BUILDING COMMUNITY CAPACITY TO MEET THE NEEDS OF OUR AGING SOCIETY: INTERDISCIPLINARY COMPETENCY DEVELOPMENT FOR PROFESSIONALS

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Abstract

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Building community capacity to meet the needs of our aging society:

Interdisciplinary competency development for professionals

(Under the direction of: Pam Silberman, JD, DrPH, Peggye Dilworth-Anderson, PhD, Suzanne Havala Hobbs, DrPH, Elise Johnston Bolda, PhD, Dennis Streets, MPH)

Communities across the United States are working to increase their capacity to become "senior friendly" or "elder ready" as the aging of the baby boom cohort swells their populations of older residents. The aim of this applied research is to enhance community capacity to address the issues of an aging society through interdisciplinary competency development for professionals working in communities. Community leaders and national stakeholders were asked via semi-structured key informant interviews about the roles played by, and knowledge and skills needed by professionals who staff community level approaches to aging. To further inform competency development for this emerging area of practice, a review of the characteristics of community level approaches to aging was conducted via document/web content analysis. Findings revealed a rich set of roles and associated tasks played by professionals including convener/facilitator, translator across disciplines, planner, nonprofit manager and resource connector. Their roles also related to knowing the population of older adults and navigating the policy/intergovernmental arena. Further, they

may play community organizer, social entrepreneur or service provider roles. Participants emphasized the *process* of developing community level approaches to aging and what competencies professionals needed to effectively assist that process. Findings also supported a relationship between community capacity and competency development in professionals. Participants identified core leadership as a building block for community capacity and described in detail how the professionals facilitated the work of that core leadership. Dissemination of the initial set of interdisciplinary competencies which resulted from the qualitative analysis process is directed at the disciplines of public health, gerontology, planning, public administration and social work.

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AAA	Area agency on aging
AARP	Formerly known as the American Association of Retired Persons
ADRC	Aging and Disability Resource Center
AGHE	Association of Gerontology in Higher Education
AIP	American Institute of Planning
AoA	Administration on Aging
APA	American Planning Association
ASA	American Society on Aging
ASCP	Association of Collegiate Schools of Planning
ASPH	Association of Schools of Public Health
CBE	Competency-based education
CASAS	Center for Advanced Study of Aging Services
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CEPH	Council on Education for Public Health
CoP	Community of Practice
CPFOA	Community Partnerships for Older Adults
CSWE	Council on Social Work Education
EFCP	Elder Friendly Communities Program
GSA	Gerontological Society of America
HHS	Health and Human Services
ICMA	International City/County Management Association

IRB	Institutional Review Board
MPH	Master of public health
n4a	National Association of Area Agencies on Aging
NACo	National Association of Counties
NASPAA	National Association of Schools of Public Affairs and Administration
NASUAD	National Association of State Units for Aging and Disability
NC DAAS	North Carolina Division of Aging and Adult Services
NCOA	National Council on Aging
NLC	National League of Cities
NORC	Naturally occurring retirement communities
NPEC	National Postsecondary Education Cooperative
PAB	Planning Accreditation Board
PoM	Program of Merit
PPACA	Patient Protection and Affordable Care Act
SUA	State unit on aging
UHF	United Hospital Fund

Chapter I
INTRODUCTION

A. Study Overview, Aims, and Research Questions

Communities are the frontline of response to the challenges and opportunities of an aging society, and the common ground for civic engagement in American public life. Over the past decade, governmental, interest group, philanthropic and university-based initiatives across the United States have increasingly recognized the critical role that communities play in meeting the needs of a growing aging population. Additionally, frontrunning communities are working to increase their capacity to become "senior friendly" or "elder ready" sometimes with support from these national initiatives or similar state initiatives but often through use of their own resources. They are faced with compelling evidence of the aging of their populations. Professionals who provide support to such community approaches to aging need not only an understanding of the changing demographics of their communities but also competency in the knowledge and skills to prepare for and adapt to those changes in a collaborative environment. There is scant evidence, however, of competency and curriculum development related to this emerging area of practice.[1]

The aim of this dissertation is to enhance community capacity to address the issues of an aging society through competency development for professionals working in

[1] Gebbie (2004) describes "emerging area of practice" as a circumstance under which sets of competencies are developed.

communities. Community leaders and key national stakeholders were asked via qualitative research what professionals who provide staff support to community level approaches to aging[2] need to know. Further, a review of the characteristics of community level approaches to aging was conducted via document and web content analysis. The results of this research were triangulated to develop a suggested set of competencies and related curriculum recommendations for this emerging area of practice. The dissemination of results and plan for change are directed at the academic disciplines of gerontology, public health, planning, public administration and social work. From these disciplines come the professionals who are targeted by this research who staff councils on aging; area agencies on aging; city/county planning departments; public health planning and program development initiatives; and city/county management.

Research questions: What competencies do targeted professionals need to enhance the capacity of their communities to respond collaboratively to the issues facing an aging society at the community level?

Related questions:

- How do targeted professionals function in "staff" roles to community level approaches to aging? What tasks do they perform?

- What knowledge should targeted professionals possess?

[2] For the purposes of this research, a "community level approach to aging" occurs when there is collaborative planning and mobilization to address the aging of a community across settings, services and organizations going beyond the efforts of any one organization or entity. See Appendix I for a more detailed definition.

- What skills should targeted professionals possess?
- What competencies do such knowledge and skills suggest as useful for the targeted professionals to possess?
- How should this information be applied to curriculum development? At the master's program level? At the interdisciplinary certificate level? At the continuing education level?

B. Background

The challenges and opportunities of an aging society will come further into focus over the next decade with the aging of the "baby boom" generation. Despite conventional wisdom related to our "mobile society," most older Americans do not move when they retire, but rather choose to age in communities where they have lived over time (Pristua, Barrett & Evans, 2006; Wolf & Longino, 2005). The 2000 Census (Hetzel & Smith, 2001) indicated that the proportion of people 65 and older in the general United States population had reached 12.4 percent, but almost 3 out of 4 counties (72%) had a proportion of older adults greater than that national average. Counties in the West and those with large population centers continued to be fairly "young" with respect to the general population, but those in the Midwest, Northeast, Appalachia and certain states like Florida tended to be relatively "older." Already in 2000, 381 of the 3,141 counties in the United States had 65+ populations of 20 percent or more (Hetzel & Smith, 2001).

Over the past decade, governmental, interest group, philanthropic and university-based initiatives across the United States have increasingly recognized the critical role that communities can and do play in meeting the needs and using the assets of a growing aging population. In 2005, the United States Administration on Aging (AoA) presented awards to seven "livable" communities that had made improvements in the six key areas of housing, transportation, accessibility, citizen participation, access to health and supportive services, and work and volunteer opportunities (AoA, 2005). AARP in its *Reimagining America* initiative (2006) which the organization styled as its "blueprint" for the future highlighted "investing in livable communities" as one of nine critical steps necessary for America to meet the challenges of an aging population. Investing would mean encouraging "community features and services that can facilitate personal independence and the continued engagement in the community's civic and social life." Also in 2006, the National Association of Area Agencies on Aging (n4a) issued *The Maturing of America Report: Getting Communities on Track for an Aging Population* in cooperation with five other key partners: International City/County Management Association, National Association of Counties, National League of Cities, Partners for Livable Communities and the MetLife Foundation. In May 2007, those same partners followed up *The Maturing of America Report* with their own blueprint to encourage "aging readiness" actions by communities (n4a, 2007). Other national initiatives such as AdvantAge (Center for Home Care Policy and Research) (Feldman & Oberlink, 2003); Community Partnerships for Older Adults (Robert Wood Johnson Foundation) (Bolda, Lowe, Maddox & Patnaik 2005; Bolda, Saucier, Maddox, Wetle & Lowe, 2006) and the work of the United Hospital Fund in New York (Vladeck, 2004) offered specific

assistance to community level approaches to aging. At the state level in North Carolina, the North Carolina Division of Aging and Adult Services (NC DAAS), building on several years of work in this area, employed a livable communities/senior-friendly communities "framework" for the 2007-2011 state aging services plan (NC DAAS, 2007) and is in the process of continuing that emphasis in a new round of planning (NC, Office of the Governor, 2010; NC Session Law 2009-407). Additionally, communities across the United States are working to increase their capacity to address their growing older populations because they are faced with compelling *prima facie* evidence of the aging of their populations (n4a, 2006; Payne, Applebaum, Molea & Ross, 2007; Scharlach, 2009b). Sometimes these communities receive support from such national initiatives or state initiatives but often they are using their own resources to increase their capacity. Professionals who staff community approaches to aging need familiarity not only with the changing demographics of their communities, but also competency to prepare for and adapt to those changes collaboratively with regard to health care systems, the built environment, transportation systems, public health initiatives, supportive services and engagement of older adults as valuable community resources.

C. Significance

While there is increasing attention to workforce development with respect to the aging of society, particularly with regard to the healthcare workforce,[3] there are still huge gaps and deficits in building workforce preparation (Bernard, LaMasus, Barry, Weiss &

[3] For example, in April 2008, the Institute of Medicine of the National Academies of Science issued a report of "a consensus study to characterize the optimal and healthcare workforce for older Americans in an aging society" entitled: "Retooling for an Aging America: Building the Health Care Workforce" (Institute of Medicine, 2008).

Salerno, 2005). Nowhere is that more evident than among professionals training to work in community settings where they are likely to address issues with respect to planning, mobilization, infrastructure development and governance. General awareness of the effect of the "demographic imperative" on workforce preparation, especially through the lens of the aging baby boomer generation, is growing (e.g. Johnson, Sabol & Baker, 2006; National Association of Area Agencies on Aging, 2010), but much less developed is specific academic preparation that provides students the knowledge and skills across disciplines to plan for and mobilize successful community responses. The research reported here informs competency-based curriculum development in this emerging area of practice (Gebbie, 2004).

While the focus of this research is on competency and curriculum development, a case can be made from the policy literature that a "policy window" as described by Kingdon (2002; 2003) has opened around community level approaches to aging and interdisciplinary education making policymakers, both in the academic and larger public policy arenas, receptive to the results of this research (Blue & Garr, 2007; Dalton, 2007; Guzzetta & Bollens, 2003; Malizia, 2006; Ruth, Sisco, Wyatt, Bethke, Bachman et al, 2008; Smith, 2008). Nationally, the United States Department of Health and Human Services (HHS) declared 2009 the "Year of Community Living" to highlight the tenth anniversary of the landmark Olmstead v. L.C. decision by the Supreme Court which "... supported community living options for people with disabilities..." (HHS, 2009). At the time of that declaration in June 2009, HHS announced new funding toward its goal of creating aging and disability resource centers (ADRC's) in every state to help older and disabled adults age in their home communities. Additionally, the Administration on Aging's recent "Community Innovations

for Aging in Place" initiative which intends "to build on the success" of earlier AoA funded community initiatives illustrates that policy interest in community level approaches remains strong (AoA, 2009). Most recently, the Patient Protection and Affordable Care Act (2010) expanded funding for ADRC's and emphasized, in a "Sense of the Senate" statement, community settings for the provision of long term services and supports. From the perspective of interdisciplinary education, the work of AARP and the John A. Hartford Foundation, among others, to infuse aging content into curricula provides models for how to affect change in the academic arena (AARP Office of Academic Affairs, n.d.; Hooyman & Peter, 2006).

Chapter II
LITERATURE REVIEW

The topic of this applied research – enhancing the capacity of communities to respond collaboratively to the issues facing an aging society through the development of competencies in the professionals who assist them – is new to the literature. There was, however, a collection of intersecting literature related to its elements to help inform its development. The broad sections of this literature review addressed three core elements: The first section (A.) highlighted the changing demographics of our society and communities and emphasizes how those changes affect the health and well-being of individuals aging in the context of communities. The second section (B.) covered the literature related to the role that communities play in addressing the issues of aging and the approaches that they use. Finally, the third section (C.) addressed the literature related to the development of competencies in the professionals who assist community level approaches.

A. The Importance of the Aging of Communities

The importance of the aging of American communities as an area of scholarly inquiry primarily emerges from what is known about both the aging of society as a whole and of individuals within the context of communities (Roberts, 2002). There is also a small but growing literature specific to communities and aging.

