

# Convening to Support Aging in Place for the Pikes Peak Region

A Project Report  
Prepared for the Innovations in Aging Collaborative  
and Peak Vista Community Health Centers

By Jody Alyn  
Jody Alyn Consulting  
[www.alynconsulting.com](http://www.alynconsulting.com)  
January 13, 2014

# Acknowledgments

The Innovations in Aging Collaborative (IIAC) and Peak Vista Community Health Centers (PVCHC) hosted a series of “convenings” to identify issues, obstacles and options to support the health and well-being of seniors in the Pikes Peak region.

Beth Roalstad is the Executive Director of IIAC, and Randy Hylton is the Director of Communications for PVCHC. They were responsible for group construction, communication with participants and administration and oversight of this project. Their clear goals, personal commitment and knowledge of both subject matter and community environment were key to the project’s success.

Many thanks to the fifty-two service provider stakeholders and senior stakeholders who gave their time, expertise and rich, forthright insights to this project and to the larger community.

Thanks also to Jody Alyn Consulting team member and note taker, Allison Monterrosa, and to Susan Hindman of Wordwise Editing for their valuable assistance.

Support for this report was made possible through the Colorado Trust’s Convening for Colorado program.



# Executive Summary: Convening to Support Aging in Place for the Pikes Peak Region

To prepare for the challenges presented by a growing aging population, the Innovations in Aging Collaborative and Peak Vista Community Health Centers partnered on a six-month project to examine factors related to aging well for older adults in the Pikes Peak region.

For this project, 52 selected service provider and senior stakeholders came together in a process known as “convening” to identify issues central to the health and well-being of seniors and to formulate actionable steps that could be taken collaboratively.

Resources and challenges were identified. The region needs better information about available resources. Challenges with regard to the health and well-being of seniors were organized into 13 major themes: transportation, communication, community awareness, daily living needs, isolation, inclusion, outdated aging model, provider workforce, insurance system, major health care gaps, care coordination/navigation, affordable housing and money.

These themes are not surprising, and add urgency to calls for thoughtful, collaborative and well-coordinated action across agencies and systems. Many individuals and organizations are making efforts to collaborate, but multiple challenges exist. In addition, current funding structures consistently work against both communication on behalf of seniors and collaboration among agencies. Yet experts from different sectors were in agreement about viable solutions.

Convening participants identified action steps that could be taken to address specific themes. The following are put forth for community review and implementation.

1. Senior service hub. Develop a center to engage seniors and engage others with seniors, bridge the interests and services of large and small organizations, partner with existing neighborhood organizations and include a strong volunteer component. Provide access for seniors to a variety of resources through this hub, including basics like help with activities of daily life, food and nutrition.
2. Medicare education/navigation system. Create an integrated system of programs for Medicare education, navigation and guidance that is “hands on,” is individually oriented and driven and includes patient/consumer guides who are responsive to different needs of people as they enter and develop understanding of the system.
3. Representation of senior voices. Ensure that a variety of senior stakeholder perspectives are at the table of all community planning efforts and that agencies are informed about what is happening; recognize the entrepreneurial potential of seniors participating in solutions that affect them.
4. Inclusive Senior Reach-type model, which identifies older adults with mental and behavioral health needs and connects them to appropriate resources before they reach a crisis point. Integrate behavioral health services, publicly provided services and quality of

life support services for seniors; bring a variety of elder voices to this discussion. (A steering team is in place.)

5. Community briefing, networking and/or listening event. Develop a forum for taking better stock and becoming better informed about what already exists in the community and at what levels. Multiple ideas were generated about what form this could take.
6. Expanded reach of the Yellow Book. Develop creative collaborations with the Area Agency on Aging to leverage its Senior Information Directory (aka, the Yellow Book) and other public resources and to get the word out more broadly; for example, every senior-serving organization might include a link to and brief explanation of this free, public resource on their website.
7. Coordinated, collaborative and accountable solutions. Identify “major doers” and solution-driven stakeholders to meet regularly; to champion each issue (theme) and to ensure clear responsibilities, strong communication and effective collaborative actions. Have this group serve as a “liaison” to governmental and funding entities, providing research and subject matter experts when needed and as a resource on collaborating effectively.
8. Innovative funding solutions. Convene identified subject-matter experts to delineate viable alternatives to current funding systems that reward inefficiencies, block collaboration and produce undesirable results. Bring these subject-matter experts together with higher-level health, business, payer and political leaders to discuss options and create a blueprint and action steps for moving forward with cost-shifting, bundling and/or other options.

