your support to sustain this effort.

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