Aging of Society

From 1900 to 2000, the proportion of the US population aged 65 and over increased dramatically. Older adults comprised 4.1 percent of the population in 1900 and 12.4 percent by 2000 (Wilmoth and Longino, 2006). While some of that demographic shift can be attributed to improvements in medical care, the shift began with improvements in public health that took place within communities such as sanitation, and food and water quality (Manton, 2008). Even more dramatic than the overall growth in the older adult population has been the increase among the 85 and older group. By 2006, US Census interstitial population estimates had the 85 and over population at 5.3 million with projections of reaching nearing 21 million by 2050 (Federal Interagency Forum on Aging-Related Statistics, 2008). Interestingly, the decade between the 1990 and 2000 censuses was the first time since the US Census began in 1790 that the growth in the older population was not faster than the growth in the overall population (Hetzel & Smith, 2001). This brief slowing in the growth rate was only a temporary lull resulting from low birth rates during the Great Depression (Fuguitt, Beale & Tordella, 2002). Once the so called "Baby Boom" cohort (born between 1946 and 1964) ages into the 65+ range the growth in older adult population will grow more rapidly until 2030 when it is projected to stabilize at around 20 percent of the overall population (Federal Interagency Forum on Aging-Related Statistics, 2008). Some other developed countries are already approaching older adult rates of close to 20 percent including Italy and Japan (Federal Interagency Forum on Aging-Related Statistics, 2008).

Aging of Communities

While there is a growing national conversation about the impact of the aging of individuals and society as a whole on communities, the literature that lays out the demographics of aging communities in the United States is very sparse. Reports and studies focused on how to help communities cope with a growing number of aging residents often revert to using the demographic profiles of the aging of society as a whole to make their case for the importance of the issue (e.g. Alley, 2007; Kochera, Straight & Guterbock, 2005; National Association of Area Agencies on Aging, 2006).

The most compelling demographic data available to illustrate the issue of aging communities flow from straightforward US government analyses that provide data on the proportion of adults 65 and over in US counties (Federal Interagency Forum on Aging-Related Statistics, 2008; Hetzel & Smith, 2001). Census data from 2000 indicated that while the general proportion of the population 65 and over was 12.4 percent, 2,263 of America's 3,141 counties, or 72 percent, had proportions greater than 12.4 percent. In 381 counties, older adults were already 20 percent or more of the population by 2000. Regional summaries revealed that counties in the Midwest (82 percent) and East (78 percent) exceeded the national proportion of 72 percent more often than counties in the West (55 percent) which was a relatively young region. The South, at 69 percent overall, was a very diverse region with respect to aging counties. The 2000 Census found county estimates of the 65 and over population in the South ranging from 3 percent in Chattahoochee County, Georgia which is home to a large military installation to 35 percent in Charlotte County in the retirement destination state of Florida (Hetzel & Smith, 2001).

Government funded studies also shed light on the differences between the aging of metropolitan vs. nonmetropolitan areas. The United States Department of Agriculture's publication *Rural America* in the fall of 2002 devoted an issue to the demographics of rural aging. In that issue, Rogers (a USDA demographer) emphasized that "rural areas generally have a higher proportion of older persons in their total population than do urban areas...as a result of aging-in-place, outmigration of younger adults, and immigration of older persons from metro areas." Further, Rogers noted that non-metro older adults were more likely to have chronic health conditions and live in poverty than their metro counterparts. These conditions place greater stress on rural communities, many of which have limited resources and infrastructure, to provide services and supports (Rogers, 2002).

In the same issue of *Rural America*, Fuguitt, Beale and Tordella (2002) examined older adult population trends among nonmetropolitan vs. metropolitan counties. They found that the growth in the net gains of older adults in rural populations abated somewhat in the 1990's after several decades of growth. This abatement was due to low birth rates during the Great Depression and out migration of workers to metro areas after World War II leaving fewer people to reach 65 in rural areas. Those events, coupled with immigration of people under the age of 65 to some rural areas, slowed the aging of rural America somewhat during that decade. For example, in the 1990's, 740 non-metro US counties had no growth or declines in the proportion of their populations that was elderly compared to 399 counties in the 1980's. Nevertheless, 1,565 non-metro counties did experience growth in elderly population in the 1990's, and growth rates are expected to rebound widely with the aging of the Baby Boomers. Fuguitt, Beal and Tordella (2002) also revealed more about what type of

non-metro counties experienced the most growth in older adult population. They divided non-metro counties into the economic groupings of recreation, manufacturing, farming and mining and found that growth rates for both older and younger people were both strongest in the recreational counties that we commonly think of as retirement destinations.

The aging of communities, however, is not restricted to rural communities. While rural communities often have larger proportions of older adults relative to their overall populations, large numbers of older adults currently reside in urban and suburban communities. These areas are expected to grow with the aging of the Baby Boom generation. Current Population Survey (CPS) data from 2001 indicated that there were approximately 43,425,000 adults over the age of 60 in the US with 33,336,000 living in metropolitan areas (Rogers, 2002). Among the oldest old (those 85 and older) there were 3,293,000 total with 2,505,000 living in metropolitan areas (Rogers, 2002). Of the ten largest US cities from the 2000 Census, six had more than 10 percent of their total populations that were 65 and older. For example, New York City had 11.7 percent older adults (937,857 persons); Chicago 10.3 percent (298,803 persons); and Philadelphia 14.1 percent (213,722) (Hetzel & Smith, 2001). Analysis by Frey (2007), as a part of the Brookings Institution Living Cities Series, found that the "pre-seniors" (a term Frey uses for people 55 to 64) will increase "nearly 50 percent in size from 2000 to 2010." Further, that pre-senior growth is fastest in "exurban" parts of large metropolitan areas including Las Vegas, Austin, Atlanta and Dallas. As today's pre-seniors age in suburbs of the largest metropolitan areas (New York, Chicago, Philadelphia and Los Angeles), by 2040 those suburbs will become relatively

older than their respective urban areas challenging the characterization of suburbs as places where young families live (Frey, 2007).

Already within such urban and suburban areas, concentrations occur of older adults who have either aged in place in what are increasingly termed naturally occurring retirement communities (NORC's)[4], or who have moved into purpose built housing for older adults. Concentrations of older adults in such communities or neighborhoods may rival or exceed those common in rural areas. NORCs have not been subject to extensive research in the scholarly literature. However, the articles which have appeared in the popular press and in the research literature suggest that there may be as many as 5,000 such communities in urban areas across the US (Masotti, Fick, Johnson-Masotti & MacLeod, 2006).

Another demographic pattern that is important to understand in relation to the aging of US communities is migration trends of older adults (Roberts, 2002). While some older adults do make moves in retirement, Longino and colleagues (e.g. Wilmoth & Longino, 2006; Wolf & Longino 2005) who have studied the migration patterns of older adults have found that our society is not quite as mobile as the popular media image. Wilmoth and Longino (2006) indicated that "Migration rates, particularly long-distance permanent migration, are relatively low among older adults. Only 4% to 5% of adults aged 60 and over make interstate moves in a five-year period ..." Wolf and Longino (2005) found that mobility rates during the last half of the twentieth century actually declined with much of the decline related to a decrease in short-distance moves and that long-distance move rates

[4] Naturally occurring retirement communities are defined and discussed more comprehensively in Chapter II, Section B.

remained relatively stable. AARP Knowledge Management[5] (2005) in a series of studies (including Prisuta, Barrett & Evans, 2006) similarly found that nine out of ten adults 60 and over had lived in the same house or in another house in the same county for the 5 year period before the Census. Further, AARP survey data from the same series of studies revealed that most people 60 and over were "highly satisfied with their communities, regardless of the characteristics of those communities . . ." Such analyses give weight to the concept of many older adults "aging in place" in communities across America where they have resided for decades.

Aging of Individuals within the Context of Communities

The data about the aging of society and of communities confirm commonly accepted notions in health and human service delivery about the increase in the numbers and proportions of older adults with which communities will have to cope. But why does having relatively more older adults mean anything different to a community than having more adults in general? What about older adults makes them a group for which professionals need specific competencies in order to plan and implement policies, programs and services effectively? The data on how people are aging individually and in the context of communities can help illuminate the need for specific knowledge and skills on the part of professionals.

[5] AARP Knowledge Management is the internal data gathering arm of AARP, formerly known as the AARP Research Group.

The straightforward answer to those questions is that the need for the type of services and supports that are frequently provided in the context of community settings increases with age (Albert, 2004; Castle, Ferguson & Schulz, 2009; Cox, 2005; Roberts, 2002). For example, transportation needs often increase with age (Rosenbloom, 2009). About 7 million older adults do not drive. Most "nondrivers" are women (80 percent) and health conditions often play a role in their transportation challenges. Additionally, older adults with low incomes are far less likely to own a vehicle than older adults with moderate or higher incomes. For these nondrivers, public transportation and other community features and services which foster mobility like pedestrian walkways and volunteer transportation services can be essential to their well-being (Houser, 2005; Hunter-Zaworksi, 2007). Housing is another service that is delivered at the community level where needs may change with age (Pynoos, Caraviello & Cicero, 2009). Even before the economic downturn in late 2008, older Americans were experiencing a relatively higher incidence of housing burden than younger adults (defined as spending more than 30 percent of income on housing costs). US government statistics compiled from the American Housing Survey for 2005 indicated that 41 percent of older adults experienced housing burden. Comparatively only 37 percent of all US households experienced housing burden in 2005 (Federal Interagency Forum on Aging-Related Statistics, 2008). In addition to the financial dimension of housing need, Krout and Wethington (2003) summarized other dimensions of housing need that are related to planning housing options for older adults in communities: how well the option was integrated with service provision; how well the option could adapt to health and disability challenges; and how well the housing option fostered social engagement. A third example of how service

needs change with age relates to the prevalence of chronic disease. Eighty percent of older adults have at least one chronic disease and 50 percent have at least two. Cardiovascular diseases account for most chronic conditions. Many public health strategies, such as the CDC's Healthy Aging Program, rely heavily on community level partners and interventions to prevent chronic conditions and ameliorate their effects (CDC, 2009). Because the incidence of Alzheimer's Disease and related dementias increases with age and affects not only the health of the victims but also that of their family caregivers, caregiving increasingly is being framed as a public health concern related to chronic disease (CDC, 2009; DeFries, McGuire, Andresen, Brumback & Anderson, 2009; Talley& Crews, 2007).

Addressing the needs of frail or vulnerable older adults and their caregivers for service and supports within a community context is a key rationale for emphasis on community level approaches to aging (Roberts, 2002). The literature related to aging and communities, however, reminds us that viewing all older adults through the lens of service needs can mask the diversity of older adults as fully participating residents in communities (Gonzales & Morrow-Howell, 2009; Roberts, 2002). Increasingly, older adults are being viewed as resources within communities that strive to be more livable for all ages as well as healthy places to age (e.g. Henkin & Zapf, 2006; Kochera, Straight & Guterbock, 2005; National Association of Area Agencies on Aging, 2006; Simatov & Oberlink, 2004c). Some of the demographic trends that help to shape a more complete picture of older adults as they age in communities include: the decline in chronic disability[6] among the older population;

[6] Note: Manton defines the chronic disability "threshold" as impairment in activities of daily living (e.g. bathing, dressing, eating) or instrumental activities of daily living (e.g. meal preparation, managing money, using transportation) lasting 90 days or more. Chronic disability is different than a chronic illness, such as

the relative increase in the use of home and community-based services; the multiple caregiving roles played by older adults; the growing diversity of the older population; and contributions made by older workers and volunteers.

Chronic disability is declining among older adults: While older adults are living longer than a century ago, that increase in life expectancy is not simply adding disabled years at the end of life (Fries, 2003; Manton, 2008). Chronic disability rates among older adults have been declining on an annual basis. Manton and colleagues have tracked chronic disability rates for over two decades via the National Long Term Care Survey. The percent of persons 65 and over without any chronic disability has gone from 73.5 percent in 1982 to 81.0 percent in 2004/5. For the same time period, the percentage of adults with chronic disabilities who lived in a more institutional setting (usually a nursing home) went from 7.5 percent to 4.0 percent of those 65 and over (Manton, 2008). The challenge for communities will be how to help older adults continue to make improvements in staying healthy. Already, the growing obesity epidemic among Boomers has demographers concerned about the long term consequences on chronic disability (Manton, 2008; Wilmoth and Longino, 2006).

More older adults who do need care are being cared for in community settings where they desire to receive services: Kane and Kane (2001) emphasized this preference among older adults to avoid more institutional settings and be served at home. Numerous AARP surveys, including a national survey reported by Bayer and Harper in 2000 which found that 82 percent of older adults did not want to move from their homes even if they develop a care

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cardiovascular disease, diabetes or hypertension. Chronic illnesses may, or may not, lead to limitations in activities in daily living.

need, also support this preference. Manton (2008) noted, as have many others including Kasper and O'Malley (2007), that reduction in institutionalization rates, specifically nursing home use, is in large part due to more older adults receiving care in home and community-based settings including assisted living facilities. Hence, communities are challenged to assure that such care is available, accessible and affordable. After the mixed results of early studies related to the cost savings of providing community-based care, long range trends now appear to show evidence of the cost-effectiveness of serving frail older adults in the community (e.g. Grabowski, 2006; Kaye, LaPlante & Harrington, 2009; Mollica, Kassner, Walker & Houser, 2009). Recent federal policy initiatives seek to encourage the development of community-based care and connect that care both to social supports in communities via the creation of Aging and Disability Resource Centers (HHS, 2009) and "medical homes" in communities via Medicare (CMS, 2009a,b).