While economic constraints and demographic change affect almost every sector of society across the United States, local solutions may exist with regard to resources for aging that would not only support aging well in the Pikes Peak region but could also secure the region’s position as a true innovator in the field.

# Convening to Support Aging in Place for the Pikes Peak Region

## PROJECT OVERVIEW

“Aging in place” is a term used to describe the trend of older adults living independently in the residence and community of their choosing as they age. Over the last 10 years, research has shown that people prefer to age in place.<sup>1</sup> In 2010, a widely cited AARP study found that 88 percent of adults over age 65 said that this was what they wanted to do.<sup>2</sup> Older adults who age in place may require certain adaptations and support. Those who are not able to age in place can put even greater burdens on health care systems, support networks and community services.

The impacts of a fast-growing older population are about to wash over health care systems, support networks, economies and communities. The Colorado State Demography Office expects the senior population in El Paso County (those over 65) to increase by 179% in the next 30 years.<sup>3</sup> To address these findings and the rising tide of need, the Innovations in Aging Collaborative (IIAC) and Peak Vista Community Health Centers (PVCHC) partnered on a six-month project to examine factors related to aging well for older adults in the Pikes Peak region. The vision is for the region to be “a great place to age.”

For this project, selected service provider and senior stakeholders were convened to:

- Identify resources and services needed to support older adults who choose to age in place in the Pikes Peak region;
- Determine what gaps in, and barriers to accessing, resources and services might exist;
- Encourage collaboration and identify some actionable steps for closing gaps and removing barriers.

## PURPOSE AND METHOD

Service provider and senior stakeholders came together in a process known as “convening” to discuss issues central to the health and well-being of seniors. In contrast with educational events or focus groups, convenings provide dedicated time for people to share information, learn from each other and actively engage in collaborative conversations that could reduce fragmentation and lead to shared solutions.

IIAC invited participants to three convenings. Questions were developed to direct the discussion to the project’s objectives. This consultant facilitated each convening. The consultant’s note

---

<sup>1</sup> Wiles, J., et al. (2012). The meaning of aging in place to older people. *The Gerontologist*, 52 (3), 357–66. Retrieved from <http://gerontologist.oxfordjournals.org/content/52/3/357.full>.

<sup>2</sup> AARP report prepared by Teresa Keenan. (2010). *Home and community preferences of the 45+ population*. Retrieved from <http://assets.aarp.org/rgcenter/general/home-community-services-10.pdf>.

<sup>3</sup> Adams, T. H. (2011). *Aging in El Paso County, CO: A report from the Innovations in Aging Collaborative*, p. 14. Retrieved from <http://www.innovationsinaging.org/images/pdf/Aging%20in%20El%20Paso%20County%20Tucker%20Hart%20Adams.pdf>

taker attended all meetings. Project managers from IIAC and PVCHC attended the first two convenings as hosts and attended the third as participants.

## CONVENING A

Convening A consisted of three discussion groups with a total of 26 senior stakeholders. These stakeholders contributed to issue identification and solution building from their direct experience of central issues.

IIAC does not provide direct services. It called on 20 other senior-serving organizations and community contacts to refer participants in three Colorado Springs neighborhoods: Westside, Hillside and Rockrimmon. These communities were prioritized for their demographics (higher concentrations of older adults and retirees) and for their existing infrastructure (e.g., senior-serving community centers).

Nine Westside group participants came from multiple referral sources. Leaders of a neighborhood group, the Savvy Seniors, brought 14 Hillside group participants together. Though invitations also went out through multiple referral sources in Rockrimmon, only three people attended that group. Reasons for the poor turnout in Rockrimmon are unknown.

