Overcoming Obstacles to Effective Senior Falls Prevention and Coordinated Care

A Toolkit for Program Success

March 2017

Senior Falls Prevention and Coordinated Care

Abstract:

This Toolkit is intended for executives, managers, designers, program staff, outreach staff, consultants, and contractors dealing with, or considering creating or updating, policies and programs to reduce the frequency and/or severity of falls among seniors. These policies and programs may be governmental, non-governmental, for-profit, or a combination of these, as may be the partners they seek to provide support to the programs. Reflecting consultations with the professionals acknowledged below, this Toolkit identifies common obstacles to the development and implementation of effective senior falls prevention and coordinated care policies and programs, annotated lists of resources that may help with overcoming the obstacles, and descriptions of how to confront the obstacles and use the resources to make the programs effective and achieve success.

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I. Introduction: Our Communities are Aging

Every day in the U.S., 10,000 people turn 65 years old. Within the next fifteen years, one in five people will be over the age of 65 and half of that cohort will be over 80 years old. The Centers for Disease Control and Prevention (CDC) reports that one in three people age 65 years or older fall annually.[1] Although a majority of these falls may only cause a minor injury such as a small cut or bruise, at least 10 percent will result in a hip fracture, traumatic brain injury, or other life-altering injury. A fall can have a significant impact on a senior's ability to remain in their home and live independently. More than 40 percent of seniors hospitalized after a serious fall injury are unable to return to living on their own.[2] Falls also have an enormous impact on our economy. In 2015, the annual costs of senior falls were nearly $32 billion; by 2020, it is expected to grow to more than $67 billion.[3] Although people tend to become more susceptible to falling as they age, falls are not a preordained part of the aging process. Fall risks can often be mitigated by exercise and physical activity, and home modifications, among a range of measures.
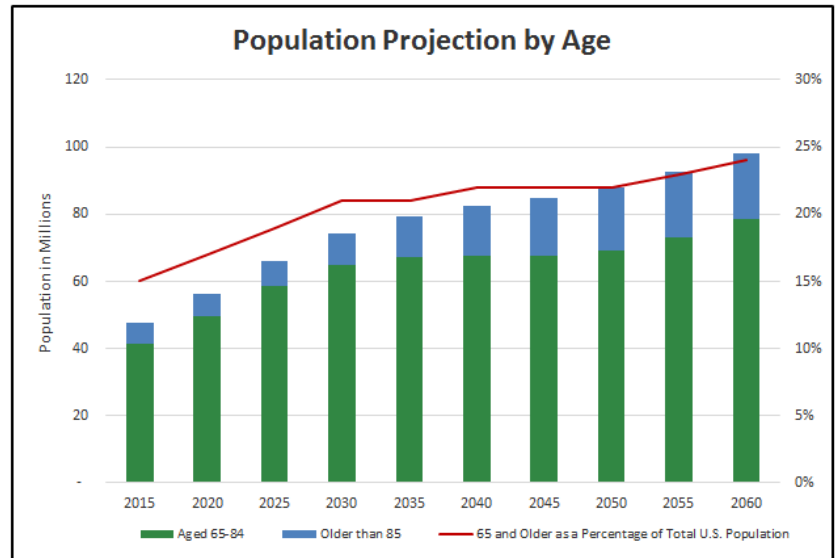
Source: U.S. Census Bureau, Population Division. Table 9. Projections of the Population by Sex and Age for the United States: 2015 to 2060 (NP2014-T9). Release Date: December 2014
Adapted from Fall 2013 HUD Evidence Matters
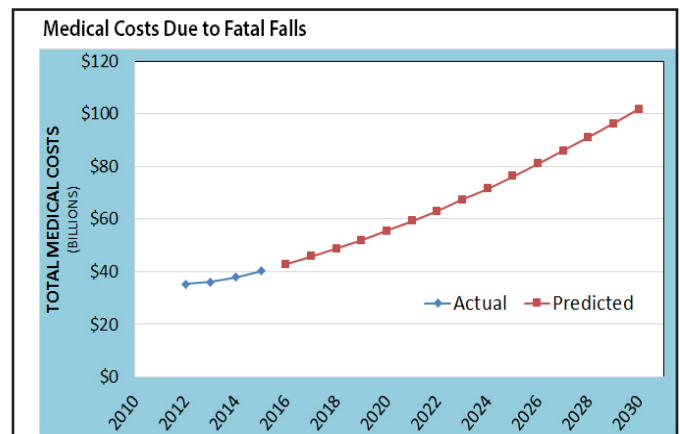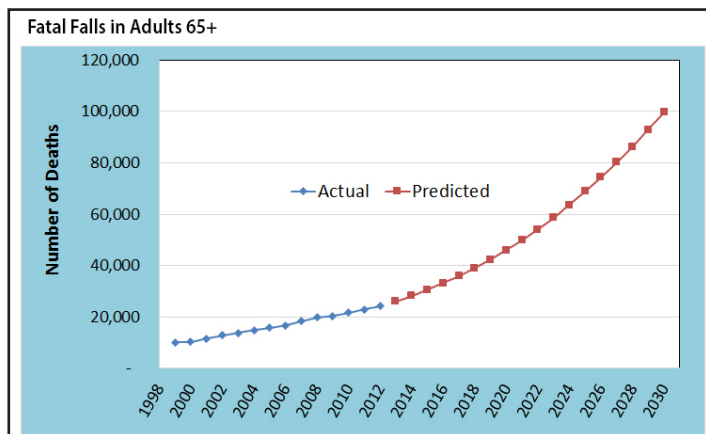
Source: Adapted from Houry et al. 2016 / The CDC Injury Centers Response to the Growing Public Health Problem of Falls Among Older Adults

[1] *Important Facts about Falls*. www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html.

[2] *Preventing Falls: A Guide to Implementing Effective Community-Based Fall Prevention Programs*. www.cdc.gov/homeandrecreationalsafety/falls/community_preventfalls.html

[3] *Costs of Falls Among Older Adults*. www.cdc.gov/homeandrecreationalsafety/falls/fallcost.html

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Obstacles to Senior Falls Prevention and Coordinated Care

The National Institutes of Health (NIH) reports that more than half of senior falls occur at home, [4] yet few homes have the features necessary to help older adults safely navigate in them. [5] Additionally, at some point, most seniors will require support at various levels of coordinated care to remain in their homes, ranging from assistance with common activities ranging from transportation and grocery shopping to preparing meals and bathing, and from house cleaning to ensuring medications are taken on schedule.

Few seniors, especially those who are moderate- to low-income, have any type of long-term care (LTC) insurance to help cover their cost of care as they age or to help offset the cost of home modifications that could help them remain safe in their own homes. In 2013, nine percent of older adults were living below the poverty level and six percent more were considered "near-poor" (i.e., their income was between the poverty level and 125 percent of that level). Overall, most seniors devote a significant amount of their income and savings to housing and healthcare costs. In 2013, seniors spent more than 12 percent of their total household expenditures on healthcare and almost half of senior households spent more than a quarter of their income on housing costs. [6]

Clinical screenings and home assessments, interventions ranging from home modifications and repair to exercises that address senior gait and balance, and build strength, and coordinated care can help keep seniors healthier and safer at home. However, these types of interventions and models of care frequently face significant policy and implementation barriers, including:

- lack of coordinated care among community social service, housing, and health care providers;
- restrictive reimbursement policies that limit the ability to coordinate government funding;
- inadequate staff and training resources; and
- ability to reach their most important stakeholders: seniors.

"No Place Like Home": Overcoming Obstacles to Aging in Place

AARP reports that 87 percent of seniors expressed a strong preference for "aging in place" for as long as possible, by either remaining in their own home or living in an affordable home elsewhere within their community.[7] Aging in place generally provides easier access to friends and family, but it may also require home modifications and care beyond seniors' economic means. Nonetheless, helping seniors age in place is much more

[4] NIHSenior Health, Falls and Older Adults. https://nihseniorhealth.gov/falls/causesandriskfactors/01.html
[5] U.S. Census Bureau, 2011 American Housing Survey. Accessibility/Safety Features in U.S. Homes
[6] *A Profile of Older Americans:* 2014. www.aoa.acl.gov/aging_statistics/profile/2014/docs/2014-profile.pdf
[7] www.aarp.org/livable-communities/info-2014/livable-communities-facts-and-figures.html

cost effective than having them transition to life in a nursing home or assisted living facility. The cost of care for a community-dwelling senior is approximately one-fifth the cost of care in a nursing home. [8]

Creating partnerships to coordinate care between agencies on aging, housing, community development, and public health can help ensure that seniors receive needed preventive services to remain independent and safe in their homes

Policymakers and planners can use regulatory and legislative policies to promote age-friendly communities where seniors have a variety of affordable housing options; safe street and sidewalk conditions; and access to transportation to get them to the places and daily services they need. The U.S. Department of Housing and Urban Development's (HUD) Fall 2013 edition of Evidence Matters offers several ideas for how home and community environments can be built or retrofitted to help create age-friendly communities that allow seniors to age in place. AARP's Network of Age-Friendly Communities provides additional resources as well as a practice of care network to help communities create or maintain supportive resources for seniors as they age.

How to Use this Toolkit

HUD's Office of Lead Hazard Control and Healthy Homes (OLHCHH) created this Toolkit to help bridge the gap between providers of housing and community development services and providers of public health and aging services. It is designed to help these stakeholders – and others that may be able to contribute to the falls prevention effort – effectively work together to find ways to overcome policy and program barriers to creating effective senior falls prevention and coordinated care programs. Materials included in the Toolkit reflect input from HUD's expert panel on senior falls prevention as well as information obtained from a comprehensive literature review.

This first section of the Toolkit provides key information about why we should be concerned with the current state of our aging communities and the threats posed to the health and wellbeing of our seniors. It also considers the broader economic impact if we do not take action to address this issue. The second section describes the utility of a clear program mission statement. The third section provides guidance on finding and building the right types of partnerships and stakeholder groups to achieve the program's goals. The fourth section focuses on how to make the case for the program's project(s) to potential funders and identifies potential funding sources. The fifth section addresses how to ensure the sustainability of the program through evaluation and outreach.

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[8] www.huduser.gov/portal/periodicals/em/fall13/highlight1.html#title

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II. Mission: Overcoming Obstacles to Change

Change typically happens when people and organizations with shared visions agree to work together, or partner, to make that vision a reality. Partnerships can take many forms, but before an organization can begin building a partnership that embraces a new approach for senior falls prevention and coordinated care, it will need to construct a strong program mission statement that captures the overall goals and intended outcomes of the partnership. This statement should encompass the actions and goals envisioned for the partnership and serve as the starting point to recruit partners.

In creating a program mission statement, people should think about the achievements of existing partnerships and consider what successes of those models should be replicated or improved upon, and what weaknesses in them can be overcome. When starting from scratch, consider what a successful program or policy would look like to your organizations and the seniors in your community. Identify the issue you are attempting to tackle (i.e., your cause), the actions needed to address the issue, and what change or impact you hope the partnership or collaborative will achieve.