Older adults fill key caregiving roles within communities (Houser & Gibson, 2008; Talley & Crews, 2007; Zedlewski & Schaner, 2005): Older adults are not always the recipients of care but frequently are caregivers of other people. Older spousal caregivers may take care of their more frail partners. Young older adults (typically in their sixties) may be taking care of parents who are in their eighties or nineties. Grandparents may provide childcare for grandchildren or take on parental roles. And older adults may be caring for adult children who are disabled, particularly for those with developmental disabilities (Talley & Crews, 2007). Communities will need to be supportive of the caregivers in these roles through educational and respite services.

The older adult population is growing more diverse: While the older population is not as racially and ethnically diverse as younger age groups, diversity is increasing (Roberts, 2002). This increase is especially true for Hispanic elders. Hispanic older adults comprised 5.6 percent of the older population in the 2000 census. By 2050, Hispanics will comprise 16 percent (Wilmoth and Longino, 2006). Diversity among older adults will challenge communities to develop multiple approaches to supports and services which are responsive to diverse cultural approaches and help diminish disparities in access to services (e.g. Carlton-LaNey & Washington, 2009; Kornblatt, Eng & Hansen, 2002; Shenfil, 2009). Yoshida, Gordon and Henkin (2008) also described older immigrant and refugee elders as assets within their families and communities for the caregiving and other helping roles they fill.

Older adults engage in civic life: Older adults are increasingly seen as an important part of the fabric of communities (Henkin & Zapf, 2006). A number of initiatives around the United States are beginning to highlight and encourage the continued civic engagement of older adults via continued participation in the workforce and volunteer and charitable activities (Goggin, 2009; Gonzales & Morrow-Howell, 2009). Zedlewski and Schaner (2005), analyzing data from the 2002 Health and Retirement Study as a part of The Retirement Project of the Urban Institute, highlighted: "Almost 80 percent of Americans age 55 and older engage in at least one type of productive activity, averaging nearly 1,300 hours of productive activity each year." They went on to note that while participation in the workforce does decrease with age, 30 percent of people 65 to 74 are employed and more than 30 percent of older adults participate in some type of formal volunteer activity. The National Academy on an Aging Society (n.d.) which has a Civic Engagement in an Older America

project and Civic Ventures (www.civicventures.org) are two of the more prominent national efforts that seek to help communities engage older adults as a resource more effectively.

B. Communities: Role, Capacity and Approaches to an Aging Society

Role of Communities in Society

The potential for community level approaches to an aging society in the United States flows from the role of communities in society in general and in American culture in particular. Putnam's work on social capital in the United States (Putnam, 2000) sparked a resurgence of discussion about the role of community networks and associations in American life (Roberts, 2002). While Putnam's work, summarized in his seminal publication, *Bowling Alone* (2000), began as a somewhat negative description of the diminishment of social capital in the United States,[7] he has used it as a rallying cry "to restore American community for the twenty-first century through both collective and individual initiative." AARP used Putnam's work to stress the need for community engagement in its Beyond 50 Series report on livable communities for successful aging (Kochera, Straight & Guterbock, 2005). Cannuscio, Block and Kawachi (2003) have applied Putnam's work to the concept of successful aging. They used Kawachi's and Berkman's (2000) definition of social capital "as the resources available to individuals and groups through their social connections in their communities." Like Putnam, Cannuscio, Block and Kawachi (2003) began by illustrating the negative impact of a decrease in community ties through a case study analyzing the age composition of the people

[7] Putnam (2000) presented statistical trends which illustrated that after a growth in civic participation during most of the twentieth century, by the last couple of decades of that century, such participation was on the decline.

who died during the July 1995 heat wave in Chicago. Seventy-five percent of the over 700 people whose deaths were attributable to the heat wave were over the age of 65. Further analysis of neighborhoods, however, showed variation in the concentrations of elderly persons who died: "Communities with an active street life, where neighbors saw each other and interacted on a daily basis, were more successful at protecting residents against the risk of death." The authors go on to emphasize that older adults on the whole are more likely to be engaged in civic activities than younger members of communities and to suggest that older adults "make up a progressively higher proportion of community members who hold together the social fabric" (Cannuscio, Block & Kawachi, 2003).

Cannuscio, Block and Kawachi (2003) also discussed the tensions between the American values of individualism and independence, which are often associated with successful aging, and the reliance on community ties. The policy theorist Kingdon (e.g. 2002) described a similar set of tensions in American culture between individual or community goals, or individualism and communitarianism. This literature about the role and potential of community provides insight into why the current emphasis on community level approaches to aging is so compelling to Americans. While older Americans value individualism and independence, as a generation, they also have relatively high levels of civic engagement and reliance on community ties.

Enhancing Community Capacity

Community level approaches to an aging society are examples of collaborative activity within communities to address key community issues. Communities sometimes tackle a range of issues such as public safety, education or economic development in

comprehensive ways. There are many factors that can enhance communities' capacity to be successful as they plan and mobilize to address such key issues. The literature on community capacity provides some insight. The Center for the Advancement of Community Based Public Health (Baker, Davis, Gallerani, Sanchez & Viadro, 2000) in a widely-circulated Centers for Disease Control (CDC) guide to evaluation of community health programs defined community capacity as:

> The commitment, resources, and skills that a community can mobilize and use to address community issues and problems and strengthen community assets; the characteristics of communities that affect their ability to identify and address social and economic health issues; the cultivation and use of transferable knowledge, skills, systems, and other resources to affect community—and individual—level change.

Foster-Fishman, Berkowitz, Lounsbury, Jacobson and Allen (2001) conducted an extensive literature review and identified the factors needed for collaborative capacity. As a result, they produced an "integrated framework" for building capacity and a wide-ranging inventory of related competencies and processes. Drawing from the work of a CDC symposium on community capacity (summarized by Goodman, Speers, McLeroy, Fawcett, Kegler et al 1998), Foster-Fishman and colleagues (2001) defined *collaborative capacity* as "conditions needed for coalitions to promote effective collaboration and build sustainable community change." They described four levels of collaborative capacity as well as the skill/knowledge sets that community partners need to create effective collaboratives. Some of the many knowledge and skill sets they identified included general skills such as conflict resolution, effective communications and program planning, design, implementation and evaluation as well as being "knowledgeable and skilled in policy, politics, and community

change." Additionally, Foster-Fishman et al (2001) found the need for competence in understanding "the problem domain," "targeted problem," and "target community" (Foster-Fishman, et al, 2001). Goodman et al (1998) also addressed the need for skills in relation to community capacity. Their skills list overlapped those found by Foster-Fishman and colleagues and emphasized the need for "skilled advocates," as well as skills in "collecting, analyzing, and reporting data on needs, opportunities, barriers and resources." Further, the expert consensus process summarized by Goodman and colleagues (1998) concluded that: "The level of community capacity may be lower in the absence of skills to produce and implement quality plans."

In this research, the community issue/problem domain is the aging of communities and the sets of competencies (knowledge and skills) relate to the professionals who are helping community members use information and other assets to design solutions related to community level approaches to aging; thus, building community capacity.

C**ommunity Level Approaches to Aging**

The interest in community level approaches to aging has increased along with the resurgence in the interest in communities and the growth in the aging population. The scholarly literature related to community level approaches is growing (e.g. Scharlach, 2009a and 2009b), but in its infancy. It is focused primarily on typologies of the characteristics of communities that are considered frontrunners with regard to their approaches and includes a few case studies of those communities. The practice literature is more abundant but also is focused on characteristics of communities, awareness building case studies and

assessments/checklists to assist communities to gauge their level of preparedness to address the needs of growing numbers of older adults. To facilitate discussion, the literature on community level approaches to aging can be divided roughly into four parts: the preparedness literature related to communities preparing to deal with growing numbers of older adults; approaches connected to livable communities' movements for all ages; cross-disciplinary policy/research agenda literature; and the concept of naturally occurring retirement communities and related grass roots activity.

Preparing Communities to be Elder-Friendly: The major focus of activity during the early 21st century with respect to community level approaches to aging has been on preparing communities to deal with growing numbers and proportions of older residents. Terms such as *senior-friendly community*, *elder-friendly community*, and *age-prepared community* are now ubiquitous in the aging practice literature but are just beginning to appear in the scholarly literature. Alley, Liebig, Pynoos, Banerjee and Choi (2007) began to explore the concept of preparedness but concluded that there was no uniform definition. Their working definition assumed that "elder-friendly community...generally refers to a place where older people are actively involved, valued and supported with infrastructure and services that effectively accommodate their needs." Additionally, they noted that this definition relates back to the concept of "person-environment fit" first introduced into the gerontology literature by Lawton and Nahemow in 1973 (Alley, Liebig, Pynoos, Banerjee & Choi, 2007). Wahl and Weisman (2003) reviewed the development of the sub-discipline of environmental

gerontology[8] which has its roots in the work of Lawton, and concurred that environmental gerontology has theoretical and applied connections to "age-friendly" communities. Recently, Scharlach (2009a) adopted person-environment fit as the first of six "underlying principles [of the movement to create aging-friendly communities] related to adaptation and functioning in later life."

Alley et al (2007) further explored the concept of elder-friendly communities by comparing characteristics of such communities identified by older adults with those of researchers and practitioners. Older adults' perspectives were assembled from several studies that asked older adults to identify characteristics of elder-friendly communities. To gain the perspectives of practitioners and researchers, the authors invited, "fifteen national leaders in the fields of gerontology, urban planning and community development" to be part of a Delphi process to define elder-friendly (Alley et al, 2007). They noted that there was considerable overlap in the characteristics identified by both groups. Both older adults and researchers and practitioners included such characteristics as safety and access to transportation and other essential services as important. The researchers and practitioners, however, were more detailed in the characteristics they included. For example, "caregivers support services" and "supportive zoning for senior housing" were important for researchers and practitioners. Table 1 summarizes the characteristics from the Delphi process.

[8] Environmental gerontology focuses on "the description, explanation, and modification or optimization of the relation between the elderly person and his or her environment" (Wahl & Weisman, 2003).

Table 1: Elder-Friendly Community Characteristics: Delphi Study, 2002 (Alley et al, 2007).

Accessible and affordable transportation
Available in-home or long-term care services
A wide variety of appropriate housing options
Responsive health and long-term care
Ability to obtain services with reasonable travel
Personal safety and low crime rates
Elders considered vital part of community
Caregiver support services
Accessible public and service buildings
Elder-relevant issues present in local agenda
Recognition of and response to unique needs of seniors
A wide selection of services
Adequate pedestrian and traffic controls
Supportive zoning for senior housing
Age-appropriate exercise facilities