Senior stakeholders voluntarily provided personal demographic information. This helped assure that a cross-section of community voices was represented. These seniors had lived in the Pikes Peak region for an average of 32.5 years (range: 3-50 years). Ten were 65-69 years of age (38.5%), three were 70-74 years (11.5%), six were 75-79 years (23.1%) and five were 80 years or older (19.2%).<sup>4</sup> Five identified themselves as retired military (19.2%), three as military dependents (11.5%) and twelve were not affiliated (46.2%).

Participants were distributed across a relatively educated spectrum. Two had some high school (7.7%), three were high school graduates (11.5%), nine had completed some college (34.6%), six were college graduates (23.1%) and four had graduate degrees (15.4%). Across the three groups of Convening A, greater racial and ethnic diversity was represented than exists in El Paso County: 10 identified themselves as Caucasian (38.5%), 10 as African American (38.5%), three as biracial (11.5%) and one as Native American (3.8%).<sup>5</sup> Latinos were greatly underrepresented, with only one person identifying as such (3.8%).<sup>6</sup> Men were also significantly underrepresented, with only four in attendance (15.4%).

## CONVENING B

Leaders, decision makers and subject matter experts in 41 senior-serving organizations were invited to attend one of two meetings in Convening B. A total of 24 participants from 19 organizations participated, 12 in each meeting.

---

<sup>4</sup> Not every participant answered every question, and totals will not equal 100%.

<sup>5</sup> Adams, *Aging in El Paso County, CO*, 15. In 2010, Caucasians accounted for 72.9% of the population in El Paso County.

<sup>6</sup> *Ibid.* In 2010, 19.2% of the population of El Paso County identified as Latino or Hispanic.

Convening B participants represented health care, education, faith-based, public safety, nonprofit, for-profit and governmental programs, agencies and organizations. These participants and their organizations are currently working on central issues in the field. They included executive directors and officials from the following:

- All About Dignity
- Aspen Pointe
- Catholic Charities
- Colorado Springs Fire Department (CSFD)
- Colorado Springs Health Partners
- Colorado Springs Senior Center
- El Paso County (EPC) Department of Human Services
- EPC Public Health Department
- Greccio Housing
- Health Advocacy Partnership Tri-Lakes
- Golden Circle Meals Program, Housing Authority of Colorado Springs
- Program of All-Inclusive Care for the Elderly (PACE)
- Pillar Institute for Lifelong Learning
- Pikes Peak Area Council of Governments, Area Agency on Aging (AAA)
- Pikes Peak Community College (PPCC)
- Rocky Mountain Healthcare Services
- Senior Resource Council
- University of Colorado, Colorado Springs Aging Center (CUAC)
- YMCA of the Pikes Peak Region

## CONVENING C

Selected service provider and senior stakeholders were invited to Convening C, which consisted of one two-hour meeting. With two exceptions, participants in Convening C had participated in a prior group.

Themes from the two prior convenings were summarized and distributed to participants, who were asked to 1) provide feedback on whether this was a reasonable picture of factors affecting the capacity to age in place in the Pikes Peak region and 2) recommend action steps that could be taken collaboratively to address one or more themes.

## FINDINGS

The following summary describes themes and examples that emerged during Convenings A and B and were amended after Convening C. In every group, discussions of questions about resources were shorter and more diffuse than those about challenges. Convening C participants suggested that this theme summary is more a “sketch” than a “snapshot” because more detail exists about current services and resources than was captured in this format.

Participants in Convening C agreed that 1) the region needs better education and awareness of the programs that are available; 2) people need to understand what these programs do, how to find them and how to use them; and 3) links, structures and collaborations between agencies and senior stakeholders who know neighborhoods and may informally provide information or services to peers need to be strengthened. Bringing senior stakeholders (“end users”) and service providers together worked well and was a “rare conversation venue.”

## THEMES

Meeting notes were analyzed for common themes. Complete notes for each session were provided to IIAC and PVCHC.