For example, the Step-by-Step Exercise to Create a Mission Statement, created by Nonprofit Hub,[9] can help you organize your concepts and goals to develop a strong program mission statement.

Please note, in regard to developing your program mission statement, selecting partners, and determining program goals and implementation approaches, that this Toolkit is not intended to provide guidance on selecting, creating or implementing a specific type of senior falls prevention intervention or coordinated care model, because many other organizations have already undertaken that task. For guidance on program development and implementation, see, for example:

- Centers for Disease Control and Prevention (CDC). Preventing Falls: A Guide to Implementing Effective Community-Based Fall Prevention Programs.
- Centers for Medicare and Medicaid Services (CMS). Integrated Care Resource Center.
- National Council on Aging (NCOA). Falls Prevention.

PREVENTING FALLS:
A Guide to Implementing Effective Community-Based Fall Prevention Programs

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

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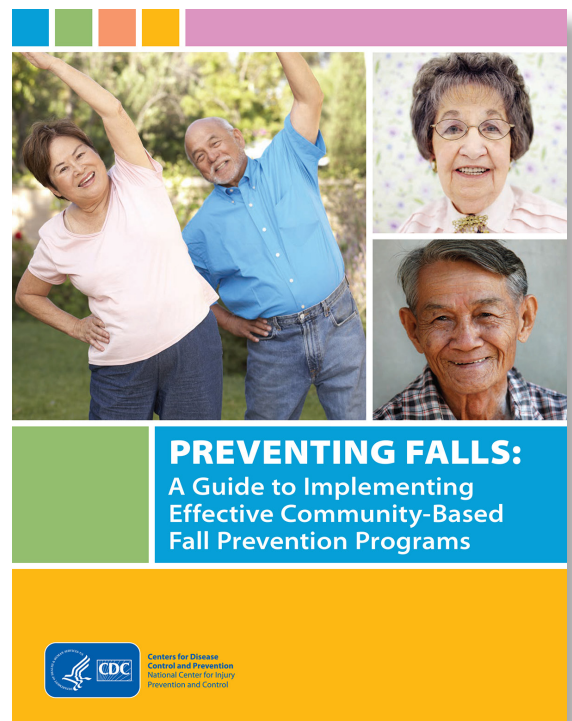
[9] Nonprofit Hub is an online educational tool that provides nonprofits an array of resources to improve their organizations and communities. The Exercise document mentioned above is useful for program missions as well as the organizational missions for which it is written. http://nonprofithub.org/

For evaluation information and guidance about using coordinated care models, see, for example:

- The Commonwealth Fund website, especially its Coordinated Care Models webpage.
- Safety-Net Providers In Some US Communities Have Increasingly Embraced Coordinated Care Models, a report by the Center for Studying Health System Change (HSC) evaluating coordinated care models. [10]

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[10] 'Safety-Net Providers In Some US Communities Have Increasingly Embraced Coordinated Care Models.' Health Affairs 31:8 1698-1707. August 2012. Cunningham P, Felland F, and Stark L. Available at http://content.healthaffairs.org/content/31/8/1698. NOTE: The Center for Health Systems Change (HSC) merged with Mathematica Policy Research (MPR) and ceased operations as an independent organization.

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III.   Building Partnerships to Overcome Obstacles

One of the keys to overcoming obstacles to effective senior falls prevention and coordinated care policies and programs are:

- Recognizing that your organization cannot do it alone; and
- Creating strong partnerships with organizations that share your vision. Partnering with other organizations prevents you from having to "re-invent the wheel" and often provides access and experience that your organization may not have.

Your program mission statement should define what type of partnership or collaborative you want to create. For example:

- Are you trying to build a team of service delivery partners to provide senior falls prevention interventions and coordinated care? Or
- Are you trying to build a collaborative that supports changes to legislative and regulatory policies to improve service delivery?

While not mutually exclusive, the structure of your partnership will vary based on what you want to accomplish.

It is important to understand that building a partnership does not happen overnight. While collaborating with other organizations can help achieve your goals, it also takes time, resources, and patience. Before you start recruiting partners, evaluate the resources, including staff and financial, and expertise your organization has to dedicate to the process. Also, determine if you need to seek additional funding to support your effort.

This may also be the time to consider if you can or should be joining someone else's partnership instead of starting your own. You may find an opportunity to work with an existing partner or coalition that could use your organization's expertise to expand its services or re-energize its efforts. If no promising partnership opportunities emerge, begin considering what benefits your organization offers potential partners, and what type of organizations you need to engage to successfully accomplish your shared goals.

A partnership or collaboration focused on helping seniors age in place might include people and organizations with expertise in public health, aging, housing, and community development. It also might include academics and universities that offer programs targeted to geriatric care. In some instances, it may require breaking down longstanding silos. Potential partners should bring access to various resources and funding you may not currently have, and include or have connections to decision-makers such as elected or appointed officials and fund funding organizations, and people who regularly influence decision-makers. Partnering with diverse organizations enables both your organization and theirs to contribute skills and expertise to the project's overall objective from a range of perspectives.

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It is important to consider reaching beyond your traditional partners when building a partnership. Affordable housing and community development corporations (CDCs) have been supporting housing and economic development and providing services to community residents since the 1960s. Many own and manage affordable senior housing complexes that offer resident services; some also provide services to seniors living in the surrounding community. Given their limited resources, CDCs are always interested in partnering with other organizations. If partnerships have not already been established, public health and agencies on aging should consider working with these local nonprofit housing providers to leverage available resources. A recent study on the 42 state Senior Falls Prevention Coalitions found that few listed affordable housing providers or CDCs as partners. [11]

Recruiting Partners

As you build a list of potential partners and begin outreach efforts, you will need materials that outline what your partnership intends to accomplish. Consider drafting an overview that includes your mission statement, background on the issue you want to address, and how the proposed partnership would work to solve the problem.

The overview should include an overall description of the proposed project along with a description of each type of partner(s) needed to meet its goals. The overview should also provide an initial framework for how various partners would work together, what skills and services each offers the partnership, the potential resources they would bring, and a clear understanding of how each partner would complement others. As your program takes shape and you recruit partners, both your mission statement and proposed framework may change to reflect specific objectives that your partners want to achieve.

Your first contact with a potential partner should always be through a phone call or direct face-to-face meeting to introduce yourself and provide some basic background about your organization. This step is especially important if you are "cold calling" a potential partner, because people are often more apt to respond to a call or meeting request than an email from a stranger. It also improves your ability to express your enthusiasm for the program and create a good first impression, which can help foster the relationship. Before the initial call or meeting, drafting talking points based on the materials you have created will help you convey what the potential partner's

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[11] *State Fall Prevention Coalitions as Systems Change Agents: An Emphasis on Policy.* Schneider EC, Smith ML, Ory MG, Altpeter M, Beattie BL, Scheirer MA, Shubert TE. Health Promotion and Practice. 2016 Mar;17(2):244-53. http://journals.sagepub.com/doi/full/10.1177/1524839915610317.

role would be and why you think they are a good fit for the program. During the early phases of recruitment, there may be questions that you will not be able to answer. Keep a running list of them as you meet with potential partners. These questions will help you reconfigure the framework of the program as necessary and clarify your mission as you develop the case for engaging other organizations to become partners, and gaining support from funders.

Housing and Health Care: Partners in Healthy Aging may help you learn more about building partnerships between health and housing organizations. Produced by LeadingAge, a nonprofit membership organization representing disciplines across the aging services spectrum, it is a toolkit designed to help housing and healthcare partners learn how to work together on joint initiatives to improve the health, safety and wellbeing of low-income seniors.

Partnership Agreements

Partnership agreements solidify each partner's commitment to the project. What those agreements look like and provide depend upon the type of partnership you are building. A partnership created to work on legislative and regulatory policy issues may simply require a memorandum of understanding (MOU) that details the commitment of each partner and what resources they bring to the effort. It may also include a non-compete funding provision and/or a requirement to submit funding proposals jointly. Some of these same elements could be included in an agreement for a service delivery partnership, but a delivery of services agreement will require a more extensive business agreement that clearly outlines agreed-upon services and financial issues. Nonprofit Collaborations: The Structural Options may help you understand the best option for your particular partnership.

Fostering partnerships among public health, housing, and aging entities can help set the stage to meet the challenges of our growing senior population. The list of potential partners identified here may help fill a gap in your delivery of services to seniors as well as help build support for improved policies and practices to reduce falls and coordinate senior care.

Potential Partners

Housing & Community
- Community Action Partnership
- Enterprise Community Partners
- Habitat for Humanity®
- HUD Field Offices
- Local Initiatives Support Corporation (LISC)
- National Alliance of Community and Economic Development Associations (NACEDA)
- National Housing Conference's (NHC) Center for Housing Policy
- National Housing Trust (NHT)
- National Low Income Housing Coalition (NLIHC)
- NeighborWorks® Network
- Rebuilding Together
- State and Local Housing Trust Funds

Workforce Development
- AmeriCorps
- DOL Apprentice Programs
- Workforce Investment Boards

Aging and Public Health
- AARP Network of Age-Friendly Communities
- American Hospital Association (AHA)
- American Nurses Association (ANA)
- American Physical Therapy Association (APTA)
- American Public Health Association (APHA)
- American Occupational Therapy Association (AOTA)
- Community Health Workers
- Health in Aging
- National Aging in Place Council® (NAIPC)

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Potential Partners

This list of organizations and coalitions may help you consider potential partners and what they offer your collaborative. National organizations can connect you to their state and local members as well as provide more information about the types of programs and services their members offer. Organizations already involved in senior falls prevention and/or aging in place initiatives may provide resources and links to research that can help support local policy and program efforts, as well as offer suggestions to overcome obstacles you might encounter. In addition to the organizations listed below, please also consider reaching out to and partnering with labor unions, civic organizations, and other community leaders who often interact with and influence community-based seniors. They can potentially provide insight and input on additional ways to improve service delivery and coordinated care to help seniors safely age in place. (Please note the non-endorsement disclaimer provided at the beginning of this document. It applies to all of the organizations and materials listed throughout this toolkit.)

Housing and Community Development

Although few housing or community development groups were listed as partners in existing state falls prevention coalitions,[12] public health and aging agencies interested in providing falls prevention interventions and creating coordinated care models should consider working with these groups because they often provide much needed affordable housing for seniors as well as trained staff to conduct home modifications. Most of these groups work directly in states and/or localities, so the links provided here are primarily to national organizations that may be able to connect to their state and/or local partners.

National associations and intermediaries can provide guidance to public health and aging sectors looking to partner with community-based organizations (CBO) as well as help you connect with local organizations in your area or region. For example:

- NeighborWorks® Network. NeighborWorks® America provides quarterly training institutes that feature sessions on issues from developing and empowering community leaders to providing resident services for vulnerable populations such as seniors. Its network includes local community nonprofits.
- Enterprise Community Partners -Local Offices. Enterprise Community Partners recently released Aging in Place Design Guidelines for

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[12] Ibid., 5.