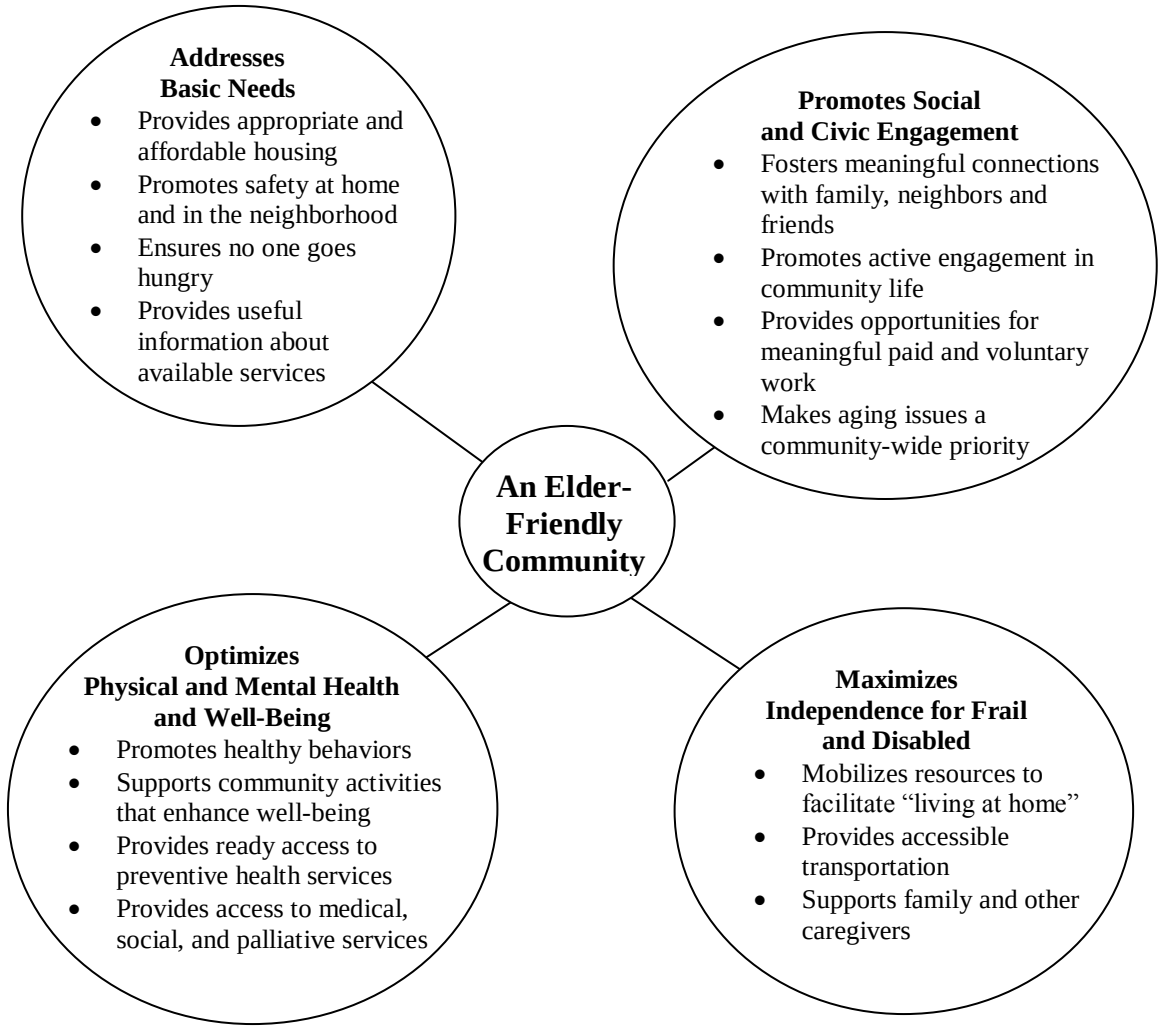
Alley and colleagues (2007) also highlighted several initiatives that relate to the concept of community preparedness to address aging issues.[9] Those community level approaches to aging included the AdvantAge Initiative, a project of the Center for Home Care Policy and Research (Feldman and Oberlink, 2003). One of the purposes of the AdvantAge Initiative was to develop "a model of an elder-friendly" community. As a part of model development, focus groups of older adults were conducted in several communities across the United States to identify elements for the model. Four major components of an elder-friendly community were identified: "addresses basic needs," "promotes social and civic engagement," "optimizes physical and mental health and well-being," and "maximizes independence for frail and disabled." Figure 1 illustrates the relationships AdvantAge described among the components and more detailed goals and indicators of health and social

[9] For these initiatives, the goal generally is to encourage greater preparedness among participating communities as well as communities at large rather than to declare some communities as prepared and others as not.

well-being. For example, "provides appropriate and affordable housing" is a goal under the basic needs component, and indicators which might be used to track progress toward that goal include the percentage of older adults who are in affordable housing (spending less than 30 percent of their income on housing) and of those who are able to age in place (Center for Home Care Policy and Research, n.d.; Feldman & Oberlink, 2003; Simatov & Oberlink, 2004a, b, & c). Hanson and Emlet (2006) described a case example of a community (Pierce County, Washington) using the AvantAge model. This case study is of particular interest because it is perhaps the first example in the peer-reviewed literature in which quantitative data related to measures of an elder friendly community are reported. The descriptive data were generated from a random sample of 514 older community residents in Pierce County, WA. These residents were surveyed by telephone to collect information about the indicators of elder-friendliness. On the positive side, findings included that 81 percent of older adults were satisfied generally with their neighborhoods and that 90 percent participated in cultural, religious or recreational activities. On the more challenging side, only 50 percent of older respondents were physically active three or more days a week, 30 percent spent more than 30 percent of their income for housing and 56 percent indicated that they had one or more unmet care needs (Hanson & Emlet, 2006).

Additionally, Oberlink and Stafford (2009) described the successful use, via an AoA funded initiative, of the AdvantAge model including the related four-step planning process "on a statewide basis" in Indiana. Stafford (2009) also incorporated use of the AdvantAge model into his book, *Elderburbia: Aging with a Sense of Place in America*.

Figure 1: Components of an elder-friendly community (Feldman &Oberlink, 2003).



Another elder-friendly communities' initiative identified by Alley et al (2007) was the Elder Friendly Communities Program (EFCP) in Calgary, Canada (Austin, DesCamp, Flux, McClelland & Sieppert, 2005; Austin, McClelland, Perrault & Sieppert, 2009). EFCP focused on five Calgary neighborhoods. The research and demonstration program, created through a partnership among a university, city and Canadian health region, emphasized a "community development" approach which Austin et al (2005) defined as promoting "the recognition, acquisition, maturation and connection of community assets to benefit the whole." Austin and colleagues (2005) also noted the relationship to community capacity of the community development approach they described. They indicated that "[b]uilding community capacity is both a goal and a method that is embedded in a number of innovative initiatives designed to promote elder-friendly communities" and cited AdvantAge and Community Partnerships for Older Adults as two examples. More recently, they (Austin et al, 2009) highlighted "capacity building" as a foundational principle of the program and emphasized that it "fostered long-term commitments to innovation, knowledge development, and transfer."

Community Partnerships for Older Adults (CPFOA) is an example of a somewhat more specialized community level approach to aging than the general elder-friendly communities initiatives (Bolda, Lowe, Maddox & Patnaik, 2005; Bolda, Saucier, Maddox, Wetle & Lowe, 2006) . While CPFOA, an initiative of the Robert Wood Johnson Foundation, emphasized community-wide collaboration, it also centered on addressing the needs of frail older adults and their caregivers as well as promoting planning for the future numbers of frail older adults in a community (Bailey, 2009). Over an eight year period,

CPFOA communities received technical assistance and grants for strategic planning and 16 of those communities progressed on to receive implementation awards (Community Partnerships for Older Adults, various dates). When Bolda and colleagues (2005) described the early development of CPFOA, they indicated conceptual linkages to both community development and social capital theories drawing on the work of Putnam (e.g. Putnam, 2000) and Kawachi and Berkman (2000) among others.

Approaches Connected to Livable Communities' Movement: Although there is a great deal of conceptual overlap among most community level approaches to aging that emphasize preparedness, those with strong ties to livable communities' initiatives are often featured in the practice literature (Alley et al, 2007). For example, the considerable body of work fostered by AARP on preparing communities for growing numbers of older adults has strong linkages to the livable communities' movement. These AARP publications (e.g. Arizona State University Herberger Center for Design Excellence, 2005; Bridges, 2007; Kochera, Straight & Guterbock, 2005; Oberlink, 2008) provide information, checklists and examples designed to help communities assess their progress towards livability for older adults. Definitions of both community and livable community promulgated by AARP as part of the Beyond 50 series, and featured in the practice literature have been adopted for use in this research:

- *Community:* Communities are "People living within a specific area, sharing common ties, and interacting with others" (Kochera, Straight & Guterbock, 2005).

- *Livable community:* A community that "has affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life" (Kochera, Straight & Guterbock, 2005).

One of the hallmarks of the livable communities' movement is its connection to the built environment. Alley et al (2007) define *built environment*, using the National Institute of Environmental Health Sciences (www.niehs.nih.gov) definition as "Those aspects of our environment that are human modified such as homes, schools, workplaces, parks, industrial areas, farms, roads and highways." Alley and colleagues (2007) go on to define from the literature other key terms that they relate to both livable and elder-friendly communities and the built environment including accessibility, universal design, visitability and walkability. For example, the livable communities movement emphasizes that, to encourage healthy aging through increased exercise and social interaction, communities should not only encourage walking groups but also plan for how the built environment can encourage such activities.

In addition to the work fostered by AARP, another body of practice literature related to preparedness and livable communities has been funded by the MetLife Foundation and published by the National Association of Area Agencies on Aging (2006 & 2007). The work was done in partnership with the International City/County Management Association, Partners for Livable Communities, and the National Association of Counties and National League of Cities. The partnership built on the earlier "Aging in Place" initiative of Partners for Livable Communities (2005). It emphasized the concept of livable communities for all

ages which stressed that many of the community features that would help older adults age in place would also be beneficial for other population groups across the lifespan. For example, accessibility features which aid older adults with mobility limitations such as automatic door openers are useful to other groups including parents with strollers and delivery people.

The widely disseminated first report of the partnership, *The Maturing Of America: Getting Communities on Track for an Aging Population*, included the results of a survey of 10,000 local governments across the United States to "determine their 'aging readiness" (National Association of Area Agencies on Aging, 2006). The survey had a lower than anticipated response rate (18 percent) and other methodological limitations, but responding local governments were fairly evenly spread across geographic regions and across city and county size categories as measured by population. The major finding of the survey was "that only 46 percent of American communities have begun to address the needs of the rapidly increasing aging population." With respect to planning for an increase in the number of older adults in their communities, "slightly over 50%" of the local governments indicated that they were involved in such planning. Given that communities that were involved in such planning probably were more likely to respond to the survey, these numbers would appear to overestimate the degree of preparedness. The second report of the partnership, *A Blueprint for Action: Developing a Livable Community for All Ages* (National Association of Area Agencies on Aging, 2007), is very similar to the AARP publications aimed at helping communities assess their readiness and move forward with preparedness. Another wave of survey data is being collected by the partnership and is expected to be reported out in May 2011. That new initiative is entitled *Maturing of America II: Getting Communities on track*

for the Baby Boomers and has the American Planning Association (2011) as an additional partner.

The Aging in Place initiative has continued to be active. A series of reports from workshops that the initiative held in major cities around the United States in conjunctive with the National Association of Area Agencies on Aging (n4a) were issued in 2009 – 2010 (Aging in Place, n.d.). The topics of those workshops ranged from housing and transportation/mobility options to community design, land use planning and engaging community leaders.

All of these initiatives to encourage community level responses aimed at preparation for growing numbers of older adults have substantial web presences for dissemination to foster replication, diffusion and/or implementation. The sites typically feature reports, newsletters and case examples from frontrunner communities as well as assessment tools/checklists for other communities to use to assess their degree of preparedness.

Cross-disciplinary policy/research agenda literature: Additionally, there is an emerging literature which seeks to influence policy and research agendas related to preparing communities for growing numbers of older adults. This literature cuts across several disciplines. For example, Deborah Howe, a planning educator and chair of the Department of Community and Regional Planning at Temple University, stressed "building aging-sensitive communities" to funders' of smart growth and livable communities (Howe, 2001). Masotti and colleagues (2006) took a public health approach to healthy aging policy from the perspective of naturally occurring retirement communities. (See the following section for the

definition of naturally occurring retirement communities.) And Lehning, Chun and Scharlach (2007) addressed structural barriers (e.g. zoning policy) to aging friendliness from the disciplines of social welfare and aging, Further, Lehning's forthcoming dissertation (Center for the Advanced Study of Aging Services, 2010, Summer) is entitled "Local Government Adoption of Aging-Friendly Policies and Programs."

Most recently, Scharlach and colleagues at the Center for Advanced Study of Aging Services (CASAS) at the School of Social Welfare at the University of California, Berkeley, have been conducting several related research efforts which cut across disciplines and models of community level approaches to aging. The first product, a *Compendium of Community Aging Initiatives,* was issued in March of 2010 to document "in a single place the various efforts across the country to help communities become more 'aging friendly" (Center for the Advanced Study of Aging Services, n.d.). The *Compendium* (Center for the Advanced Study of Aging Services, 2010, March) focused on listing and describing "121 community aging initiatives" from survey data. By the summer of 2010, the CASAS website also was reporting a new typology of "community initiatives" that emerged from the survey data that "revealed five distinct types of community initiatives" including "community planning models," "system change models," "residence-based services" initiatives, "consumer networks," and "individually-based services" initiatives (Center for the Advanced Study of Aging Services, n.d.).

Naturally Occurring Retirement Communities and Related Activity: In 1985 Hunt and Gunter-Hunt introduced the term "naturally occurring retirement communities" (NORC's) to describe housing complexes or neighborhoods where the residents were aging

over time resulting in a relatively high proportion of older adult residents. While NORC's often have been associated with urban concentrations of older adults (e.g. MacLaren, et al, 2007; Masotti, et al, 2006; Vladeck, 2004), the term can be applied to any community with a high concentration of older adult population. The New York State experience with NORC's has been the most documented aspect of NORC's in the United States in the scholarly and practice literature. MacLaren, et al, summarizing that experience in 2007, offered this definition of NORC's: "age-integrated buildings, housing complexes, or neighborhoods with large numbers of people 60 years or older." MacLaren and colleagues were particularly focused on NORC's that had developed supportive service programs and identified 35 such programs that were established between 1986 and 2001 including 28 in New York City. Many of the supportive service programs in New York NORC's were developed in cooperative apartment buildings with the help of philanthropic or governmental funding. In New York City, supportive service programs in NORC's have received extensive assistance from the United Hospital Fund's Aging in Place Initiative (Vladeck, 2004). Vladeck (2004) highlighted the "hallmarks" of these supportive service programs including "coordinated health care and social services and group activities on site" as well as promotion of independence and healthy aging. Because the New York NORC experience has been so well documented, it is frequently used as an example of service development in NORC's in the more popularized media. Over the last two years, UHF has developed a NORC Blueprint website (www.norcblueprint.org) that provides "how to" information for replications including a list of "tools" related to knowledge and skills development topics such as evaluation and planning (United Hospital Fund, n.d.).