## RESOURCES

Responses about existing and “easy access” resources that support aging ranged widely.

1. The community network. The senior-serving network of agencies and organizations – as well as specific named organizations, programs or services and friends/family networks – is seen as useful and essential support for aging in place.
  - a. The Colorado Springs Senior Center, Silver Key, PACE and the Area Agency on Aging (AAA) were named most frequently as resources by those in both Convenings A and B.
  - b. Some resources were more familiar to senior stakeholders (e.g., Savvy Seniors) and others were more familiar to service provider stakeholders (e.g., CUAC).
2. Local hospitals and emergency rooms. These are visible, easy to access and well regarded. One person’s comment expressed a general sentiment: “We have two good hospitals that are devoted to their communities.”
3. Military retirement benefits. Tricare and other military benefits provide a substantial measure of security and improved access to health care and prescriptions.
4. The natural environment and access to free, healthy exercise options. Every senior group mentioned some variation of climate, beauty, fresh air and sunshine, as well as accessible trails and exercise programs (e.g., Silver Sneakers, tai chi at PPCC).
5. The Yellow Book. The Senior Information Directory published by AAA is a widely trusted resource and resource directory. It provides a comprehensive list of services and qualified service providers. People wanted to know, “How do we make sure people know about the Yellow Book?”
6. PACE. The Program of All-Inclusive Care for the Elderly (PACE) is well-regarded by professionals and well-loved by those it serves. This is because “they work with you” to offer alternatives, they customize interventions according to patient/client preferences and beliefs and caregivers receive sufficient reimbursement. PACE provides a model that “solves many of the problems” related to senior health, well-being and aging in place.
7. Hospice. Service providers say that the hospice options in this region are “wonderful” and all follow Medicare guidelines.
8. Electronic record system. This “may be a step in the right direction.” People talked about the move to electronic medical records as a resource that is beginning to work now and



will continue to add value, especially with regard to increased efficiency and coordination of care.

9. Alternatives that emphasize choice and prevention. Where available, these alternatives are preferred by seniors and lauded by all; e.g., skin cancer screenings at PVCHC, Medicare not requiring referrals for specialists and Kaiser’s preventive focus.

## CHALLENGES, GAPS OR BARRIERS

A number of these themes provide supporting evidence for issues identified in IIAC’s 2011 report on aging.<sup>7</sup>

1. Transportation. The lack of affordable, reliable, available transportation affects access to all activities and resources, especially health care and including mental health. Every group named transportation as a profound barrier to aging well in the Pikes Peak region. Needs include and are not limited to:
  - a. Flexibility. Smaller vehicles, even on a limited schedule, are needed to get to grocery stores and other common destinations that are not otherwise accessible.
  - b. Coverage of geographic locations, physical convenience and accommodation. “Transportation has to be physically convenient for those who have problems walking.” The overall feeling was summed up with, “Worst bus system. Ever.”
  - c. Free or low-cost options. Current options are expensive, and costs are increasing.
  - d. Creative use of assets. For example, community vans could be made available for neighborhood or grassroots groups.
  - e. Access to transportation hubs such as airports and train stations.
  - f. “Efficiency” and environmental responsibility.
2. Communication between providers and seniors. The lack of reliable information exchange from resource agencies to seniors and their families, and to resource agencies about senior/family needs, puts seniors at risk and places extra demands on systems. Challenges include and are not limited to:
  - a. How to get information out, especially in an emergency (fires and floods).
  - b. Generational technology gap, for many reasons including financial and physical.
  - c. Language barriers for those whose primary language is not English.
  - d. Public agencies not reaching the diverse public. Federal and state dollars are coming to the community for the benefit of seniors, but the information isn’t being given to the whole community. This is a source of significant frustration. “These services are for everybody, but everybody doesn’t get the message.”
  - e. Seniors and families not knowing “what’s out there” in any sector.
  - f. Fear and misinformation, or no information, about Medicare. Questions run the gamut, including how to access, how to enroll, what the changes are, what it covers (e.g., hospice) and the impact of the Affordable Care Act. Overwhelming technical tomes and not enough understandable information about coverage and supplements put off senior stakeholders.