Potential Partners

Aging and Public Health-*cont*
- National Association of Area Agencies on Aging (N4A)
- National Association of Community Health Centers (NACHC)
- National Coalition on Care Coordination (NC3)
- National Coalition of Consumer Organizations on Aging (NCCO)
- National Council on Aging (NCOA)
- NCOA's Falls Free® Initiative
- State Fall Prevention Coalitions

Local and Regional Healthy Aging Collaborations
- Healthy Aging Regional Collaborative of South Florida
- New Mexico Healthy Aging Collaborative
- Massachusetts Healthy Aging Collaborative

Civil Service and Related Public Officials
- Association of State and Territorial Health Officials (ASTHO)
- National Association of County and City Health Officials (NACCHO)
- National Association of States United for Aging and Disabilities (NASUAD)
- National Council of State Housing Agencies (NCSHA)
- Public Housing Authorities (PHAs)
- State and local public health departments
- State Unit on Aging (SUA)/Area Agency on Aging (AAA)

both renovation and new construction for multifamily buildings. Its Senior Housing initiative provides links to research and case studies, as well as to the Affordable Senior Housing Learning Collaborative created with LeadingAge to support delivery of community-based services to seniors.

- Local Initiatives Support Corporation (LISC). LISC provides CBOs with critical financing and support for sustainable affordable housing and senior services.

- Habitat for Humanity® offers partnership opportunities and services that vary according to the local affiliate. Many provide critical home repairs to help low-income homeowners remain in their homes and communities.

- Rebuilding Together Affiliates. Rebuilding Together works with volunteers across the country to provide home repair and modifications to low-income community residents. Many of its affiliates are working with healthcare providers to carry out home repairs and modifications for seniors.

- Rebuilding Together and the American Occupational Therapy Association (AOTA) are working to help local occupational therapists partner with their Rebuilding Together affiliates. (The home safety checklist commonly used by Rebuilding Together to assess the safety of a senior's home and determine what modifications are needed can be found in the Appendix.)

- State and Local Housing Trust Funds provide dedicated funding for affordable housing production. Funds are used to create and renovate housing to meet the specific needs of the community. The Center for Community Change provides extensive information on housing trust funds, how they work, and where to find them.

- National Housing Trust (NHT). NHT is a nonprofit policy advocate, developer, and lender focused on preservation of affordable housing, especially housing considered "at risk of redevelopment." NHT works with community nonprofits across the country to preserve senior housing and provide key services needed by seniors to remain in their homes.

- National Alliance of Community and Economic Development Associations (NACEDA). NACEDA's membership of statewide and regional community and economic development associations may be able to help connect to your local CDCs. Alternatively, you can find CDCs in your community through your local housing and community development or planning agencies.

- Community Action Partnership represents a network of 1,000 Community Action Agencies (CAAs) across the country. CAAs provide a wide-array of services, from Meals on Wheels and health clinics to transportation for low-income community residents, especially in rural areas.

- HUD's field offices provide key information and connections on housing and community development opportunities. They may also be aware of new funding or demonstration projects that can promote aging in place and home and community-based senior falls prevention programs in your community.

Housing Advocacy and Research

These national organizations provide a wealth of information and resources about low-income housing and resident services for seniors. Several also have community-based members or local chapters.

- National Low Income Housing Coalition (NLIHC). NLIHC members are located across the nation and include individuals as well as local and state organizations committed to affordable housing and community development.

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- **National Housing Conference's (NHC) Center for Housing Policy** offers extensive research on affordable housing issues, including the impact of housing on health and seniors. **NHC's membership** includes banks, foundations, insurance companies, and a host of other organizations that can help support senior services and aging in place policies.

Workforce Development

Many CBOs provide workforce development and apprenticeship opportunities for local residents through the U.S. Department of Labor (DOL) or the Corporation of National and Community Service programs. These programs often provide hands-on home repair and renovation training and are looking to partner with organizations interested in providing these services. For example:

- **Workforce Investment Boards** help set and guide state workforce development policies and funding.
- **Apprentice Program**s featured on this DOL career website may be able to connect you to an **AmeriCorps** group in your community that provides home repair through their training programs. Although the resource is technically for job seekers, it can help you identify groups (if any) that are offering programs in your community.

Aging and Public Health

- **National Council on Aging (NCOA)** partners with various public and private sector organizations to advocate for innovative community programs and services for seniors.
- **NCOA's Falls Free® Initiative** supports 42 falls prevention coalitions across the country via quarterly calls and a policy toolkit designed to help guide the coalitions' pursuit of local policy as well as support NCOA national policy objectives.
- **State Fall Prevention Coalitions**. These coalitions are primarily managed by the state public health departments or aging agencies that administer falls prevention programs and interventions. A recent survey found few of the coalitions currently include housing and community development partners. The survey also reported that only 34 of the 42 coalitions are currently active.
- **National Coalition of Consumer Organizations on Aging (NCCO).** NCCO is a small collaborative network of state- and comunity-based senior-based consumer organizations working on community-based long-term care issues. NCCO builds support for funding and policy for federal programs, such as Medicare, Medicaid, Social Security, and the Older Americans Act. Scroll down **NCCO's homepage** to find links to state-level members in Arizona, Colorado, Minnesota, Oregon, Washington, and Wisconsin.
- **National Association of Area Agencies on Aging (N4A)**. N4A represents a national network of more than 600 Area Agencies on Aging (AAAs). Local AAAs administer most fall prevention programs, especially single interventions focused on exercise and balance. N4A resources include training and education on aging issues ranging from home- and community-based services and legislation related to the elderly to livable communities and funding opportunities at the national and local level. **Find your State and/or Area Agencies on Aging**.
- **Health in Aging** was created by the American Geriatric Society's (AGS) Health in Aging Foundation to provide consumers and caregivers with current information on health and aging. It offers an abundance of information about key stakeholders in senior falls prevention and care coordination for aging in place. Resources include materials AGS developed for its professional members and provides a searchable **list of professionals working in geriatric healthcare**.

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- National Coalition on Care Coordination (NC3) works to improve the quality of senior care by supporting care coordination in health and social sectors. NC3 advocates for policies that support care coordination between healthcare and long-term support services (LTSS). NC3's membership is a mix of national, state, and local organizations representing consumers, aging and social services, family caregivers, and healthcare professionals who recognize that coordinated care for seniors requires an interdisciplinary, patient-centered approach.

- National Aging in Place Council® (NAIPC) serves as a support network for seniors interested in remaining in their homes as they grow older. The network helps link seniors with a range of service providers and caregivers that can assist them. Access NAIPC's list of local chapters to see if your community has one or how to work with NAIPC to create one.

- AARP Network of Age-Friendly Communities is an initiative helping U.S. states, cities, towns, and rural areas prepare for an aging population. It focuses on environmental, economic, and social factors that influence seniors' health and wellbeing. Members of the network may be able to connect you to key stakeholders on senior issues in your community.

- American Hospital Association (AHA) provides extensive information about trends and research in the healthcare industry, including guidance on building community connections. Collaborate with State, Regional and Metropolitan Hospital Associations as well local hospitals and healthcare systems in your community to improve senior care policies in your community.

- National Association of Community Health Centers (NACHC) represents community health centers (CHC) that bring affordable primary and preventive healthcare services to low-income urban and rural communities. NACHC conducts research and collects data at both the national and state level. Partner with NACHC's cadre of State Affiliates or the Health Resources and Services Administration's listing of Community Health Centers operating across the country.

Frontline community healthcare professionals, such as nurses, physical and occupational therapists, and community health workers, are essential partners for successful fall prevention and coordinated care collaborates. For example:

- American Nurses Association (ANA) is the national advocacy organization for U.S. registered nurses (RNs). Nurses can play a key role in creating senior falls prevention programs and managing coordinated care. Your State's Nursing Association may be a good advocacy partner as well as help connect you to nurses and other healthcare providers in your community.

- American Physical Therapy Association (APTA) can help keep you up to date on physical therapists' (PTs') efforts on fall prevention as well as link you to its local chapter.

- American Occupational Therapy Association (AOTA) provides useful material on home modifications to help reduce senior falls as well as information, such as national and state guidelines, policy, and regulations, to help seniors safely age in place. Occupational Therapists (OTs) help identify and remedy home hazards, often in tandem with local and national home repair and renovation groups such as Rebuilding Together.
  - AOTA provides links to a number of national home modification partners who offer additional guidance about how to modify a senior's home for safety.
  - AOTA's list of State OT Associations is a good starting place to learn more about and reach out to local OTs working in your community.

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Community Health Workers (CHWs) are generally non-licensed providers of health and social services. CHWs deliver social and healthcare services to community residents, and are often residents of the community or have a strong understanding of the needs of the community in which they work. The specific roles and activities of CHWs are generally tailored to meet the needs of the community. They often fill major social and healthcare service delivery gaps, especially in rural areas. Current Medicare rules also allow for reimbursement of preventive services offered by CHWs as long as the services are prescribed by the senior's primary care physician or other licensed practitioner.

Many CHWs in the U.S. can be found in the membership of the American Public Health Association (APHA), and a few states and cities have created CHW networks, but there appears to be no national association or network of CHWs. APHA's State and Regional Affiliates may be able to connect you to CHWs in your community.

Community Health Workers (CHWs) Training/Certification Standards
Current Status

Legislation introduced

Pending legislation failed; But Has a Training/Certification Program

Laws/Regulations Establish CHW Certification Program Requirements

Statute Creates a CHW Advisory Board, Taskforce, or Workgroup to Establish Program Requirements

Has a Training/Certification Program

None

Has Training and Certification Program and State Law Licensing CHW businesses

*AK does not have a state-run CHW training program, but statutorily provides community health aide grants for third-parties to train community health aides.
+MN also allows Medicaid payments for certified CHW services

Last updated: 8/24/2016

Local and Regional Healthy Aging Collaborations

Although no national healthy aging organization appears to exist, there are a few state, local, and regional collaborations that have formed around healthy aging. They may provide your organization with a model on which to build a collaborative around healthy aging, senior falls prevention, and coordinated care in your community. For example:

- Healthy Aging Regional Collaborative of South Florida
- New Mexico Healthy Aging Collaborative
- Massachusetts Healthy Aging Collaborative

Civil Service and Related Public Officials

- Officials within the executive branch of federal, state, tribal and local governments, and the management of related entities, such as independent public housing, redevelopment, or health agencies that often coordinate with those governments, can help identify information and other resources for your program. For example:
- State and local public health departments are responsible for administering and managing much of the funding for falls prevention and coordinated senior care.
- State Unit on Aging (SUA)/Area Agency on Aging (AAA). SUAs and AAAs receive funds from the U.S. Agency on Aging (AOA) to administer supportive home and community-based services.
- National Association of States United for Aging and Disabilities (NASUAD) represents state and territorial
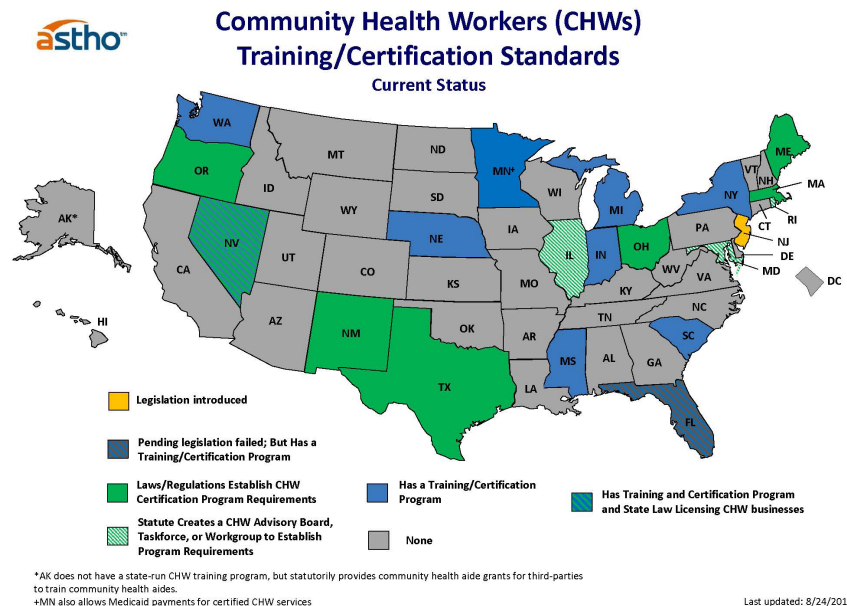
agencies on aging and disabilities, and promotes systems innovation and national policies that support senior home- and community-based services.