The discussion of NORC's in the popular media intensified considerably in 2006 when a *New York Times* feature story on a grass roots initiative in Boston among older Beacon Hill residents to help them age in place received widespread attention and distribution through email (Gross, 2006). This first article was followed by a deluge of coverage on similar initiatives and on other communities that wanted to the replicate the model. The *New York Times* story also generated a great deal of web-based sharing of how-to information about such initiatives. In February 2009, a Google search of the terms Beacon Hill and aging in place netted over 21,000 results, and the Beacon Hill website (www.beaconhillvillage.org) was keeping track of the progress of 35 replications across 18 states. By the summer of 2009 the number of identifiable replication communities had increased to 53 with over 100 more in progress (McWhinney-Morse, 2009). In early 2010, NCB Capital Impact, a non-profit community development organization, along with co-sponsor Beacon Hill, launched the Village to Village Network (http://vtvnetwork.clubexpress.com) to provide how- to information for replications (McWhinney-Morse, 2009).

The striking characteristic of these villages is that they emerge from grass roots/self-help type activity. Two types of information provide insight into the model: recent additions to the literature such as Guengerich (2009); Kalt (2010); and McWhinney-Morse (2009), as well as information from the websites of the frontrunning village communities. In addition to Boston, those include New Canaan, Connecticut (www.stayingputnc.org), Cambridge, Massachusetts (www.cambridgeathome.org), and Washington, DC (www.capitolhillvillage.org). Residents who have aged in place in a community decide that

they want to continue to do so and organize a nonprofit entity, usually funded by membership fees. The nonprofit hires core staffs of people to be located in the community to help arrange for the services and activities that will help members continue to stay in their homes. For their membership fees, older adults receive a certain minimum level of services, but most services are charged on an *a la carte* or as needed basis. Services range from classes and trips to help with activities of daily living, housekeeping and yard maintenance. Some of the services are provided by program staff, but most are provided by preferred providers via agreements with the village. From a general perspective, a village, a type of NORC, provides similar services to older residents on a fee for service basis that the New York supportive services programs in NORC's provide through public-private partnerships including governmental and foundation support.

The village model of NORC's is a compelling example of the potential role of communities in addressing the issues of an aging society, but there are many questions about the model that have not been addressed yet in either the scholarly or practice literature. Scharlach and colleagues at CASAS have announced that the "next step" on their research agenda related to community initiatives "will be a more intensive examination of the consumer network model" which includes the village model (Center for the Advanced Study of Aging Services, n.d).

C. Competency Development in Professionals

We know from the experience of frontrunner community level approaches to aging that the professionals who assist communities with these approaches come from multiple

disciplines and collaborate with other professionals and community leaders in interdisciplinary ways (e.g. Community Partnerships for Older Adults, n.d.). An extensive search of the scholarly literature found no comprehensive description of these professionals, that is not surprising given that research in the area of community level approaches is still in its infancy. Examples of such professionals that emerge from the experience of frontrunner communities and the related national initiatives include staff of councils on aging or area agencies on aging; city/county planning staff; public health planners and program directors; city/county management staff; and United Way planners and program directors. For the purposes of this research, targeted professionals are defined as those who act in staff (or similar consultative) roles to develop or implement community level approaches to aging and who are associated with the fields of aging, public health or community planning. The relevant academic disciplines include gerontology, public administration, urban/regional planning, public health, and social work. This section will review the literature related to defining and developing a set of interdisciplinary competencies relevant to these targeted professionals who assist community level approaches to aging. After broadly describing competency-based education as it relates to the targeted professionals, this section will review examples of competency development that suggest methods and context for this research.

Competency-based education (CBE) is widely used in graduate and post baccalaureate level training for health-related professionals in the United States (Calhoun, Ramiah, Weist & Shortell, 2008; Gebbie & Turnock, 2006; Scharff, Rabin, Cook, Wray & Brownson, 2008). Through CBE, learning outcomes are specified for students in relation to

the competencies they should be able to demonstrate after completing an educational experience. This research will use the definition of competency (with respect to curriculum development) employed by the Council of the National Postsecondary Education Cooperative (Jones, Voorhees, & Paulson, 2002) and adopted by other groups including the Council on Education for Public Health (2006), "the combination of skills, abilities, knowledge needed to perform a specific task." The NPEC (Jones, Voorhees, & Paulson, 2002) further notes that, "competencies are the result of integrative learning experiences in which skills, abilities, and knowledge interact to form bundles that have currency in relation to the task for which they are assembled." Writing for a broad public health audience, Gebbie (2004) offered a similar but more applied definition, "competencies are applied skills and knowledge that enable people to perform work." Some professions, such as planning (Planning Accreditation Board, 2006) and social work (Council on Social Work Education, 2008), also include values as a building block for competencies along with knowledge and skills. Other professions incorporate ethical practice issues into professional standards in other "intrinsic" ways (Holloway, Black, Hoffman & Pierce, 2009).

Several of the disciplines relevant to this research have promulgated core competencies that graduates of related academic programs should be able to demonstrate:

- *Planning:* The Planning Accreditation Board (PAB) (2006) which accredits schools of urban and regional planning uses competency-based language to describe the accreditation criteria for educational outcomes for planning graduates. Educational outcomes for planners are grouped under knowledge,

skills and values. Levels of competence are specified under each of these areas.

- *Gerontology:* The Association of Gerontology in Higher Education (AGHE) does not accredit gerontology programs directly but has promulgated core competencies (Wendt, Peterson & Douglass, 1993) which are used as a part of a curriculum review process for "Programs of Merit" in gerontology, a designation developed by AGHE (Association for Gerontology in Higher Education, 2010).

- *Public administration:* The National Association of Schools of Public Affairs and Administration (2009) has recently revised its accreditation standards (Piskulich & Mandell, 2007). The new standards use competency-based language to specify "universal required" competencies as well as directing programs to develop "professional competencies" related to applications "such as through experiential exercises and interactions with practitioners across the broad range of public affairs, administration, and policy professions and sectors" (National Association of Schools of Public Affairs and Administration, 2009).

- *Public health:* The Council on Education for Public Health (2005) which is the accreditation body for schools and programs of public health uses competency-based language to specify "core knowledge," "practical skills" and "required competencies" which entities seeking accreditation must

document in curricula. Further, there has been a number of competency development initiatives related to educating students of public health (e.g.Calhoun et al, 2008; Gebbie & Turnock, 2006). The Council on Linkages between Academia and Public Health Practice, which is a coalition of over 15 organizations including the Association of Schools of Public Health (ASPH), undertook the most wide scale initiative to develop and disseminate core competencies for public health professionals. Originally adopted in 2001, those core competencies have recently been revised (Council on Linkages between Academia and Public Health Practices, 2010). ASPH also led a project to develop core competencies for graduates of master's in public health (MPH) programs (Association of Schools of Public Health Education Committee, 2006; Calhoun et al, 2008).

- *Social work:* The Council on Social Work Education (2008) which is the accreditation body for both baccalaureate and master's level programs in social work promulgated new standards for accreditation in 2008 which embraced a competency-based education approach (Holloway, Black, Hoffman & Pierce, 2009). In defining core competencies for social work, the new standards employed a definition of competencies as "measurable practice behaviors that are comprised of knowledge, values, and skills" (CSWE, 2008).

The intent of this dissertation is to identify the set of competencies that professionals need to plan, develop and implement community level approaches to aging. It focuses on the specific set of interdisciplinary competencies that professionals need to create community

level approaches to aging, regardless of their academic background. In addition to the literature that describes the process for developing broad sets of competencies for different disciplines, there are relevant examples of processes used to develop cross-cutting sets of competencies around more specific tasks/areas. In public health, for instance, competency sets have been developed in the areas of public health leadership (Wright, Rowitz, Merkle, Reid, Robinson et al, 2000; Calhoun, Dollell, Sinioris, Wainio, & Butler et al, 2008), emergency preparedness (CDC, 2002; Subbarao, Lyznicki, Hsu, Gebbie, Markensen, et al, 2008) and translation and dissemination (Scharff et al, 2008). Writing from a social work perspective, Weil (2005) offered a list of "community practice" knowledge and skills which provides useful detail related to competencies for community dimensions of practice. Interdisciplinary sets of competencies have also emerged around conceptual frameworks such as from the work of Foster-Fishman and colleagues (2001) related to building collaborative capacity in communities.

The methods by which such competency sets are developed all employ some type of process for consulting experts and, frequently, other stakeholders. Gebbie (2004), in a how-to toolkit on competency development for public health workers, identified three "circumstances" under which competency sets may be developed. Two of the three circumstances related to established areas of practice when competencies are first identified and then later updated. The third circumstance, which is the most salient to this research, related to "Specifying competencies in emerging areas of practice" (Gebbie, 2004). Further, she noted that under the circumstance of specifying emerging areas of practice while "...there is no history of expert practitioners because the area of practice is new …there will usually

be some group of experts who have already begun to work in the field." That group of experts can then be consulted via a Delphi Method, a panel of experts method, or similar technique for input on competency development (Gebbie, 2004). For community level approaches to aging such a group of experts is beginning to emerge. For example, a daylong featured program on communities and aging ("Communities Matter: Creating Local Change") was held at the 2009 joint conference of the American Society on Aging and National Council on Aging where several national stakeholders and community leaders from frontrunning communities presented (ASA, 2009). Another indication of the emergence of experts comes from the participation of technical assistance experts in a web-based technical assistance initiative around "creating aging-friendly communities" which characterized itself as a "community of practice" (CoP). The initiative began with an online conference in early 2008 which was followed by six months of additional learning and sharing opportunities online (Lehning, Scharlach and Dal Santo, 2010). Developed by CASAS in conjunction with Community Strengths, CoP had 25+ cosponsors including AARP, APA, ASA, n4a, NACo, NCA, NLC and Partners for Livable Communities. A number of technical assistance experts took part in online presentations. Among the organizational affiliations of those experts were AARP Livable Communities, AdvantAge, the NORC Blueprint of the United Hospital Fund, Community Partnership for Older Adults, and n4a Blueprint for Livable Communities (Creating Aging-Friendly Communities, n.d.). Lehning, Scharlach and Dal Santo (2010) indicated in a summary of the initial CoP experience that, "Prior to 2008, there had not been a structure for collaboration and cross-learning among...various initiatives, nor among diverse constituencies (e.g. city planners, housing developers, transportation providers,

community development experts, social scientists) whose shared expertise is necessary for effective community change."

There also are other examples of competency development and infusion of content specific to aging that come from disciplines related to this research (Bronstein, McCallion & Kramer, 2006; Geron, Andrews & Kuhn, 2005; Silverstein, Johns & Griffin, 2008). The most detailed example is from the Council on Social Work Education (CSWE). With funding from the John A. Hartford Foundation, CSWE has fostered a multi-year/multi-site initiative to "infuse" aging content into social work education (Hooyman & Peter, 2006). Developing competency sets related to aging has been part of that initiative (Damron-Rodriguez, Lawrance, Barnett & Simmons, 2006; Galambos & Greene, 2006). Damron-Rodriguez and colleagues (2006) summarized the competency methodology describing a process that included a literature review, white paper generation, and input from academic and practice experts as well as practitioners. Both survey and focus group techniques were used to collect input. The CSWE has developed the National Center for Gerontological Social Work Education which maintains a Gero-Ed website (http://www.cswe.org/CentersInitiatives/GeroEdCenter.aspx) which is a rich resource for sharing information related to social work education and aging including competencies and related curriculum infusion materials. The geriatric social work competencies that have been promulgated by the CSWE go the farthest of those of any specific discipline relevant to this study to address community level approaches to aging. One of the leadership competencies in that set addresses community capacity to, "advocate with and for older adults and their

families for building age-friendly community capacity (including the use of technology) and enhance the contributions of older persons" (NCGSWE, n.d.).

The CSWE's National Center for Gerontological Social Work Education also offers an important example of the development and dissemination of an interdisciplinary set of competencies related to aging. The CSWE in partnership with the AARP Foundation, *American Journal of Nursing*, Family Caregiver Alliance and Institute of Health, Health Care Policy, and Aging Research at Rutgers developed an interdisciplinary initiative around supporting family caregivers (Kelly, Reinhard & Brooks-Danso, 2008). At an invitational symposium in early 2008, experts identified "the competencies that nurses and social workers need to best support family caregivers." Educational articles were developed around that set of competencies and offered via a supplement to the *American Journal of Nursing* for formal continuing professional education credits for both disciplines. Additional results from the symposium included "clinical, educational, research, and policy priorities for developing best practices for promoting and supporting family caregiving" (Kelly, Reinhard & Brooks-Danso, 2008).