---

<sup>7</sup> Ibid.

- g. Last-minute needs for information. People don't look for information until it is a crisis, and "there is no pathway in."
3. Education and community-wide awareness. "We need a huge public awareness campaign" about what appropriate aging is, how to manage the process and what happens when chronic illness is involved. "We have a lot of elderly in our community but few elders.... We don't understand what aging is really all about." Gaps include and are not limited to:
    - a. Education on this topic for all levels, all audiences. Education needs for seniors, families, caregivers, service providers, physicians, first responders and the community are wide and varied.
    - b. Continuing education and cross-training. What is learned must be sustained over time. Caregivers at all levels must learn to "think outside the box" of their own discipline, anticipate needs and provide patients with access to multiple resources.
    - c. Proactive opportunities to learn. There is need for "a place where people can have these kinds of conversations" as well as get counseling and information from experts and peers before challenges actually occur.
    - d. How to more widely disperse information about elder abuse and senior safety.
  4. Planning and daily living needs. There is no system to help with the range of daily living needs that arise as one ages in place. These include self-care needs such as wills, POAs, insurance, long-term care and finding a good doctor or gerontologist; and home care needs like yard work, housework or other chores and basic activities of daily life like bathing and eating. Services need "vetting" to ensure reliability. Commonsense options are needed to better balance adult rights and need for care/protection.
  5. Isolation. Social isolation can occur for "100 reasons," from personal hygiene to lack of energy or resources. Some seniors become more isolated when economic and social conditions force children and grandchildren out of the community for work. Social isolation is exacerbated by misconceptions and stereotypes about why people become isolated, such as thinking that isolation is a matter of personal choice. Creating networks and a sense of community or belonging for seniors can "prevent the void."
  6. Lack of inclusion. Seniors of color do not feel included in the larger senior population, and seniors in the larger population are not included with other generations. Migration and immigration complicate issues for seniors and have not been addressed.
    - a. "Agencies design programs and then conduct 'outreach'" instead of including and communicating with diverse senior communities from the start.
    - b. When seniors of color do not see themselves in program planning or marketing efforts, they are less likely to get involved and are at greater risk for alienation and isolation.
    - c. Public protections are not inclusive. City services like code enforcement are being cut back without regard to disproportionate impacts on those with greatest need. "Quality of life for seniors includes code enforcement and police security."

- d. We need a model for a new kind of senior, to keep elders integrated with other generations and to remove the stigma of aging with divisions of “us” and “them.”
7. Outdated, ineffective aging model. “The medical model does not work for aging, and there is not a model for success.” A comprehensive, preventive, systemic wellness and resilience focus that includes daily care and full recovery from health interruptions is needed to support aging in place and aging well.
  - a. “Health doesn’t happen in the hospital. It happens in the home.”
  - b. Today’s seniors need a model that recognizes and empowers them.
  - c. Proven alternative care models must be embraced.
  - d. “Legislation for health care is always stuck about 15 to 20 years in the past. In this case [regarding senior health], it’s 50 years behind.
  - e. Seniors want to be able to look at alternatives and find things that work for them. The PACE model is designed only for complicated, high-risk patients. Is it possible to take a model that works well and adapt or expand it?
8. Provider workforce problem. There is a lack of qualified workers to do this work at all levels. Availability, skill set, expertise and cultural sensitivity present significant challenges across the board. This includes:
  - a. Shortage of primary care physicians who accept Medicare across the community. Fewer doctors are taking Medicare; those that do stop, or they take on too many patients because it is not possible to financially survive otherwise. Shortage of Medicare providers leads to overuse of ERs.
  - b. Shortage of psychiatrically skilled prescribers. Medicare credentialing limits options. For those with the most complex profiles, “you can’t match the discipline with reimbursement.”
  - c. Shortage of doctors specializing in geriatrics, gerontology and aging. They are hard for seniors to find, and doctors across the spectrum are poorly prepared for the aging wave.
  - d. Medicare disincentive. “The reimbursement rates for Medicare are such a disincentive we cannot get people into the field.” Primary care reimbursement is also being decreased for doctors and hospitals.
  - e. Staff skill and resource deficiencies. “People on the front desk don’t have what they need.” Direct care staff members are “very poorly paid, very poorly educated and therefore [have] high turnover.” When skilled medical staff must care for their own aging family members, consequences happen at work and home.
  - f. Emergency medical service (EMS) limitations. The workforce in the traditional EMS model is not trained or equipped to address issues of the aging population. The picture for these patients is “complex to unravel in an eight-minute call.”
9. Insurance system. The “upside-down nature of the insurance system” focuses on volume over value, discourages sufficient time with patients to properly assess/treat, and limits essential services and care coordination. Medicare coverage changes within clinics and between clinics lead to inefficient or inconsistent care and follow-through. It is hard to understand what is covered, what is not, and when it changes. Access to pharmacies may