- National Association of County and City Health Officials (NACCHO) is a major national advocate for state and local county officials. Its map of State Associations of County and City Health Officials (SACCHO) provides a list of all states with state and local associations. The Association of State and Territorial Health Officials (ASTHO) is another resource to help you connect to local public health agencies and professionals. ASTHO also provides a wealth of information on CHW including an outline of current state standards for CHW Training and Certification.

- National Council of State Housing Agencies (NCSHA). NCSHA represents local and state housing finance agencies (HFAs) across the county. HFAs administer affordable housing programs such as Mortgage Revenue Bonds (MRBs), the Low Income Housing Tax Credit (LIHTC), and the HOME Investment Partnership (HOME). Although the federal government requires certain thresholds are met, most of the funding for LIHTC and MRBs is guided by criteria dictated by the state's annual Qualified Allocation Plan (QAP). Access NCSHA's listing of local HFAs to learn who manages these programs in your area.

- Public Housing Authorities (PHAs) provide federally and/or state subsidized rental housing for low-income families, seniors, and people with disabilities. Housing ranges from scattered site single-family to high-rise multiunit senior complexes.

As you build your partnerships, remember to communicate with, and develop a rapport with your state, tribal, and local elected and appointed officials. Keeping them informed and up-to-date about your efforts and partnerships supporting senior falls prevention and care coordination in your community, as well as the economic and health benefits, and listening to their comments and questions, can help build much needed support for system change.

Although much of the funding for senior falls prevention and coordinated care currently comes from the federal government, many decisions made at the state, tribal, and local level determine how the funding is administered and managed. By educating elected officials about the needs of our aging communities, you will help to create advocates and champions. Find contact information for your Governor, officials in your state legislature, tribal government, and local officials.

Additionally, always consider your Congressional representatives as partners in your community efforts, and keep them informed and up-to-date on successful innovative, non-traditional partnerships. They especially will want to learn about cost neutral programs or those that can potentially save taxpayer money. Educate these elected officials about the benefits partnerships create and the obstacles that must be overcome to help local communities.

Although public health and aging agencies have traditionally been at the forefront, leading senior falls prevention coalitions, affordable housing providers, and community service organizations also have the potential to facilitate strong, comprehensive approaches to senior care and aging in place efforts. Regardless of which sector leads the effort or contributes financial support, each benefits by bringing unique skills and insight that can only improve overall delivery of care.

IV.   Financing Senior Fall Prevention and Coordinated Care

According to the U.S. Department of Health and Human Services (HHS), at age 65, the typical person in the U.S. can be expected to live approximately another 20 years. One third of the over 65 age group will fall annually and more than half can expect to need some level of long-term support and services (LTSS) over that 20-year period. For some, it will be a short-term need (less than a year), but about 14 percent of seniors will need LTSS for more than five years (Favreault 2016).[13] Senior fall prevention and coordinated care programs are needed to help keep community-dwelling seniors healthy and safe, and provide the LTSS needed to help them age in place.

Creating partnerships between diverse organizations and agencies is one step toward overcoming major obstacles to providing coordinated delivery of services to seniors. Finding innovative and creative ways to fund service delivery is another. Just as partners from different sectors bring diverse skills and knowledge to the collaborative, they also often have access to different funding sources for their projects. Housing partners will be aware of grants and programs usually available to fund affordable housing rental and home repairs, while public health and aging service providers will be familiar with funds available for service delivery to seniors. The goal should be to leverage funds from various sources to create a funding pool or portfolio that supports your program and its delivery of services.

Making the Case for Your Senior Falls Prevention and Coordinated Care Program

Once you have created partnerships and have established your program's mission statement as an initial collaboration among your partners, as described in sections II and III, securing funding is often the next step. This is a very competitive process. Your program will need to stand out from many other deserving programs to show why it should receive funding. It should exemplify the triple aim framework to (1) improve delivery and quality of services to seniors; (2) improve seniors' health; and (3) reduce healthcare costs.

The Proportion of Medicaid Long-Term Services and Supports Spending For Home and Community-Based Services Varies by State, 2013

National Share = 46%
- ≤ 30% (2 states)
- 31% - 40% (14 states)
- 41% - 50% (16 states)
- ≥ 50% (10 states and DC)

NOTE: All spending includes state and federal expenditures. HCBS expenditures include state plan home health services, state plan personal care, targeted case management, hospice, home and community-based care for the functionally-disabled elderly, and services provided under HCBS waivers. Expenditures do not include administrative costs, accounting adjustments, or expenditures in the U.S. territories.
*Spending for AZ, DE, HI, NC, NM, RI, TN, and VT is not shown due to their funding authority for HCBS and/or the way spending is reported.
SOURCE: Urban Institute estimates based on data from CMS Form 64 as of September 2014.

Applications and proposals for funding should illustrate a clear story of what initiated the program from the beginning (what situation prompted the initiative) to the end (what benefit or value is the program expected to achieve). It must clearly articulate the problem you are attempting to address and the structure of the collaborative you have designed to resolve it. Proposals should include information about why a partnership approach is essential to resolve the issue and, as feasible, the list of partners and sectors you have recruited (or, optionally, and less likely to be effective, you intend to recruit) to

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[13] *Long-Term Services and Supports for Older Americans: Risks and Financing* (2016). Melissa Favreault and Judith Dey. Office of Disability, Aging and Long-Term Care Policy, U.S. Department of Health and Human Services.

the collaborative. Again, as feasible, specific qualifications and skills each organization brings to the partnership should be highlighted.
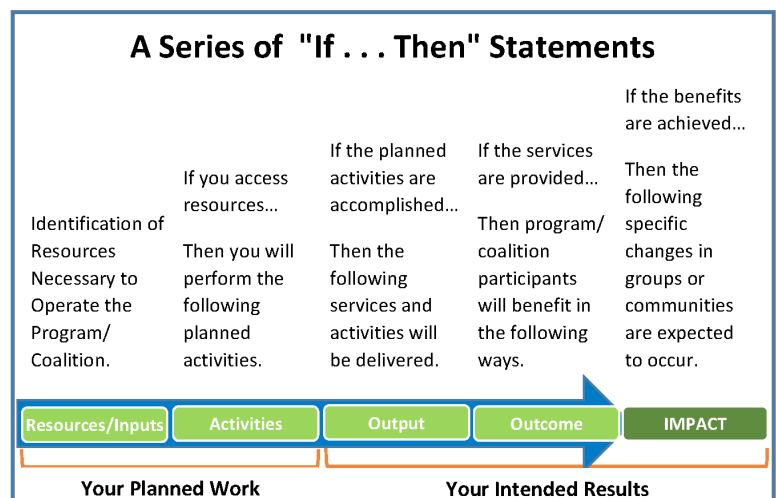
Your proposal should include a clear framework for how the organizations will work together, including which organization will be leading the efforts or ultimately responsible for the success of the program. Additionally, your proposal will also need to outline steps and implementation timelines, with a clear understanding of the milestones you intend to achieve along the way. As you develop your framework, also consider what objections or challenges you might encounter during the process to address potential concerns raised by funders. Record these barriers and start compiling responses for how you intend to manage them.

Your proposal must also provide a detailed budget that clearly outlines your expected expenditures (as well as any potential income) for the program. Your program's projected financial statements should include expected initial startup costs (if any), as well as annual expenditures for staff, services, and administration of the program. If feasible, costs related to ongoing program evaluation (see section V) should also be included as an expenditure. Outlining these costs helps potential funders understand how you intend to manage investments in your program.

If you expect that your organization and/or some partners will bring funds or other leveraging resources into the program, your financial statements should also reflect the anticipated amount (including identifying the market value of goods and services to be part of your program's leveraging). Specific letters of leveraging commitment from officials of your and/or partner organizations who have authority to make such commitments are beneficial, and are required by some funders. Providing this information helps the potential funder understand how your partnership has brought experienced key partners together to offer services versus "re-inventing the wheel." It also shows the level of organizational commitment to the program (i.e., "Money talks"). It often can also help you leverage existing funding to attract new, additional funders.

Logic models, which funders often use to assess the effectiveness of a program, can be used to help plan and implement your program. A logic model visually maps out the resources needed to operate your program, shows your planned activities, and highlights the outcomes or results you hope to achieve. Using a logic model approach to design the framework of your partnership and program may improve your chances of receiving funding. There are several examples of logic models available to help you, for example;

- The Falls Free® Logic Model, created by NCOA, can help coalitions systematically outline the activities their senior falls prevention coalitions plan to accomplish along with the outcomes and impact they hope to achieve.
- The CDC Division for Heart Disease and Stroke Prevention provides an Evaluation Guide that illustrates how to develop and use a logic model with step-by step-instructions.
- The W.K. Kellogg Foundation (WKKF) created an in-depth Logic Model Development Guide that assists with program planning, implementation and outreach. Although intended primarily for

A Series of "If . . . Then" Statements

	If you access resources...	If the planned activities are accomplished...	If the services are provided...	If the benefits are achieved...
Identification of Resources Necessary to Operate the Program/ Coalition.	Then you will perform the following planned activities.	Then the following services and activities will be delivered.	Then program/ coalition participants will benefit in the following ways.	Then the following specific changes in groups or communities are expected to occur.

Resources/Inputs	Activities	Output	Outcome	IMPACT

Your Planned Work | Your Intended Results

nonprofit organizations, the tool can be used by any organization interested in understanding and using the principles of logic modeling to develop a strong business case for funding.

Finally, your proposal or application must provide a clearly articulated "ask" (i.e., what exactly you are requesting in the way of resources, funding, authorization or support, and how exactly you know that your program will provide the intended outcomes). Developing a clear "ask" is useful for building confidence that your collaborative and its outlined service delivery proposal will prevent senior falls and provide much needed coordinated care.