Chapter III
RESEARCH METHODS

A. Conceptual Framework

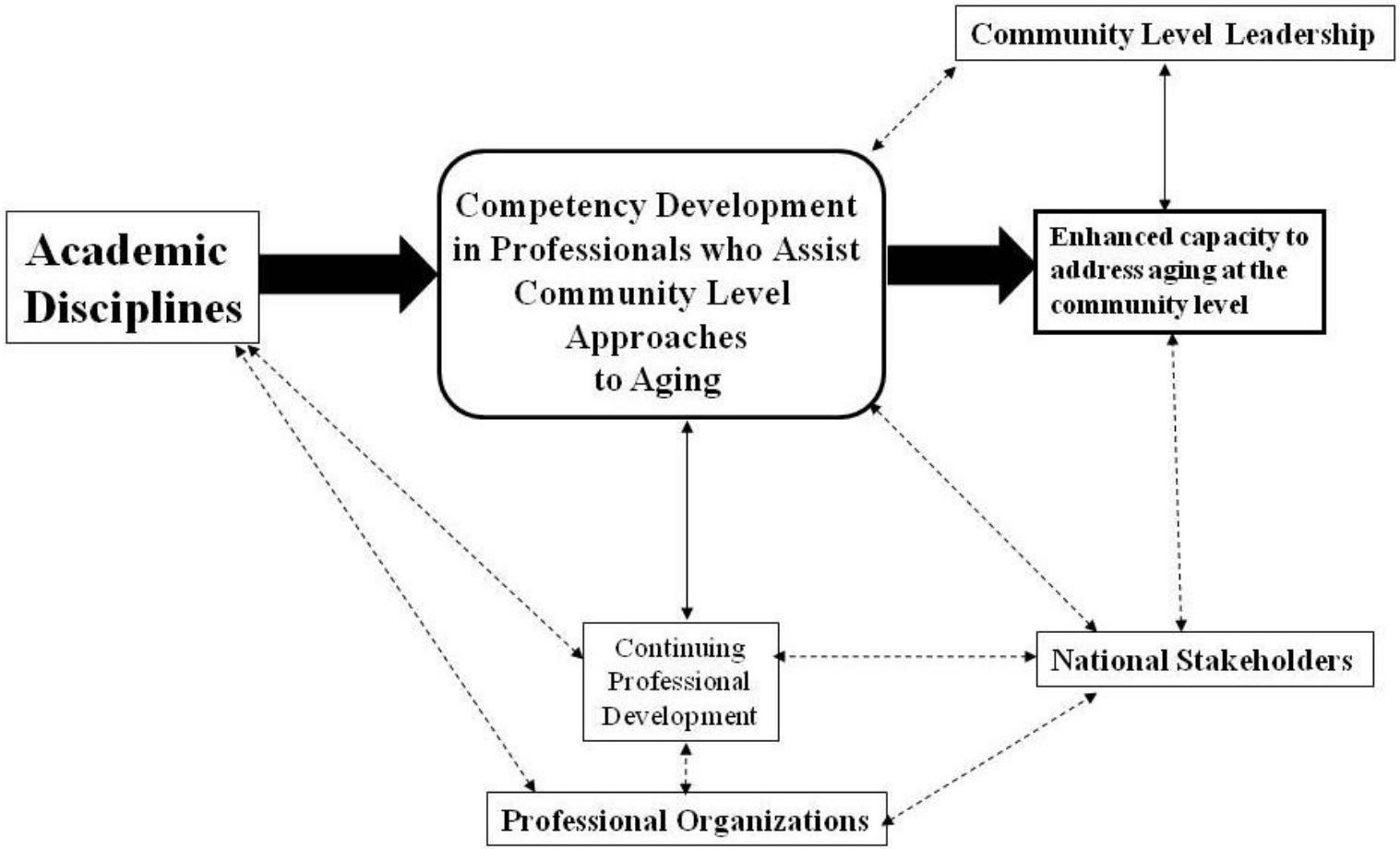
As communities plan and mobilize to address the issues of an aging society, there are a number of factors that may enhance their capacities to be successful (Baker et al, 2000; Foster-Fishman et al, 2001; Goodman et al, 1998). The conceptual framework for this research links one of those factors, competency development in the professionals who assist community level approaches to aging, to enhanced capacity in communities. Figure 2 illustrates the linkages between increased knowledge and skills in the targeted professionals which result in competency development in those professionals to enhanced community capacity. When defining community capacity, Baker and colleagues (2000) noted, "…the cultivation and use of transferable knowledge, skills, systems . . ." was needed to affect change related to community issues. With respect to community professionals, McKnight (1994) described the enhancing factors eloquently in a commentary on building community:

> To enhance community health, we need…people who respect the integrity and wisdom of citizens and their associations. They will understand the kinds of information that will enable citizens to design and solve problems. … [T]hey will focus upon magnifying the gifts, capacities, and assets of local citizens and their associations.

In the case of this research, the community issue is the aging of the population. The transferable knowledge and skills relate to professionals helping community members use information and other assets to design solutions associated with community level approaches to aging. Thus, this proposed research will delve into how the knowledge and skills of professionals who assist communities to plan, develop, and implement approaches to meet the needs of their aging populations might be enhanced through competency and curriculum development to build community capacity.

This research intends to result in a set of interdisciplinary competencies for professionals across a number of different disciplines (including gerontology, public health, public administration, planning and social work) who may find themselves assisting communities around aging issues (see Figure 2). The experience of frontrunning communities indicates that these community level approaches to aging may emerge from diverse organizational auspices. (e.g. AdvantAge communities (Feldman & Oberlink, 2003) and Community Partnerships for Older Adults sites (Bolda, Lowe, Maddox & Patnaik, 2005; Bolda, Saucier, Maddox, Wetle & Lowe, 2006). Frequently, community approaches flow from planning efforts by area agencies on aging or local councils on aging, but it is not unusual to find city/county governments, United Way planning initiatives or public health initiatives such as Healthy Communities planning groups to be in the organizational lead. Hence, it is relevant to take an interdisciplinary approach to educating the professionals who assist community level approaches to aging.

Figure 2: Competency Development across Disciplines in Professionals who Assist Community Level Approaches to Aging



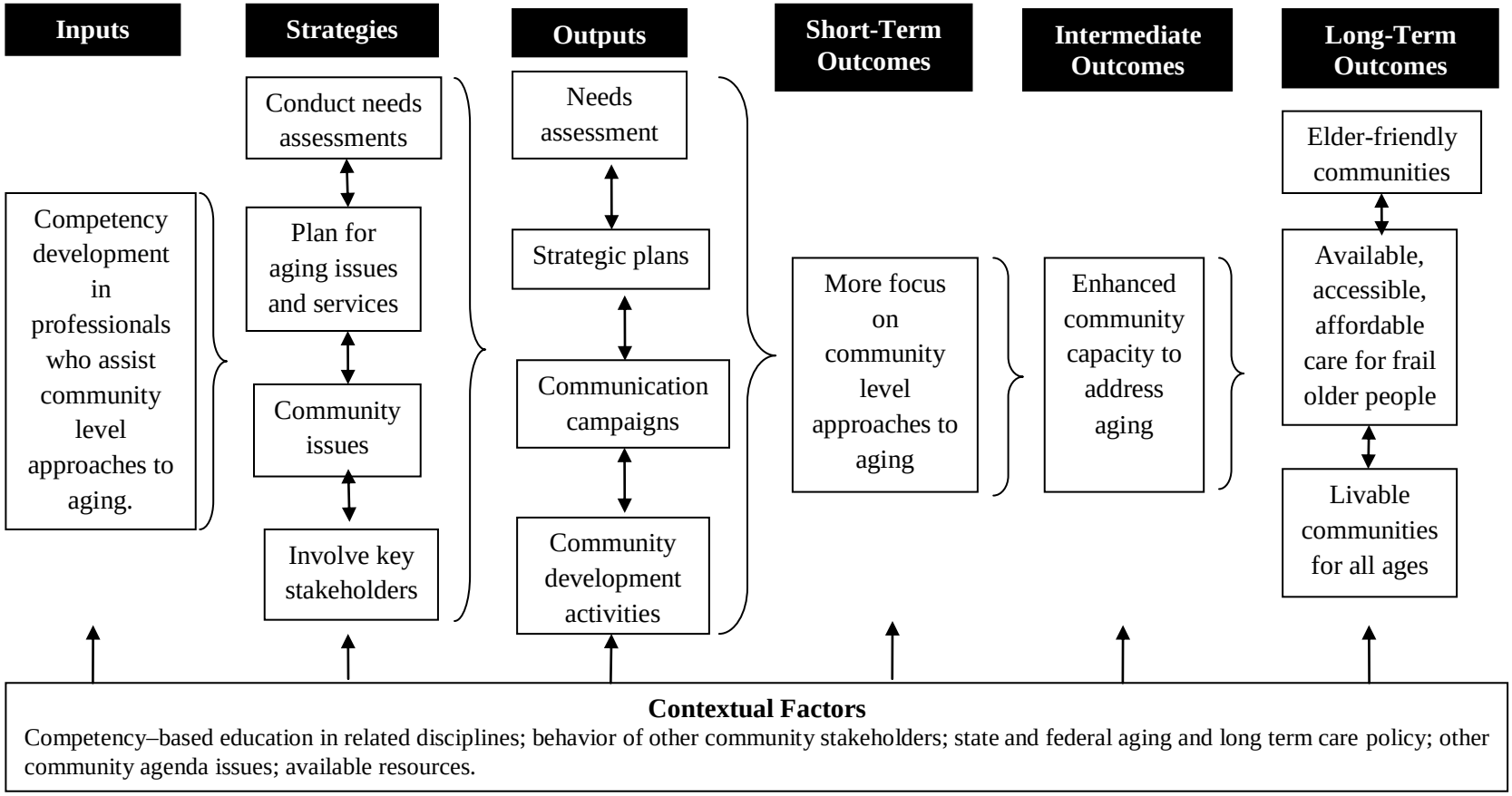
In addition to academic programs that initially educate professionals for these roles, there are opportunities to develop competencies to build community capacity as part of continuing professional development (illustrated in Figure 2). Some of these sources are affiliated with graduate degree programs (e.g. certificate programs); others may flow from professional associations and accreditation bodies, while still others may originate from governmental or free-standing auspices.

Further, it is important to recognize that there are national stakeholders which have an effect on community capacity through their efforts to encourage community level approaches to aging. These stakeholders, which include interest groups, think tanks, foundations and government, may have provided direct technical assistance and/or financial support to frontrunning communities or they may have encouraged the communities to share stories and best/promising practice information in order to learn from one another. In either case, representatives of these initiatives will have interacted extensively with professionals who staff community approaches, and it is reasonable to assume that these stakeholders will have insight into the competencies required by the professionals in these roles. And, importantly, community leaders who have participated in community level approaches to aging will have critical firsthand knowledge of the competencies needed.

While enhancing community capacity to address aging issues is a desired proximal outcome of this research, the desired distal or long-term outcomes relate to results for older adults and the community at large (Lasker & Weiss, 2003). Using the work of Joly and colleagues (2007) where they conceptually linked accreditation of public health departments to public health outcomes as a model, Figure 3 links competency development in

professionals to positive outcomes for communities. In a logic model format, an *input* of competency development in professionals is anticipated to produce *strategies*, such as conducting needs assessments and planning for services that will create *outputs* such as strategic plans and communication campaigns. Three levels of outcomes will be produced: The short-term outcome will focus more on community level approaches to aging. In the intermediate term, that focus will result in enhanced community capacity to address aging issues. Ultimately, over the long-term, the community outcomes will include increased elder-friendliness; more available, accessible and affordable care for frail older people; and more livable communities for all ages.

Figure 3: Preliminary Logic Model: Linking competency development in professionals with enhanced capacity in communities and outcomes related to the aging of communities.[10]



[10] Adapted from: Joly, B. M., Polyak, G., Davis, M.V., Brewster, J., Tremain, B., Raevsky, C., & Beitsch, L.M. (2007). Linking Accreditation and Public Health Outcomes: A logic model approach. *Journal of Public Health Management and Practice*, 13(4), 349-356.