also be affected. There are “‘god-awful’ access issues because of funding and how Colorado operates the programs.”

10. Major health care gaps. Health care gaps are created and exacerbated by insurance, especially Medicare, reimbursement structures. Major gaps include:
  - a. Dental health. Medicare does not cover dental health, which is correlated with other aspects of health. AAA has a dental program for seniors, and the wait was almost two years. Dental coverage is all but unavailable for seniors, military and civilians. This was a widely shared concern, as was vision and hearing coverage.
  - b. Mental health. Medicare does not reimburse mental health services. Few physicians have time to do complete cognitive assessments, which can be confounded by medications and hard to detect outside of the home. The senior population is experiencing a “cognitive impairment epidemic.” This also impacts first responders.
  - c. Home health care. Medicare has an extremely limited home health care benefit. Most individuals pay out-of-pocket. This is a burden to families and a barrier to service access, and leaves seniors vulnerable at home.
  
11. Care coordination and navigation. Communication between caregivers and families is “key to good, coordinated care and is unreimbursable.” There is no Medicare reimbursement for care coordination. This creates inefficiencies and risks for patients. Lack of care coordination and navigation for seniors can compromise treatment planning, quality of care and patient safety. This is a particular problem for those “on the edge.” There is no health information exchange in our community, and Medicare has no infrastructure to support it.
  
12. Affordable housing options. Housing expense is one aspect of affordable housing. The range of housing options is another. Aging in place may not be the best option for many people, but if the choice is to stay at home or go to a nursing home, who will choose the nursing home? There is no affordable middle ground and no funding for a middle ground. Seniors are also concerned about services, facilities and quality assurance related to the for-profit model in nursing homes.
  
13. Money. Decreasing resources and the “redistribution of wealth” are affecting the quality of life and the ability to age in place for seniors in many ways. Resources are breaking down; it is hard to access those that are available. Money is a factor in most of the other themes identified and was discussed in every group.
  - a. Challenges for seniors. Some seniors must “spend resources down” to qualify for services. Others are making choices either to eat or take medications. Even when services can be accessed, co-pays can be an issue.
  - b. Challenges for service providers. Service providers are stretched thin. Programs are being discontinued. Fees for free and low-cost services are increasing. Pay scales are insufficient to attract and retain qualified workers.
  - c. Challenges for collaboration. Funding deficits work against collaboration. “Huge numbers of groups are trying to ‘do collaboration.’” Getting it structured is difficult; duplications are occurring. There is a gap in funding smaller groups that

want to collaborate with established agencies. It is very difficult to find funding for the collaboration and community planning that is needed to reduce gaps, eliminate barriers and provide resources for seniors to age well. “We need a community conversation on how to use our resources.”