Where to Find Financial Support

A number of government programs provide funding for senior care, but accessing them and coordinating their resources can be challenging. Although such programs are often complex and not well-coordinated, by working closely with your local and state program administrators, you should be able to combine funds from various agencies for your project. Additionally, many foundations support senior falls prevention and coordinated care programs.

It is important to note that many programs that reduce falls among the elderly are not necessarily conceived as "falls prevention" programs. They often take a broader approach to senior healthcare by addressing multiple issues, including home environment, nutrition, and physical and social wellbeing. Some even offer coordinated health care management. Although funding for all senior service delivery programs is limited, in recent years, funding specifically for senior falls prevention has become especially tight. While some of the following funding resources may cover falls prevention specifically, others may embed falls prevention interventions as one element of an overall approach to providing healthcare and aging in place services to community-dwelling seniors.

Applying for grants takes time, effort, and patience. Plan on submitting grant applications to multiple sources (governments, foundations, insurance companies, trade groups, etc.) and applying for several years before you receive funding. Consider requesting debriefings from funders who have rejected your proposals, and use the information and insights provided to improve your future applications to them or other funders.

Government Funding

As reflected by many of the following funding programs, in recent years, HHS and HUD have proactively moved toward a more collaborative system in which both agencies provide funding and technical assistance (TA) to support state and local agencies and community partners' efforts to provide LTC and LTSS to community dwelling seniors.

U.S. Department of Health and Human Services (HHS)

The vast majority of U.S. Department of Health and Human Services (HHS) funding for senior fall prevention and coordinated care is provided through the Centers for Medicare and Medicaid Services (CMS) and the Administration for Community Living (ACL). CMS is the main administrator of funding and programs supporting

senior healthcare. The CMS Innovation Center provides information about various healthcare payment and service delivery models being tested across the country and opportunities to determine what other organizations are working on innovative senior care programs near or in your community. Partner with CMS to access more resources.

CDC National Center for Injury Prevention and Control (NCIPC)

A significant amount of the funding for senior falls prevention programs has historically come from the CDC's National Center for Injury Prevention and Control (NCIPC). In the past, it has funded numerous falls prevention initiatives and conducted an extensive amount of research on interventions. Currently, NCIPC's falls prevention funding is reserved for training service providers and STEADI Step Two, which is designed to improve seniors care by expanding education and outreach on evidence-based falls prevention programs. The STEADI (Stopping Elderly Accidents, Deaths and Injuries) Initiative provides key information to both healthcare providers and seniors to help reduce the incidence of falls in the community.

Administration for Community Living (ACL)

The Administration for Community Living (ACL) is the primary federal agency supporting fall prevention interventions. Funding comes from the Prevention and Public Health Fund (PPHF) created under the Affordable Care Act (ACA). ACL funds support the National Falls Prevention Resource Center managed by the National Council on Aging (NCOA) as well as specific Evidence-Based Falls Prevention Programs in the community. This center provides tools and resources to ACL Falls Prevention grantees and their partners. The Prevention and Public Health Fund (PPHF) Reporting Database provides funding opportunity announcements, requests for proposals, and other solicitations available for activities funded by the PPHF. ACL also maintains a Funding Opportunity Announcements that features various grants available from ACL.

Centers for Medicare & Medicaid Services (CMS)

Medicaid is the government-sponsored health insurance program for eligible low-income populations, including low-income seniors. Funding and administration is managed through state-federal partnerships. Medicaid funding in each state is a combination of state-appropriated funds and federal Medicaid funds, which are matched to the state depending on its per capita income. For example, states with low per capita income like Mississippi receive more federal Medicaid dollars than states like New Jersey or Connecticut, which have higher per capita incomes. States set their own guidelines for eligibility, services, and payment rates as long as they comply with federal Medicaid laws. Federal Medicaid laws set both specific thresholds and restrictions for what states must do to receive funding.

Although all state Medicaid programs are required to cover nursing facility costs for eligible participants, coverage for most home- and community-based services (HCBS) is optional. The ACA authorized and expanded several new waivers to increase HCBS options. States interested in delivering HCBS to Medicaid beneficiaries may elect to offer options such as the Community First Choice (CFC) or HCBS waivers. Although not all states elect to provide these options, there is an increased movement to provide HCBS as they are much more cost effective than care in a long-term nursing facility.
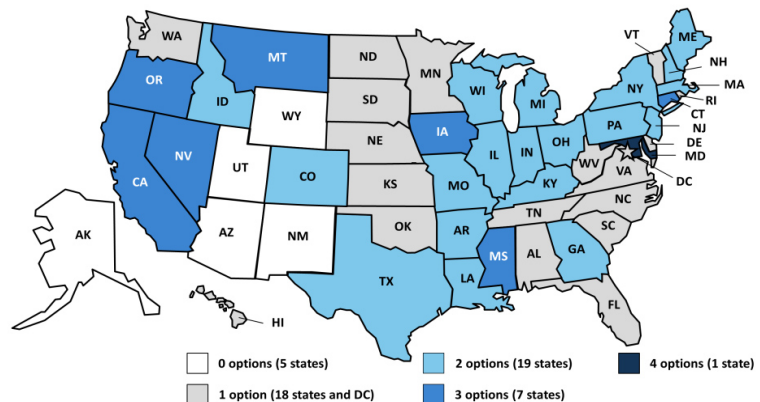
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Home and Community-Based Services (HCBS) Waivers

A Home and Community-Based Service (HCBS) waiver from HHS allows states the flexibility to design and implement a Medicaid program to meet the needs of their specific residents. HCBS waivers give a state authorization to disregard certain provisions of the Medicaid law in order to offer experimental, pilot or demonstration projects that promote Medicaid program objectives. States interested in obtaining an HCBS waiver must submit an application to CMS that outlines the program's goals and how it would operate. Applications are subject to public review and comment prior to approval.

Most States Are Participating in Multiple Medicaid Home and Community-Based Services Options (HCBS) Provided or Enhanced by the Affordable Care Act, April 2015

0 options (5 states)
1 option (18 states and DC)
2 options (19 states)
3 options (7 states)
4 options (1 state)

NOTES: Included options – Money Follows the Person Demonstration, the Balancing Incentive Program, the Section 1915(i) HCBS state plan option, and the Section 1915(k) Community First Choice state plan option
SOURCES: Medicaid.gov and state websites.

HCBS projects can illustrate and evaluate the potential of various policy approaches, such as expanding program eligibility to people not otherwise Medicaid eligible; delivery of services not typically covered by Medicaid; and innovative services delivery systems that improve care, increase efficiency, and reduce costs. Some state-granted HCBS waivers must follow more stringent rules, such as no service caps or waiting lists, and must offer services statewide. Learn more about Medicaid HCBS programs.

Community First Choice (CFC)

Community First Choice (CFC) allows states to provide HCBS and care attendants to eligible seniors to help them remain in their own homes and communities, and avoid moving to a long-term care institution. Beneficiaries direct as much of their own care as possible, including having the right to interview, hire, and fire (as necessary) care attendants. States selecting the CFC option receive an increased share of federal Medicaid payments and are subject to higher Medicaid standards (i.e., no caps on services, waiting lists, or geographic restrictions).

Money Follows the Person (MFP)

Money Follows the Person (MFP) encourages the transition of seniors from institutional care to home and community settings. Under MFP, states that opt into the program receive an increased share of federal Medicaid funds for 12 months for each Medicaid beneficiary who moves from a long-term care facility back into the community. MFP funding helps provide HCBS to seniors returning to the community to reduce the use of more expensive institutional services. Forty-three (43) states and the District of Columbia are currently participating in the demonstration program. Although MFP was due to expire in 2016 (as of this writing, the Fiscal Year 2017 Medicaid Budget had not been passed, so MFP's FY2017 status had not yet been determined), unspent grant funds awarded in 2016 can be used through fiscal year 2020.

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Program of All-Inclusive Care for the Elderly (PACE)/Living Independence for the Elderly (LIFE)

Program of All-Inclusive Care for the Elderly (PACE)/ Living Independence for the Elderly (LIFE)[14] programs are comprehensive service delivery systems for dual-eligible seniors using integrated Medicare and Medicaid funding. PACE participants are eligible for admission to a nursing home, but choose to stay in their community. PACE covers all of the beneficiary's health and long-term care needs, providing necessary medical and social services either directly or through contracts with other service delivery providers.

Although PACE was one of the earliest coordinated care initiatives, it has met some implementation challenges. It requires a substantial upfront investment; enrollees are often hesitant about changing their primary care physicians; and there are some participation barriers for middle-income seniors.[15] As of March 2017, PACE was available in 31 states.[16]

Medicare Financial Alignment Initiative

The Medicare Financial Alignment Initiative addresses the differences in financial alignments of Medicare and Medicaid funding, which may inhibit coordinated care for "dual-eligible beneficiaries." Such beneficiaries are seniors enrolled in both Medicaid and Medicare. Although Medicare pays for a broad range of services for their care, most LTSS costs are covered by Medicaid. The waiver attempts to improve the integration and coordination of healthcare and services for seniors.

Organizations seeking waivers to offer HCBS services must first verify that the option they are seeking coverage under has been selected by their state. Next, they must work with the state to develop and submit an application to CMS. The state must submit the application to CMS with the assurance that it supports the applicant's request.

State Innovation Model (SIM) Initiative

The State Innovation Model (SIM) Initiative provides financial and technical support to states to develop and test state-led, multi-payer healthcare payment and service delivery models that achieve the triple aim framework (i.e., improve the performance of the health system, increase and improve the quality of care, and decrease costs for Medicare and Medicaid Program beneficiaries). States interested in participating in the initiative must submit a State Health Care Innovation Plan proposal to CMS that describes the state's planned strategy to use all of the resources available to transform its healthcare delivery system through multi-payer payment reform and other

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[14] PACE and LIFE are basically the same program but various states use different names for the programs.
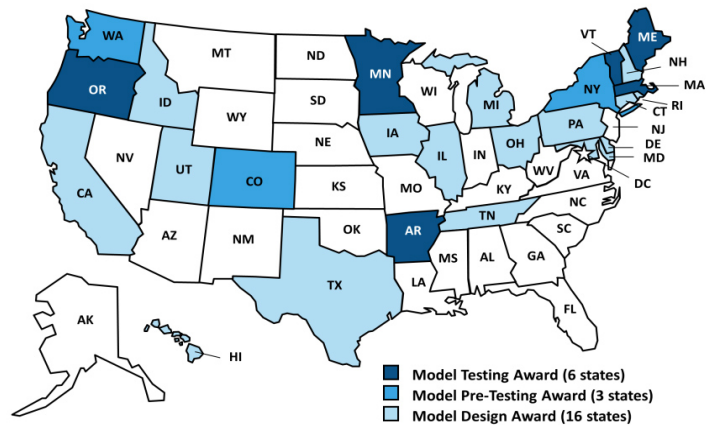
[15] 'Effects of the Program of All-Inclusive Care for the Elderly on Hospital Use', Meret-Hanke, Louise A. The Gerontologist (2011). Available at http://gerontologist.oxfordjournals.org/content/early/2011/07/06/geront.gnr040.abstract

[16] Find a PACE Program in Your Neighborhood. Available at www.npaonline.org/pace-you/find-pace-program-your-neighborhood

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state-led initiatives. Medicare and Medicaid program rules can be complex, sometimes making it difficult to use this funding for initiatives that include non-traditional providers or care settings. Population-based approaches and programs that are not run statewide can also experience difficulties using Medicaid dollars. CMS's Integrated Care Resource Center (ICRC) was created to help states learn and share best practices for delivering coordinated healthcare to dual-eligible beneficiaries. Medicaid Funding of Community-Based Prevention, a 2013 report released by the nonprofit health system, Nemours, also attempts to sort through the myths and realities of working with Medicaid funded programs. The report provides insights on how many states have learned to navigate the rules.