B. Study Design: Methods and Analysis

This research employed qualitative methods to study the competencies that professionals need to enhance community capacity to address issues of an aging society. Because so little is known about the roles or educational backgrounds of these targeted professionals, a qualitative approach to understand and "gain insight" into the roles these professionals play, and what knowledge, values, and skills they need was appropriate (Maxwell, 2005). Key informant interviews and document/web content on the characteristics of community level approaches to aging were analyzed to inform the construction of a suggested set of competencies and related curriculum recommendations. The literature on competency development supports the use of such research methods. As described by Gebbie (2004), one of the circumstances under which sets of competencies are developed is to specify "competencies in emerging areas of practice." In this case, assisting community level approaches to aging is the emerging area of practice. Gebbie (2004) further described that experts and, frequently, other stakeholders are consulted as competencies are constructed. In a specific example related to gerontology, Damron-Rodriguez and colleagues (2006) summarized the methodology that was used to construct competencies for social workers related to the topic of aging by the CSWE. They described a process that included a literature review, white paper generation and input from academic and practice experts as well as practitioners.

This research gathered and analyzed information from key informant interviews and document/web content. Data from document/web content and from the key informant interviews were analyzed using qualitative coding techniques to code the information so that

it could be broken down and reassembled into categories that informed the development of the suggested competencies and related curriculum recommendations (Farmer, Robinson, Elliot & Eyles, 2006; Maxwell, 2005; Rubin and Rubin, 2005).

Key Informant Interviews

Participant Selection: Key informants (hereafter referred to as participants) were chosen using purposeful selection. As described by Maxwell (2005), purposeful selection is useful in qualitative inquiry to both assure that a "range of variation" is present and that data from "extreme" cases that might inform the research is represented. Hence, purposeful selection in this research was used to gain insights from across the range of interests associated with this emerging area of practice. Interviews with national stakeholders included practice and academic leaders who had assisted or encouraged community level approaches to aging across multiple communities and states. They were selected because their experiences in different communities gave them insight into the competencies that staff involved in community level approaches to aging might need. They were identified through the literature and public lists of attendees at relevant interest group meetings. The community leader participants (from geographic communities) were selected from extreme cases -- frontrunner communities that have been recognized by a national initiative as having planned and mobilized to take a community level approach to aging. What made these communities "extreme" as a research interest for this study is that they were on the leading edge in developing community approaches. Therefore, frontrunner communities were likely to have leaders whose insights about competencies had been informed by experience and reflection. In addition, community leader participants were selected to assure diversity across

organizational auspices and type of community level approaches (e.g. elder-friendly, livable communities, naturally occurring retirement communities or village model). (See Exhibit 1 for more detailed information on key informant participant selection.)

Exhibit 1: KEY INFORMANT PARTICIPANT SELECTION

National Stakeholder Interviews

National stakeholders were selected who were practice and/or academic leaders who had assisted or encouraged community level approaches to aging across multiple communities and states.

Pool of Potential National Stakeholder Participants: Came from the literature review and public lists of attendees at relevant interest group meetings.

Community Leaders Interviews

Community leaders were selected from frontrunner communities who had either been in a staff leadership role or worked closely with staff as a voluntary leader while a community level approach to aging was planned, developed and/or implemented. Additionally, community leader participants were selected to assure diversity across organizational auspices and community approaches to aging (elder-friendly, livable communities, naturally occurring retirement communities or village model) as well as geographic diversity across broad regions of the nation (West, South, Northeast, Midwest, Southwest).

Pool of Potential Community Leader Participants: Came from communities recognized by the following national initiatives of frontrunner communities (number of communities): AdvantAge (12), AoA Livable Communities awardees (7), NORC Blueprint featured communities (4); Village Model early sites (4); and Community Partnerships for Older Adults communities (16). (Note because of some overlap among the communities of these initiatives, the total pool of communities numbered 35.) In addition to having been recognized as a frontrunner by at least one national initiative, the communities in this pool also represented wide geographic diversity, had both metro and nonmetro sites, had a track record of at least three years of work on a community approach and had web-presences from which contact information for leadership could be obtained.

The Principal Investigator was able to achieve the goal of interviewing a mix of national stakeholders and community leaders that were diverse geographically and that represented the range of community level approaches to aging. In the planning for this study,

it was anticipated that approximately half of participants would be national stakeholders and half community leaders. The actual mix had several participants who had held both roles: Seven participants were community leaders, six were national stakeholders and seven participants had held both roles over time. Geographically, of the participants who were community leaders or who had held both roles over time, four participants had worked with community level approaches primarily in the West/Southwest, four in the Midwest, three in the Southeast and three in the Northeast. The work of the six who were national stakeholders had spanned the United States. In terms of the type of community level approaches to aging with which the work of participants was primarily identified, five identified with Community Partnerships for Older Adults, four with Livable Communities, three with AdvantAge/Elder Friendly Communities, two with NORC's, two with the Village Model and the work of four spanned approaches.

Respondents included people who had a primary discipline in all five of the disciplines targeted in this study: gerontology (3 participants), public health (2), planning (2), public administration/policy (3) and social work (3). In addition, seven participants were identified with other disciplines, primarily in the social sciences. Three participants identified with gerontology as a secondary discipline.

Participants were affiliated with nonprofit organizations (9 participants), academic entities (7), governmental units (2), and interest groups (2) as their primary organizational affiliation. Additionally, most participants had other consulting, adjunct and/or advisory relationships which made their affiliations and resultant knowledge of community level approaches very diverse.

There were several indicators that the participants selected as part of the purposeful sampling reflected a fair degree of saturation of types of people involved in community level approaches to aging. First, participants included a diverse group of people, reflecting professional, organizational, and geographic differences. Second, participants were asked directly about other information/resources useful for review related to this research. Additionally, while it was not part of the approved protocol to ask if there were people who should be contacted about the research, participants sometimes proffered that type of information. By the end of the interviews, often the materials suggested for review had been mentioned previously or the person suggested had already been interviewed as part of the initial purposeful sample described earlier. Third, by the final interviews, the core information coming from participants was almost always reinforcing of themes and categories from earlier interviews rather than introducing new material.

Recruitment: Initial contact with potential participants was made by the principal investigator via email. (See Appendix II for recruitment email and phone message scripts, factsheet and interview guide.) At that time, they were provided with a factsheet about the study and asked to provide contact information for use in scheduling an interview time. Most potential participants responded affirmatively to the initial email request. Follow-up contacts were necessary in only a few cases. In all, twenty-two potential participants were contacted; twenty of whom went on to become participants in this research. No person who was invited to participate in the study actively declined to do so. One person, who appeared to have a heavy travel schedule during the contact period, did not respond to email or voicemail invitations. A second person was unable to be contacted.

Consent and confidentiality: Participants initially acknowledged their willingness to participate in the study through their response to the email recruitment message or phone contact and the scheduling of an interview. The factsheet, that they received as an attachment to the recruitment email, provided them with information about confidentiality and risk (see Appendix II). At the beginning of each interview session, participants were asked to respond to four questions as part of the consent process: (1) Did you receive the factsheet about the study? (2) Did you have an opportunity for any questions you might have about the study or your participation in it to be answered? (3) Do you agree to participate by being interviewed? (4) Do you agree for this interview to be recorded?

More about the Interviews: The principal investigator conducted semi-structured interviews by telephone with key informants. Most of the questions asked were open-ended. (See Appendix II for interview guide.) In general, participants were asked about:

- how they related to community level approaches to aging;
- the roles filled by and tasks performed by targeted professionals;
- what knowledge and skills they thought that targeted professionals should have;
- how values and community capacity building related to this emerging area of practice; and
- suggestions for competency and curriculum development.

All participants also were asked to identify documents for potential inclusion in this research and to provide information about their own educational backgrounds and professional and organizational affiliations.

Interviews ranged in length from approximately 35 minutes to 90 minutes with most (13 out of 20) falling between 50 and 65 minutes. Participants were sent the interview guide via email when the interview was scheduled and again with a reminder notice a day or two before the interview was conducted. They were also encouraged to have the interview guide available during the interview. Many participants had made notes related to the questions in advance of the interviews. All participants responded in some way to all the questions on the interview guide. Most participants were very eager to discuss the subject and prolific in their comments.

Analysis of participant interviews: All interviews were recorded and transcribed to facilitate complete, accurate analysis. Answers to the semi-structured questions were transcribed verbatim and entered into the software program EZ-TEXT (Carey, Wenzel, Gelaude, Sheridan, Reilly et al, 2008) to create a qualitative database from which to manage and analyze the interview data. EZ-TEXT, designed in conjunction with and made available by the CDC, is considered appropriate for "use by researchers who are collecting and analyzing semi-structured qualitative data" from "interviews with a sample of individual respondents" (Carey, Wenzel, Gelaude, Sheridan, Reilly et al, 2008). It allowed for a robust exploration of the themes in the interviews via the creation of computerized coding in order to augment physical coding of the data. All electronic and hardcopy processing and storage methods for data were designed to assure its integrity and confidentiality.

More about coding of participant interviews: The codebook developed for the interview database may be found in Appendix III. Numerous notes and coding memos also were used to document the coding process for the responses to participant interviews. Below are two summaries from those notes that provide insight into the coding process:

Role coding: Coding began with the roles (and associated tasks) played by the targeted professionals because that information was considered the most fundamental to understanding the competencies needed by professionals. Extensive open coding took place over a two week period using both computerized and physical coding of the data. Initially, a list of 140 different key words and phrases from the interviews associated with roles/tasks was generated. Roles were then created to categorize those items. Five role categories emerged fairly quickly and then more coding passes through the data were made and categories added until all of the items had been meaningfully included. In all, ten role categories were created and from those and the related key words and phrases the initial codebook was developed. All direct coding was done by the principal investigator. Over the course of the analysis period, role categories were refined and two were renamed to clarify meaning based on input from committee members. The ten role categories are presented in Chapter IV; Section A, on the findings from participant interviews as well as in codebook in Appendix III (see parent code of ROLEPRO for listing of codes). One of the goals of coding was to create roles that were discrete, but there were some relationships and overlap among the categories which are noted in Section A of Chapter IV.

Competency Coding: A similar process took place to generate items associated with responses about competencies. Participants, however, did not necessarily specify whether a

competency related response was associated with a knowledge or skill area. Most participants preferred to simply discuss what targeted professionals should know or be able to do although many went on to use terms like knowledge base and skill sets at some point in their responses. The knowledge and skills areas were seen as the primary building blocks for competencies from the definition of competency used by this study and provided to participants in the Interview Guide: "The combination of skills, abilities, knowledge needed to perform a specific task" (Jones, Vorhees, & Paulson, 2002). Thus, a response was coded as indicating a competency domain if a knowledge, skill or competency related to the domain was identified by a participant. For more on the findings and analysis related to competencies, see Chapter IV, Section D.

Table 2: **Summaries of Characteristics of Community Level Approaches to Aging (Document/Web Content Analyzed)**

Organization/Author	Title/Characteristics Summary	Citation or url information
AARP/Arizona State	*Livable Communities: An evaluation guide./*Checklist	AARP Policy Institute: Arizona State University Herberger Center for Design Excellence. (2005)
AARP/Kochera, et al	*Beyond 50.05: A Report to the Nation on Livable Communities: Creating Environments for Successful Aging./*Community Recommendations	AARP Policy Institute: Kochera, A., Straight, A. & Guterbock, T. (2005).
AARP/Oberlink	*Opportunities for Creating Livable Communities/* Components & Barriers	AARP Policy Institute: Oberlink, M. (2008).
AdvantAge/Feldman & Oberlink	*Developing community indicators to promote the health and welfare of older people./*Domains	Feldman, P. & Oberlink, M. (2003). *Family and Community Health*, 26(4), 268-274.
Alley et al	*Creating elder-friendly communities: Preparations for an aging society/*Delphi Summary	Alley et al (2007) *Journal of Gerontological Social Work*, 49(1/2), 1-18
Community Partnerships for Older Adults	*Unifying Principles*	www.partnershipsforolderadults.org/aboutcpfoa/
National Association of Area Agencies on Aging	*The Maturing of America Report: Getting Communities on Track for an Aging Population/* Survey Results	National Association of Area Agencies on Aging (2006) and partners.
National Association of Area Agencies on Aging	*A Blueprint for Action: Developing a Livable Community for All Ages/* Challenges &Action Steps	National Association of Area Agencies on Aging. (2007).
United Hospital Fund	*NORC Blueprint: A guide to community action/*Steps & Guiding Principles	www.norcblueprint.org

Document/Web Content Analysis

A second aspect of the research involved a document/web content analysis of summaries of characteristics of community level approaches to aging. The principal investigator reviewed characteristics to identify the knowledge and skills needed by targeted professionals who staff such approaches. As illustrated in Table 2, during the five-year period from roughly 2003 to 2008, a number of resources were promulgated at the national level that summarized characteristics of approaches. Often these summaries were "idealized" in that they represented some group of people's idea of what a community that is responsive to growing numbers of older adults should reflect. The summaries themselves came from a variety of sources including survey data (e.g. AdvantAge, Feldman & Oberlink, 2003; Maturing of America, n4a, 2006); expert opinion (e.g. Delphi process summary, Alley et al, 2007) or compilation of ideas from within a multi-site initiative (e.g. Unifying Principles, CPFOA, n.d. or Guiding Principles, NORC Blueprint, n.d.). Generally, the resources appeared in the form of checklists or bullet points within reports or web pages to provide guidance to developing community level approaches and were widely circulated on the internet (e.g. AARP materials).