## COLLABORATION (Convenings B and C only)

### WHAT’S WORKING

1. Working relationships among colleagues. Many professionals in different agencies are “patchworking” solutions for clients and express personal satisfaction in meeting needs this way. Essential ingredients in successful collaborations include mutual respect, true engagement, ownership, shared solutions and, above all, trust.
2. Collaboration in a crisis. “[The region] is recognized on a national basis for collaboration” on the basis of its responses to emergencies like fire and flood.
3. Colorado Springs Police Department and the Pikes Peak Elder Abuse Coalition. This group of 15 or 20 service agencies all working together was cited as an example that “collaboration among providers is finally working” with open communication, responses to senior clients that extend beyond an immediate need to other identified needs and creative solutions in filling gaps.
4. Other existing efforts to address challenges. Convening C participants generated a list of organizations and collaborations that they knew to be working in each of the 13 identified challenge areas. This list was captured in the meeting notes. In addition, the following collaborations were suggested as working examples to draw on:
  - CUAC’s collaborations with PVCHC, in particular, and with PACE, AAA and Silver Key
  - Aspen Pointe and PVCHC
  - Community Health Partners
  - Peak Military Care Network
  - Joint Initiatives
  - AAA’s Ethics Committee for Skilled Nursing
  - AAA’s Regional Advisory Committee

### CRITICAL ISSUES/OPPORTUNITIES

1. Silos and duplication. “The way we work together is a plus if you know who to work with, but there is a downside” to collaboration in the region. Several groups offer the same services in their own areas; they create programs to fix what’s under their roof though similar programs exist elsewhere.
2. Fundamental provider collaboration. Getting people in a room together, teaching them and giving them support to stick with it can help with profound workflow issues. “If we

all know what each other does, and someone comes and asks us for help and we aren't the place for the person to go, we can limit the number of calls that person makes, limit the frustration ... and get people to the right resource."

3. Systems change: getting the right people. "If you're really looking at changing a system, you've got to have the right people at the right tables" with honesty and openness about the issues; with transparency, especially about funding, and with shared prioritization and agreements.
4. Addressing organizational tensions. Sometimes there are tensions between the requirements of collaboration and the strategic plans of individual organizations. The missions or priorities of these organizations may actually compete. Transparency and open conversation about individual missions and plans can help move past assumptions and balance individual organizational needs with larger community needs.
5. Avoidance of key issues. Real costs to real innovation can prevent necessary conversations and informed choices. Examples of this are:
  - a. Centralized system of data access. A health information exchange in our community is essential to making progress on communication, navigation and many other issues identified in these convenings. Costs of purchase, training and maintenance limit community support and conversation, even though cost savings could be realized. Medicare has no infrastructure to support this.
  - b. Prevention and wellness. Prevention is cheaper than episodic care. Seniors are eager for less-expensive and less-intrusive options. The change to a prevention/wellness model has long-term savings and initial costs.
6. Funding. "Funding is the missing piece, and we have the solution." Innovative thinking is needed. Options proposed include:
  - a. A special health tax district.
  - b. Cost shifting. "We can either keep driving up the costs of EMS or look at the system as a whole and cost shift to put funds in the right place." Eighty percent of CSFD calls are medicals, and almost 70% of those are non-emergency.
  - c. Bundling. Insurers/payers are increasingly interested in "bundles" and reducing payout over time. "There is a huge amount of money flowing the wrong direction." This could be solved with a longitudinal plan for systemic change and conversation with payers.
  - d. Cross-segment dialogue. Conversation between higher-level health, business, payer and political leaders could make systemic change.
7. "We need to do business differently."

## RECOMMENDATIONS FOR ACTION

This project calls attention to issues central to the health and well-being of seniors in the Pikes Peak region and – more specifically – to resources, gaps, barriers and some actions that will lead to effective collaboration and shared solutions to the challenges of aging well.

The findings will surprise no one who is familiar with the impending “silver tsunami” of aging baby boomers and its associated issues, or with the added challenges unique to the Pikes Peak region.<sup>8</sup> They do, however, create a fuller context for calls to intentional, collaborative and broadly coordinated action. IIAC and PVCHC will work with identified partners on the following action ideas, now put forth for community review and implementation.