State Innovation Models (SIM) Round One Awards

- Model Testing Award (6 states)
- Model Pre-Testing Award (3 states)
- Model Design Award (16 states)

SOURCE: Centers for Medicare & Medicaid Services

U.S. Department of Housing and Urban Development (HUD)

Numerous Department of Housing and Urban Development (HUD) programs provide affordable housing to moderate- and low-income seniors in communities across the country. Housing programs include Section 202 Supportive Housing, which is a production program specifically for the elderly, as well as public housing and housing choice vouchers administered by local PHAs, and privately owned multifamily housing subsidized by HUD. Many of these programs also include supportive service programs to help senior residents age in place. Most, if not all, such residents living in HUD-subsidized homes are dual-eligible Medicaid/Medicare beneficiaries. Although many HUD-assisted properties provide supportive services, these services are often funded with CMS funds through cooperative agreements with CMS service providers.

Section 202 Supportive Housing for the Elderly Program

Section 202 Supportive Housing for the Elderly is the only HUD program that provides housing exclusively to seniors. HUD offers rent subsidies and loans to private, nonprofit organizations to develop supportive housing for very low-income seniors. Demand for Section 202 housing is very high. It is not uncommon for seniors to be on wait lists for a year or longer. HUD issues grants and notices of funding availability (NOFA) to support provision of services to seniors living in Section 202 housing.

Supportive Services Demonstration for Elderly Households

HUD launched the Supportive Services Demonstration Project in 2016 to provide social resources and support to vulnerable populations living in HUD-assisted multifamily developments targeted to senior households. An

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interdisciplinary team, composed of an Enhanced Service Coordinator and Wellness Nurse, will provide supportive services to the collective needs of all residents. The team will also provide preventive health services and education, and act as a liaison with primary care and service providers. Resident participation is voluntary.

HUD Assisted Living Conversion Program (ALCP)

The HUD Assisted Living Conversion Program (ALCP) is a HUD grant program designed to encourage private, nonprofit owners to convert some or all of a multifamily building into an Assisted Living Facility (ALF) or Service-Enriched Housing (SEH) to help seniors age in place. ALFs must be licensed and regulated by the state (or by the local jurisdiction if there is no state law for licensing and regulation). SEHs provide supportive services to seniors who need assistance with activities of daily living in order to live independently.

Although the level of conversion assistance varies from state to state, HUD sets minimum required standards for construction (e.g., accessible bathrooms, community kitchen, and lounge or recreational facilities) and programming (e.g., 24-hour crisis response staffing and three meals per day).

HUD Supportive Service Programs

Service Coordinator Program

The Service Coordinator Program provides funding to hire Service Coordinators in HUD-subsidized multifamily housing that serve seniors. The Service Coordinator delivers long-term community based support, which connects residents with services ranging from meals, transportation, and housekeeping to medication management. Funding for Service Coordinators comes from either competitive grants or the property's excess income or residual receipts.

The Service Coordinator Program replaced the Congregate Housing Services Program (CHSP), which provided funding to Section 202 and public housing communities to help frail seniors age in place and avoid transitioning to long-term care institutions. CHSP communities provide residents meals and non-medical services such as housekeeping, transportation and social services. CHSP funds can also be used to provide service coordinators. Although no new contracts have been awarded under CHSP since 1995, some existing funds continue.

Resident Opportunity and Self-Sufficiency (ROSS) Service Coordinator Program

The Resident Opportunity and Self-Sufficiency (ROSS) Service Coordinator Program is similar to the Service Coordinator Program in that it supports provision of services, such as meals, housekeeping and transportation, as well as assists with medication management. However, ROSS Service Coordinators specifically serve seniors residing in PHAs and senior housing facilities provided by nonprofit community partners.

Other Government Grant and Funding Opportunities

U.S. Department of Agriculture (USDA)

Section 504 Home Repair Program

USDA's Rural Development agency administers the Section 504 Home Repair Program, which provides loans and grants to very-low-income seniors to repair and improve their homes to remove health and safety hazards.

U.S. Department of Transportation

Enhanced Mobility of Seniors and Individuals with Disabilities

The Federal Transit Administration (FTA) Enhanced Mobility of Seniors and Individuals with Disabilities program provides direct funding to states to provide grants to community nonprofit organizations that offer transportation services to seniors and people with disabilities. Nonprofit recipients of the state grants can use this funding to provide seniors transportation to daily activities, such as grocery shopping, as well as to senior falls prevention classes and healthcare appointments.

Each state is a direct recipient of funds from this FTA grant program. Funds are apportioned based on each state's share of population for these groups of people. Nonprofit groups hoping to help meet the transportation needs of the elderly and persons with disabilities in areas where the service provided is unavailable, insufficient, or inappropriate to meeting these needs should contact their state transportation office to inquire about these funds. There is a 20 percent local match required for this grant program.

Government Grant Search Engines

The federal government sponsors several grant search engines that operate across all federal agencies.

National Institute on Aging (NIA)

National Institute on Aging (NIA) provides research grants and funding that may help support efforts to accurately track and evaluation program impact.

Grants.gov

Grants.gov lets you find federal grant opportunities and download applications using multiple search factors. It also provides extensive information about the federal grants process process.

USASpending.gov

USASpending.gov shows where and what federal grants have been awarded. It could be used to determine potential partners or identify similar projects that are already underway or in place in your community.

Non-Governmental Funding

Pay for Success (PFS)

Pay for Success (PFS) is a relatively new funding model in which payment for services is tied to measurable outcomes. Under this type of outcome-based financing, funding is provided after agreed-upon services have been delivered and met their prescribed objective(s). If the outcomes are not achieved, the service provider is not reimbursed for their services.

Service providers typically receive funding on an on-going basis for the work they do or what the services they provide, such as the number of people they serve or number of hours worked. However, this does not guarantee that the services they provide produce their intended impact. Under a PFS funding arrangement, a program only receives funding if its services can show measurable outcomes and meet their goals. For example, if an intervention program is supposed to reduce the number of seniors that fall, the provider only receives funding for the program when they can show fall rates among seniors have declined. To be fair, an independent evaluator is usually recruited to decide if the agreed upon outcomes have been met.

Since service providers rarely have the resources needed to provide services without immediate reimbursement, Social Impact Bonds (SIBs) and other investment mechanisms were created to provide the up-front funding needed to launch and run the program for a specified period of time (usually a span of several years).
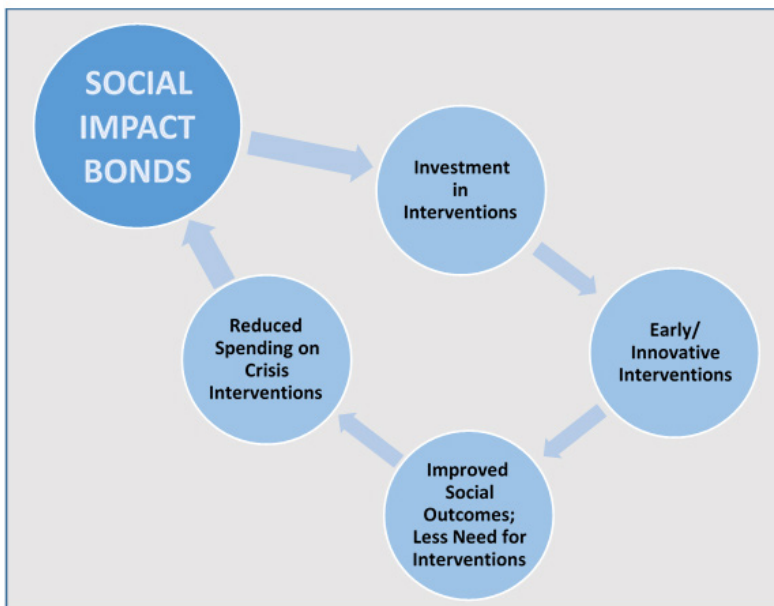
Source: Adapted from
https://en.wikipedia.org/wiki/Social_impact_bond#/media/File:Social_Impact_Bond_diagram.JPG

The government uses investment tools such as SIBs to help service providers raise upfront funding for their programs. SIBs purchased by private commercial and philanthropic investors provide the capital to fund the delivery of services. If the project is successful, the government repays the investors. However, if a program does not meet its goals, the investors lose their investment.

Given the time and resources necessary to launch and implement successful programs, some foundations have also begun providing grants to support the first year or two of operation. This could be especially useful for a senior falls prevention and coordinated care collaborative, which involves referrals and service delivery from several partners who may not have previously worked together.

Foundation grants could help provide a "buffer" as partners learn to work together and address program start-up issues.

PFS initiatives are being used to scale up programs and interventions shown effective at a demonstration or smaller scale, as well as to test innovative models of service delivery. They have the potential to help the government be a better financial steward of public monies while still providing much needed services. However,

given the nascent nature of PFS initiatives, there is some uncertainty regarding how well they will work and what happens to the ability of the service provider to continue providing services once the contract period ends. Learn more about PFS funding at the Pay for Success Learning Hub.

Private Insurance Plans

Funding senior falls prevention and coordinated care programs funded through private insurance depends not only on whether a senior obtained long-term care (LTC) insurance, but also what the purchased package covers. According to the American Council of Life Insurers, many LTC insurance policies cover home-based services, including home modifications to help make a senior safer to navigate and avoid falls, but these services may have had to be selected at purchase. Perhaps more importantly, although many reports indicate that approximately 70 percent of the population will require LTC as they age, only about 10 percent of seniors currently carry LTC insurance. The premiums for this insurance are high, and recent news reports indicate that costs are continuing to climb and that some LTC insurers are leaving the market. [17]

Under the ACA, private insurers must pay for some clinical preventive services, including evidence-based screenings and counseling if the U.S. Preventive Services Task Force (USPSTF) recommendations rate them an "A" or "B." In the 2012 release of USPSTF's recommendation on falls prevention, only exercise or physical therapy and Vitamin D supplements for seniors "at increased risk for falls" received a grade high enough for coverage. Seniors with private insurance whose doctors prescribe an exercise-based falls prevention intervention regimen, which requires a fee to attend, may be eligible for reimbursement.

Foundations

The following foundations and philanthropic organizations support efforts to reduce senior falls and help older adults age in place.

AARP Foundation

The AARP foundation supports organizations whose evidence-based interventions make a direct impact on the quality of life for seniors. It offers grants to nonprofits providing low-income seniors with affordable safe housing and care.

The Commonwealth Fund

The Commonwealth Fund is a private foundation that supports independent research on healthcare issues, and provides grants to improve healthcare practice and policy. Its health policy program supports innovative policies and practices.

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[17] John Hancock Withdrawing from Long-Term Care Market. Forbes Magazine, November 10, 2016. Available at: http://www.forbes.com/sites/jamiehopkins/2016/11/10/john-hancock-withdrawing-from-long-term-care-market/#48fb4104232b

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The Harry and Jeanette Weinberg Foundation

One of the largest private charitable foundations in the U.S., The Harry and Jeanette Weinberg Foundation, assists low-income and vulnerable populations through nonprofit grants to direct-service providers. The foundation's largest single funding availability area supports organizations that help low-income seniors continue to live independently in their communities.

Health in Aging Foundation

The Health in Aging Foundation, created by the American Geriatric Society, supports research on older adults and advocacy efforts that promote programs and policies that help older people lead healthy, active lives.

Robert Wood Johnson Foundation (RWJF)

The Robert Wood Johnson Foundation (RWJF) supports research and programs targeted to community health and systems change. It has awarded several grants to CBOs, universities, and other nonprofits to improve senior care.

Rockefeller Foundation

Initiatives run by the Rockefeller Foundation support programs targeted to improve healthcare, create sustainable cities, and impact investment and innovative financing, such as SIBs, which are used to help fund innovative healthcare programs.

Tufts Health Plan Foundation

The Tufts Health Plan Foundation is a regional funder that supports programs to advance age-friendly communities in Massachusetts, Rhode Island, and New Hampshire.

Home Instead Senior Care Foundation

Created in 2013, the Home Instead Senior Care Foundation launched the innovative "GIVE 65" crowd-fundraising platform to provide grants in which they collaborate with nonprofits to raise funds for their project and increase overall awareness of healthy aging.

Foundation Center

The Foundation Center is a national nonprofit that helps connect organizations looking for various types of funding to donors interested in supporting their work. The Center offers a comprehensive database of more than 140,000 foundations and donors to help nonprofit organizations find needed funding, and provides guidance on how to identify appropriate funders and pursue grant opportunities.

Affinity Associations

The following "affinity" associations support foundations that fund aging and health-related issues. Although they do not offer grants or assistance to social sector organizations seeking grants, they often provide resources and information about projects and initiatives that may be occurring in your community. As you approach local grant-making organizations for support, helping them connect with these affinity organizations might also strengthen your case for support.

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Grantmakers in Aging (GIA)

Grantmakers in Aging provides resources for funders interested in supporting Falls Prevention and Aging in Place Initiatives. However, there is no link to member organizations.

Grantmakers in Health (GIH)

Grantmakers in Health has members that support healthcare and healthy communities initiatives. Although GIH does not offer assistance to grant-seekers, it is possible to learn more about the organization's Funding Partners.

National Association of Area Agencies on Aging (N4A)

Many national membership associations, such as the National Association of Area Agencies on Aging, also track and feature funding national, state, and regional opportunities for their members.

V.   Sustaining a Senior Falls Prevention & Coordinated Care Program

Once you have built your partnership and secured funding for your program, the next step is to determine how to sustain it. Sustainability requires effective implementation; ongoing outreach and publicity with key decision-makers; regular engagement with partners to ensure their needs and the needs of the community are being met; and continued funding to support the program's mission. These steps may also help you achieve your ultimate goal: preventing senior falls by impacting legislative, regulatory, and policy decisions about service coordination and funding for senior falls prevention and coordinated care.

Program Evaluation

Evaluating your program is one of the most challenging responsibilities. Funding does not always cover evaluation costs and staff members may be resistant. Staff often perceive evaluation efforts as diverting program resources and time away from clients. Effective evaluation should start before you actually launch your program to capture the processes and challenges encountered during every step of program design, development, and implementation. Program evaluations are typically conducted to answer questions about whether a program is working as intended and, if not, to identify and explain why. Evaluations inform decisions and next steps about the program, including whether it should be continued, what are the needed adjustments, and can or should it be expanded to additional communities.

You can evaluate your program by seeking answers to these basic questions:

- Program design: Are services being offered to the right audience? Were the best partners for the task recruited? Are there gaps in services and/or partnerships? Have the appropriate marketing materials been created?
- Implementation: Are partners providing the agreed upon services? Is funding being allocated correctly to various services? Are partners working effectively together, making referrals as necessary, sharing information, and seeking joint funding? Are program outreach and marketing reaching and engaging the intended audiences?

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- Performance outcome objectives: Are seniors receiving the care and services they need to safely age in place? Have falls been prevented and health improved? Is the program reducing healthcare costs and effectively delaying transition to long-term care? (Note that access to some or all of these data may be constrained by privacy and other laws and regulations, e.g., under the Health Insurance Privacy and Affordability Act).

Your evaluation should refer back to the goals and objectives set as you made your case for program funding. Were milestones met? Were they exceeded? If not, why not? If you encountered obstacles, they should be detailed along with an explanation of how you were able to overcome them. Your evaluation should also provide an opportunity to work with your service provider partners to determine how to better coordinate and improve service delivery. If you employed a logic model to help create your business case for potential funders, use it to facilitate your program evaluation. Academics with expertise in program evaluation (especially, statistical and other quantitative program evaluation methods) recruited to participate in the program may also provide expertise on your program evaluation. You might consider working with them to set up an ongoing evaluation process as well as assess the program's process and evolution strategies.

How you conduct your program evaluation is nearly as important as what you evaluate. Because program funding and approval decisions often rely on the ability to compare "apples to apples," the evaluation must clearly articulate the goals of the program; how it was funded; how it was designed and implemented, and by whom; and its intended audience. Without a clear articulation of content, process, and program audience, funders and decision-makers have a difficult time determining if a program has demonstrated enough merit to receive continued funding and support. Not having and using a sound evaluation of your program may also hamper your ability to inform future legislative and regulatory policies.

Although intended as a guide for their project directors, the W.K. Kellogg Foundation Evaluation Handbook could be a good resource to consider as you construct your program evaluation.
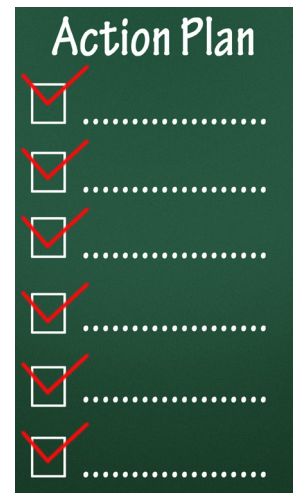
Outreach and Awareness

How your community learns about aging in place, reduces senior falls, and coordinates senior care is up to you. Your program and the people it serves can help educate the community about why your services are important as well as help them understand how to get involved. Although your outreach plan may take a variety of forms, it should be proactive, enabling members of the community to connect to your program goals and objectives before your services are needed, e.g., before a fall occurs. The first step in creating an outreach plan is identifying what you want to accomplish with your efforts. Goals might include increasing the visibility of senior falls prevention and the coordinated care services your program offers; building

and expanding support for aging in place policies with the community and your funders; and connecting with seniors and their caregivers/families.

Although you will need to design outreach materials that address diverse audiences, it is important to remember that seniors are one of the main stakeholders. Terminology used to describe the services offered by the program should appeal to them. For example, although "aging in place" has become common terminology for many housing and public health professionals, it may not resonate or even be understood by seniors and their families. Similarly, although "falls prevention" may be the main goal of your services, many seniors will reject such programs and interventions because they think the services are for "old people" and they do not see themselves in that category. Even families who recognize a relative is aging might not understand the value of your services until a crisis occurs. Consequently, outreach materials should be structured to resonate with your audience. For example, services could be stated as offering "independent living" and promoting "age-friendly communities" as opposed to "falls protection" or "senior care."

Materials should clearly outline the following information: whom the program serves; what services are provided, along with any related costs; when services are provided and how frequently; where the services are offered (e.g., in-home or at a senior or community center); once you have created your outreach materials, you will need to develop a strategy to disseminate the information to key stakeholders such as funders, partners, civic organizations, and seniors and their families. Your outreach strategies should help you create a presence in the community as well as break down barriers to providing access to information needed by many seniors and their families. As feasible, ask seniors participating in your program to encourage other seniors to take advantage of the services. Have participating seniors act as "ambassadors" by talking to policy decision-makers and funders on your behalf, which will communicate how important it is to their ability to age in place and remain in the community.

Outreach strategies should be tailored to reach seniors and beyond. For example, although not all seniors use or have access to the Internet, social media such as Facebook and blogs can help you share information with younger family members, funders, elected officials, and other partners and stakeholders. Use your website to highlight success stories and provide a calendar of events with descriptions of available services such as classes. Create

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brochures and newsletters that highlight your program services and activities as well as promote various partners participating in the program. Develop and maintain a database or listserv of contacts and stakeholders, and use to disseminate the newsletter or calls to action when you need stakeholder support for specific events or activities.

Remember to meet seniors where they are: if few seniors in your community use the Internet, mail documents to them; post and announce information where seniors congregate such as Community and Senior Centers, houses of Worship, and civic organization meetings; post stories local community papers. Start with strategies you and your partners are most comfortable with, and then expand to those outside your traditional "box." Finally, do not underestimate word-of-mouth, not only for raising awareness, but also for building support and attracting new partners.

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Partner Engagement

As your program develops, it will be important for you to review the objectives of the partnership and continually evaluate how well it is meeting your and your partners' expectations. You may need to adjust resources, partner roles, timelines or other elements of the partnership to achieve your goals. You may even need to modify your goals to reflect evolving political or funding dynamics.

Ideally, once your program has launched, you should foster a rapport with your partners and their staff members to increase understanding of the value each organization brings to the project. It might be useful to host "brown bag" lunches or webinars during which staff from the partners can provide presentations on the mission and operation of their organizations or agencies, and what they contribute to the partnership. Partner organizations could also share and provide trainings to each other on specific topics and the tools each organization uses in their senior work (e.g., how to determine what intervention(s) should be offered to meet the needs of a specific subset of seniors).

Funding Continuity

Ensuring ongoing financial stability is daunting for nearly every program. For example, many senior falls prevention programs launched with seed money from CDC were challenged to find new funding sources when CDC's grants ceased.

The first step to ensure financial stability is verifying the effectiveness of your program, and that it is meeting or even exceeding the goals and the needs of its target audience. It is much easier to sustain funding if you can provide supportive data that show how the program has improved the health and well-being of seniors in the community.

Another step to ensure that funds remain available is to build a diverse partnership with access to various funding resources. You can also include some (or all) of your funders as active partners in the endeavor, if this approach is within their operating style. Although it does not guarantee funding, treating funders as project partners helps ensure they are invested in the project with more than just money.

Additionally, instead of relying solely on government funds, look for opportunities to make your program self-sustaining. For example, conduct community fundraising events, and provide fee-for-payment services to higher income seniors and use those funds to offset costs for low- to moderate-income seniors. Work with state, tribal and local legislators to make coordinated senior care a budgetary line item or to create a Senior Care Trust Fund, similar to a state or local Housing Trust Fund, in which funds are specifically earmarked for senior falls prevention and coordinated care.