1. Senior service hub. Develop a center to engage seniors and engage others with seniors. Such a center may bridge the interests and services of organizations large and small. It may partner with existing neighborhood organizations and include a strong volunteer component, with seniors serving as volunteers and with volunteers of all ages working with seniors.<sup>9</sup> Seniors will have access to a variety of resources through this hub, including help with activities of daily life, food and nutrition.
2. Medicare education/navigation system. Create an integrated system of programs for Medicare education, navigation and guidance. Such a program will need to be “hands on,” individually oriented, individually driven and individually connective, with patient/consumer guides who are responsive to different needs of different people as they enter and develop understanding of the system.
3. Representation of senior voices. Ensure that a variety of senior stakeholder perspectives are at the table of all community planning efforts and that agencies are informed about what is happening. Recognize the entrepreneurial potential of seniors participating in solutions that affect them. Encourage board engagement for seniors.
4. Inclusive Senior Reach-type model, which identifies older adults with mental and behavioral health needs and connects them to appropriate resources in the community before they reach a crisis point. Integrate behavioral health services, publicly provided services and quality of life support services for seniors. Bring a variety of elder voices to this discussion. (A steering team is in place.)
5. Community briefing, networking and/or listening event. Become better informed about what problem solving exists in the community. Multiple ideas were generated about what form this could take, including a “speed network” or “speed share” event for line staff, leadership and senior stakeholders; a comprehensive “forum for listening”; a traveling

---

<sup>8</sup> Ibid. Adams coined this term in the previously cited report, which also details these issues.

<sup>9</sup> Participants in Convening C discussed this as a Senior Volunteer Center. They knew many organizations were doing some work with volunteers, but none with a comprehensive effort. However, Pikes Peak United Way already has a volunteer center. Silver Key has an extensive volunteer network. IIAC and its hub partners will work with these and others to determine the best way to achieve a comprehensive volunteer system that includes seniors and accomplishes the linkage, engagement and efficiency functions envisioned by Convening C.

Senior Resource Fair that provides opportunities to learn about community resources at difference sites across the community; and a large community-wide summit that creates work plans to address priorities with timelines, responsibilities and accountabilities.

6. Expanded reach of the Yellow Book. The Senior Information Directory (aka the Yellow Book) is a credible, needed list of resources that AAA has published almost every year since 1967.<sup>10</sup> Yet very few participants and no senior stakeholders could say what it was or where to get a copy. Distinctions between the Yellow Book and a for-profit directory were not clear. Creative collaborations with AAA should be developed to leverage the Yellow Book and other public resources more productively. For example, every senior-serving organization could at least include a link to and brief explanation of this free public resource on their website.
7. Coordinated, collaborative and accountable solutions. Identify “major doers” and solution-driven stakeholders to meet regularly, champion each issue (theme) and ensure clear responsibilities, strong communication and effective collaborative actions. This group could also serve as “liaison” to governmental and funding entities, providing research and subject matter experts as needed; as “convener” of collaborators on theme areas as appropriate and as a resource on collaborating effectively.
8. Innovative funding solutions. Convene identified subject-matter experts to delineate viable alternatives to current health care funding systems that reward inefficiencies, block collaboration and produce undesirable results. Bring these subject matter experts together with higher-level health, business, payer and political leaders to discuss options and create a blueprint and action steps for moving forward with cost-shifting, bundling and/or other options.

Demographic changes and economic constraints affect almost every sector of society in almost every part of the United States. The aging population will particularly impact the Colorado Springs area. However, the community is rich in expertise on aging and in commitment to support the health and well-being of seniors. New models for community collaboration that include senior voices, service integration and health care coordination will be critical to the support of those who want to age in place. Locally generated solutions, especially with regard to seemingly intransigent systemic issues, appear to be in reach – solutions that not only would support aging well in this region but also could position the region as an innovator in the field.

With the community will to take deliberate and truly collaborative action, the Pikes Peak region could indeed become a most remarkable place to age.

---

<sup>10</sup> Area Agency on Aging. *Yellow book: 2012–2013 senior information directory*. Retrieved from <http://www.ppacg.org/files/AAA/2012%20Yellow%20Book.pdf>.