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Inform Legislative, Regulatory and Policy Change

The convergence of aging baby boomers, the high cost of healthcare and long-term care, and an inadequate supply of affordable senior housing has created an unprecedented opportunity for public health, affordable housing, and community service providers to inform and direct how senior care is managed in the U.S. As providers of community health and housing services, your insight and expertise on the functionality and cost effectiveness of senior falls prevention and coordinated care programs are essential.

Look for opportunities to provide input to critical community planning processes. For example, under ACA, tax-exempt hospitals must complete Community Health Needs Assessments (CHNA) every three years that identify critical health needs and how to work with the community to address them. Every five years, PHAs are required to submit plans to HUD that outline their policies, programs, operations, and strategies to meet local housing needs; nonqualified plans must also submit annually. [18] Annually, HFAs must publish Qualified Allocation Plans and consider public comments on their criteria, including services, for how funds for housing programs such as Low Income Housing Tax Credits and Mortgage Revenue Bonds will be awarded. Cities and states with Housing Trust Funds determine what services can be offered using those funds. These planning processes give public health, housing, and community development providers the opportunity to influence regulations and policies on how senior care and housing are addressed. It also presents an opportunity to engage and build relationships between and with local hospitals, housing authorities, and community nonprofits.

Additionally, your program and its outcomes will inform legislative and regulatory actions only if you partner with your local, state, and federal public health and housing officials. Become an advocate for senior falls prevention, aging in place, and senior care. Share evaluations of your program with these officials and highlight what works well with their programs and funding, and what creates barriers to your program implementation. Share your program's success stories with the media and policymakers.

Learn more about legislation and policy by reviewing the Falls Free® manual: Advancing and Sustaining a State-Based Falls Prevention Agenda: The Role of Legislation, Policy, and Regulation. Stay abreast of changing policy priorities and proposals by getting involved with national organizations such as the National Council on Aging (NCOA), LeadingAge, the National Council of State Housing Agencies, and the National Conference of State Legislatures.

The Appendix provides a range of additional resources to help support your aging in place and senior falls prevention partnerships.

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[18] Public Housing Agency Plans, U.S. Department of Housing and Urban Development. Available at http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/pha

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Resources

A Profile of Older Americans: 2014, Administration for Community Living (ACL). Available at http://www.aoa.acl.gov/aging_statistics/profile/2014/docs/2014-profile.pdf

Centers for Medicare & Medicaid Services.
PACE. Available at https://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html
State Innovation Models Initiative. Available at https://innovation.cms.gov/initiatives/state-innovations/index.html.

Cost of Falls Among Older Adults. Centers for Disease Control and Prevention (CDC). Available at http://www.cdc.gov/homeandrecreationalsafety/falls/fallcost.html

Section 202 Supportive Housing, U.S. Department of Housing and Urban Development. Available at http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/progdesc/eld202

Livable Communities, AARP Public Policy Institute. Available at http://www.aarp.org/ppi/issues/livable-communities/

The Henry J. Kaiser Family Foundation
Medicaid and Long-Term Services and Supports: A Primer. Available at
http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/
Preventive Services Covered by Private Insurance Plans under the Affordable Care Act
Available at http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/

Long-Term Care Insurance: Protection for your Future. The American Council of Life Insurers. Available at https://www.acli.com/-/media/ACLI/Files/Consumer-Brochures-Public/LTCI-ConsumerBrochureUpdate_4-17-14.ashx?la=en

Long-Term Services and Supports for Older Americans: Risks and Financing (2016). Melissa Favreault and Judith Dey
Office of Disability, Aging and Long-Term Care Policy, U.S. Department of Health and Human Services. Available at
https://aspe.hhs.gov/pdf-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief

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APPENDIX

Home Assessment and Modification Checklists

- Rebuilding Together Home Modification Checklist
- HUD Aging at Home: Guide for Home Improvement
- AARP Is My Home Fit

General Resources

- National Council on Aging (NCOA)

  NCOA is a nonprofit advocacy and service organization focused on building partnerships between government, business and nonprofits to improve the lives of seniors. Through programs for seniors, services and advocacy, NCOA works to increase the visibility of challenges that aging individuals encounter on a daily basis.

Aging in Place / Age-Friendly Communities

- AARP Livable Communities

  AARP offers a vast amount of resources to help communities meet the needs of seniors interested in aging in place

  — Where We Live: Communities for All Ages (2016)
  — Aging in Place: A State Survey of Livability Policies and Practices

    A joint publication with the National Conference of State Legislatures
  — Livable Communities: Toolkit and Resources

    AARP's series of toolkits, "how-to" guides, and online materials help community leaders create livable, age friendly communities.

- Aging in Place Design Guidelines: For Independent Living in Multifamily Buildings

  A joint venture between Enterprise Community Partners and OZ Architecture

  These Guidelines, along with Enterprise's Aging in Place charrette tools, checklist, and prioritization tool, supplement existing resources for sustainable, affordable housing.

- Best Cities for Successful Aging: Programs with Purpose

  This summary describes innovative ways various communities are working to help seniors age in place. Examples include: an interfaith organization program in Phoenix, AZ, that connects seniors to volunteers who help with activities such as home repair projects, transportation and groceries; a senior transportation network in Portland, ME; and a program in St. Louis, MO, where seniors teach low-income children how to be healthier.

- HUD Evidence Matters

  — Aging in Place: Facilitating Choice and Independence
  — Measuring the Costs and Savings of Aging in Place
  — Community-Centered Solutions for Aging at Home
  — Making Your Community Livable for All Ages: What's Working!

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This 2015 report from the National Association of Agencies on Aging (n4a) provides strategies to help communities develop effective Livable Community initiatives. The report features several examples of the steps and lessons learned from local communities moving to make their communities more age-friendly.

- National Aging in Place Council (NAIPC®) News and Events

  This source provides information on market trends, consumer products, senior issues, legislative and regulatory updates, and other activities related to the National Aging in Place Council®. You can view newsletters by clicking on the month headline.

Falls Prevention

Key CDC Publications

- Preventing Falls: A Guide to Implementing Effective Community-Based Fall Prevention Programs

  "How-to" guide for CBOs interested in implementing evidence-based fall prevention programs. It provides guidelines on program planning, development, implementation, and evaluation. It also provides examples of successful programs, describes resources needed to implement and sustain programs, and offers valuable tips

- STEADI (Stopping Elderly Accidents, Deaths & Injuries)

  A tool kit for health care providers who treat seniors at risk of falling or who have fallen in the past. The Toolkit contains resources and tools to help make fall prevention an integral part of a clinical practice.

Falls Free® Initiative

- Falls Free® Initiative is a coordinated national effort to address the growing public health issue of fall-related injuries and deaths in older adults.

  — 2015 Falls Free® National Action Plan

  — Describes steps that should be taken to reduce the growing number of falls and fall-related injuries among older adults. This is an updated plan which builds on the original 2005 Falls Free® National Action Plan.

  - o Example of a State Action Plan (WI)

  — State Fall Prevention Coalitions

    Contacts for State Fall Prevention Coalition to find a fall prevention program near and to learn about fall prevention efforts

- National Falls Prevention Resource Center

  The Center serves as a national clearinghouse of tools, best practices, and other information on falls and falls prevention to raise awareness about the risk of falls and how to prevent them. The Center was by NCOA with a grant from the Administration for Community Living and is integrated with resources from the Falls Free® Initiative.

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Funding Reports

- [Staying at Home: The Role of Financial Services in Promoting Aging in Community](#)

  This 2016 report, written by staff from the National Community Reinvestment Coalition (NCRC) and published by the Federal Reserve of San Francisco, provides several examples of diverse partnerships between community development, healthcare, and financial institutions to promote healthy aging in place partnerships.

- [Medicaid Funding of Community-Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models](#)

  This 2013 report from Nemours, a nonprofit health system, clarifies some of the complex rules surrounding use of Medicare funding for preventive programs in the community.

- [On-Site Health Services at Affordable Senior Housing Properties Impact Hospital Visits and Healthcare Costs](#)

  This National Low Income Housing Coalition (NLIHC) report details how supportive health services at affordable senior housing properties can reduce hospital visits and lower healthcare costs.

Integrated and Coordinated Care

LeadingAge

- [LeadingAge](#) is a national nonprofit membership organization that represents the full spectrum of the aging services field.

  — [Center for Housing Plus Services](#)

    This is a LeadingAge resource center, which facilitates the development, adoption and support of innovative housing solutions to help moderate- and low-income seniors age safely in their homes and communities.

  — [Affordable Senior Housing Plus Services: What's the Value?](#)

    This 2015 report, which was produced by LeadingAge, provides supportive information that both housing and public health professionals can use to bolster the case for supportive senior services.

- [Civic Works: Cities for All Ages](#)

  This brochure outlines the comprehensive services, including home repair and safety modifications, case management, and referrals, provided by a nonprofit community organization in Baltimore, MD.

- [Integrated Care Resource Center (ICRC)](#)

  The ICRC was launched by CMS to help states share and learn about best practices for delivering coordinated healthcare to high-need, high-cost dual-eligible Medicare/Medicaid beneficiaries. ICRC helps states develop integrated programs that coordinate the full range of medical, behavioral health, and long-term services and supports required by dual eligible individuals. The ICRC offers both one-on-one technical assistance services and group services.

- [Medicaid Integrating Care](#)

  This resource provides information about the programs CMS is promoting to encourage states to provide Medicaid and Medicare benefits through a single delivery system. The Integrated Care model would provide quality care for dual eligible beneficiaries, improve care coordination, and lower administrative burdens.

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Partnerships and Coalitions

- Sample Partnership Memorandum of Understanding (MOU)

  This sample MOU demonstrates the type of details your partnership might consider including as you forge your collaborative.

- Housing and Health Care: Partnering in Healthy Aging *A Guide to Collaboration*

  This guide was developed by LeadingAge to help housing and public health providers understand how to effectively partner to provide services to seniors.

- A Practical Guide to State Coalition Building to Address a Growing Public Health Issue

  This Guide was produced by NCOA to help organizations and public health departments create senior falls prevention coalitions to promote policy and legislation at the state and national level.

- Partnering to Promote Healthy Aging: Creative Best Practice Community Partnerships

  A manual developed by the National Council on the Aging (NCOA) that provides insights to aging, health, and public health services on how to build state and local level partnerships that promote healthy aging.

Policy and Legislation Guidance

- Advancing and Sustaining a State-Based Falls Prevention Agenda: The Role of Legislation, Policy and Regulation

  This document from NCOA can help state senior falls prevention coalitions understand how to influence policies, legislation, and regulations at the national and state level.

- Keeping the Aging Population Healthy: Legislator Policy Brief

  This guide was developed by the Healthy States Initiative, a collaborative effort between the CDC and the Council of State Governments (CSG), to give state leaders such as legislators and health department officials information needed to make informed public health decisions.

- State Falls Prevention Legislation

  This is a list of legislation and statues passed in every state compiled by the National Conference of State Legislatures (NCSL).