A protocol was used for selection of the summaries of characteristics to be analyzed. In general, summaries of characteristics were identified in two ways: via the initial literature review and by participants during key informant interviews. To be included, summaries of characteristics had to have multi-site, national relevance. Summaries of characteristics of community level approaches to aging that met those criteria were analyzed through a qualitative sorting process to link the characteristics to knowledge and skill areas. For

example, a characteristic such as "a wide variety of appropriate housing options" reported by Alley et al (2007) as indicative of elder-friendly communities was linked with knowledge areas such as living arrangements, housing, disability, housing options for older adults, universal design, and the Americans with Disabilities Act. The findings were then triangulated with those from the key informant interviews to assess convergence, dissonance and completeness (Farmer, Robinson, Elliot & Eyles, 2006). See Section D of Chapter IV for further information on the findings of the document/web analysis.

More about resources suggested for review by participants: In all, participants mentioned approximately 43 resources in their responses as being useful for review related to this research including 34 web-based resources and nine articles/books. (Note: It was somewhat difficult to define what constituted a discrete resource because several were packaged as web-based resources such as toolkits. For counting purposes, a web-based resource was defined as a "package" of materials related to a topic or a pdf document on the topic.) Of the 43 resources identified by participants, eight were among the resources already identified during the general literature review related to summaries of characteristics of community level approaches to aging and included in Table 2. The remaining 35 resources were not included in analysis because they did not contain a summary of characteristics related to community level approaches to aging that also had multi-site, national relevance. Most of the remaining resources suggested by participants were already, or subsequently have been, incorporated into the appropriate sections of this dissertation. A few of the resources had more relevancy as training materials or examples and will be included in other products related to this research. (Note: An itemized list of the resources is not included in

this document because of the possibility that naming certain resources would help identify participants with whom those resources are associated.)

Data Analysis and the Use of Triangulation: This research also used triangulation techniques to enhance the validity of results (Farmer et al, 2006; Maxwell, 2005; Stringer, 2007). In this case both multiple methods (document analysis and key informant interviews) and multiple data sources (documents/web content, national stakeholders and community leaders) were triangulated to enhance the completeness of the information being used to inform the development of competencies. (See Figure 4, derived from Oliver-Hoyo & Allen, 2006.) Farmer and colleagues (2006) when describing the qualitative research methods related to capacity building noted: "Researchers can also choose to enhance validity by triangulating various approaches to form a more complete picture of the issue of interest." As illustrated in Figure 4, data from the three points of the triangle (documents/web content, community leaders and national stakeholders who encouraged communities) were analyzed to form the basis for constructing a set of competencies and related competency-based curriculum development.

Institutional Review Board/Human Subjects Review: The Principal Investigator sought and obtained IRB approval from the University of North Carolina Institutional Review Board in August 2009 prior to the beginning of any interviews. In July of 2010, an IRB renewal was requested and granted so that data analysis could continue if needed past the original one year approval period.

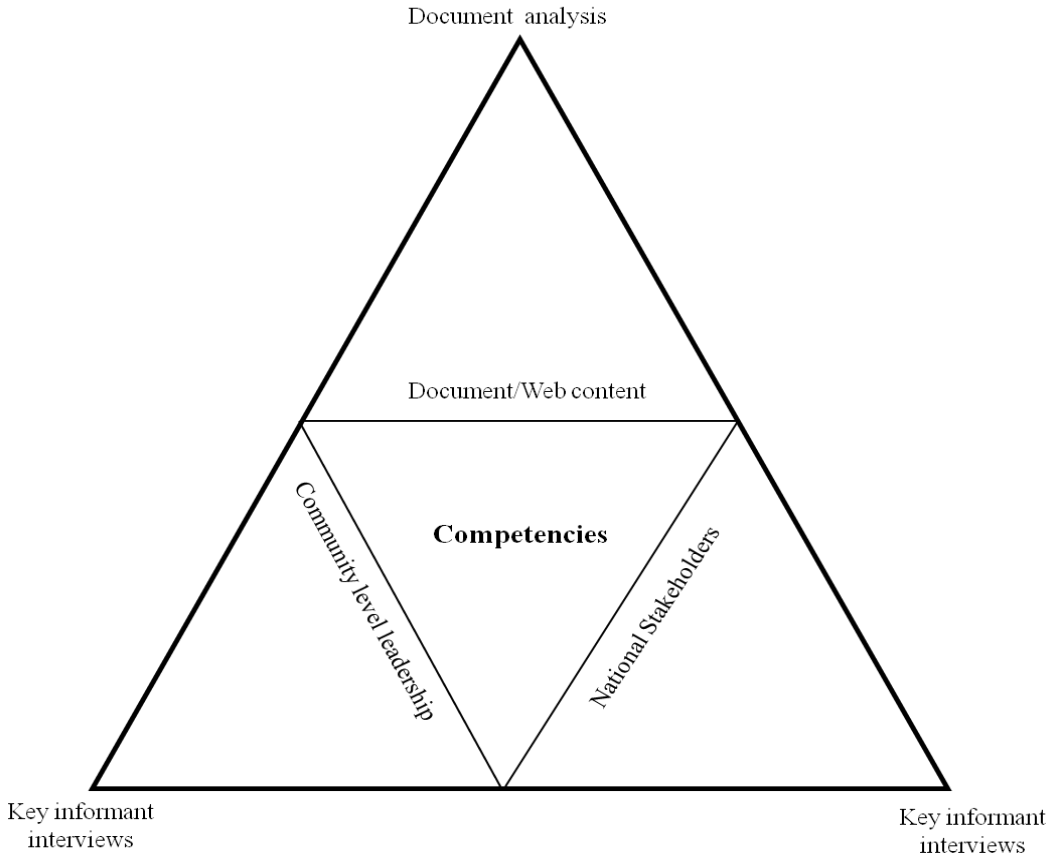
Limitations to this Research: By its very nature, this applied, qualitative research has inherent limitations. Because it endeavors to capture elements of an emerging area of

practice from which to construct competencies, it may or may not capture all of the competencies needed as this area of practice evolves over time. An essential question is whether the key informant interviews and document analysis provide a complete enough description of the roles filled by the targeted professionals, as well as the requisite knowledge and skills needed, to construct a valid set of competencies. Triangulation of methods and sources enhances the potential for completeness but does not guarantee it (Farmer et al, 2006).

Another important limitation to the research at this juncture is that, while committee members provided insight and guidance, the principal investigator performed all the coding and analysis. She endeavored to remain objective in her analysis, but her own disciplinary perspectives of public health and aging may have influenced the process.

As discussed further in the conclusions and recommendations presented in Chapter V, this research should be seen as a first, step to analyze this emerging area of practice.

Figure 4: Competency Development via Triangulation of Research Sources and Methods
[derived from Oliver-Hoyo &Allen, 2006]



C. Research Timeline

As summarized in Exhibit 3, this research took place over a 14-month period from August of 2009 to October of 2010. The proposal was approved in August of 2009, as was the IRB. Participant interviews ran from October 2009 until mid-April 2010. Transcription and data entry, as well as preliminary analysis, took place from December 2009 to May 2010. Qualitative coding and analysis of participant interviews occurred primarily over the three-month period from May to August 2010. Analysis of the written documents and web content

occurred from June to August 2010. Final analysis and production of this dissertation document took place during July and August 2010. Also, during July 2010, IRB renewal was sought and granted to allow for data analysis to continue if needed past the original one year approval period. Defense of this dissertation occurred in October 2010.

Exhibit 2: Research Timeline

Activity	Timeframe
Proposal Approved	August 2009
IRB Submission (Initial)	August 2009
IRB Approval	August 2009
Participant Interviews	October 2009 to April 2010
Interim Reporting to Committee	Periodically beginning December 2010
Transcription/Data Entry/Beginning Analysis	December 2009 to May 2010
Qualitative Coding/Analysis of Participant Interviews	May 2010 to August 2010
Document Analysis of Characteristics of Community Level Approaches to Aging	June 2010 to August 2010
IRB Renewal for Data Analysis to Continue	July 2010
Final Analysis; Triangulation Activities; Competencies Emerge	July 2010 to August 2010
Draft Final Document	July 2010 to August 2010
Dissertation Defense	October 2010

Chapter IV
FINDINGS

This dissertation addressed the overarching research question:

What competencies do targeted professionals need to enhance the capacity of their communities to respond collaboratively to the issues facing an aging society at the community level?

Several related sub-questions helped to inform competency development. The findings from those sub-questions are presented here, organized in four sections: (A.) Roles of the Targeted Professionals and the Nature of Their Work; (B.) Values and Community Capacity; (C.) Recommendations for Curriculum Applications; and (D.) Competencies and Associated Knowledge and Skill Areas.

A. Roles of the Targeted Professionals and the Nature of their Work

Roles/Tasks Research Questions: *How do targeted professionals function in "staff" roles to community level approaches to aging? What tasks do they perform?*

Participants described a rich set of roles and related tasks for the targeted professionals to inform competency development. After extensive coding, in order to facilitate analysis, the roles were grouped into ten categories which are summarized in Table 3. More detailed descriptions of each role category are found below and in the code book in Appendix III. While each role category is fairly distinct, there are some relationships and

overlap among the categories which are noted in the descriptions. In general, there was a great deal of agreement among participants on roles for targeted professionals related to developing community level approaches to aging. Five of the ten roles were described by at least 18 out of 20 participants and eight of the ten roles were described by at least half of participants. The remaining two roles, social entrepreneur and service provider, described by six and four participants respectively, facilitate the discussion of important role relationships and associated competencies.

Table 3: Summary of Roles for Targeted Professionals (from Participant Interviews)

Role Category	Number of Participants Describing Role
Convener/Facilitator	19
Translator across Disciplines	19
Planning	19
Nonprofit Management	18
Resource Connector	18
Knowing the Population	17
Policy/Intergovernmental Relations	14
Community Organizing	10
Social Entrepreneur	6
Service Provider	4

Convener/Facilitator: Most participants (19 out of 20) described a role fundamental to this area of practice that was characterized by convening, facilitating, communicating and working with groups to build consensus. Also associated with this fundamental role were analyzing and engaging stakeholders. Table 4 summarizes illustrative responses from participants about this role. In general, the role encompassed engaging "the broad

community" and the "very basic nurturing tasks" associated with convening community groups:

> One of their key tasks is to figure out how to engage the broad community and set-up a governance structure. They have to engage the broad community and create the feedback loop and community conversation that allows community voice in shaping the focus of the program so that's issue number one (Participant F).
>
> There are these very basic nurturing tasks that must be done. That can be anything from maintaining a database to regular mailings, emailings, creating a new folder for the [group] to keep all the different pieces of it coordinated and communicated. Communication with each other. So there is a real coordination issue and communication issue that in very practical terms requires staff support (Participant A).

Table 4: Participant Responses Describing the Convener/Facilitator Role of Targeted Professionals

Participant	Response
A	There are these basic nurturing tasks that must be done…communication with each other. So there is a real coordination issue and communication issue that in practical terms requires staff support.
C	To serve as coordinators and staff support for the work groups.
D	The issue of effective communication is critical through all levels of a successful project.
F	One of their key tasks is to figure out how to engage the broad community.
G	To convene communities—pull them together to talk about some of these areas.
J	But the main responsibility of the staff person is to be a really effective facilitator of keeping all of the pieces moving and together.
K	Typically what they do is either perform or facilitate a planning process of convening stakeholders.
L	There needs to be a dedicated staff person sitting somewhere to be able to insure that meetings get planned, minutes get done, follow-ups get done, relationships get developed.
M	The glue to make sure that the meetings are called, that people get together and that there are plans and things to carry out the plans.
O	Our number one task—role or task—that we serve as is as convener
P	One of the roles is the convener and facilitator.
S	You have to have somebody who is comfortable talking to people at a lot of different levels.

Translator across Disciplines: Participants frequently (19 out of 20) described a translator role related to understanding and applying the evidence base for community level approaches to aging across disciplines/areas. This role included learning the "language" of

other disciplines/areas well enough to encourage such interchanges beyond a superficial level and "translation" of their own work and the work of others to the broader community. This role also encompassed "being knowledgeable about what we mean by evidence-based programs" (Participant G), "identifying research" (Participant N), "understanding the evidence base" (Participant K), and being "able to understand the need for evidence-based outcomes" (Participant Q). One participant emphasized that "it takes commitment and a shared language" when you are trying to work across disciplines (Participant T). Another participant, whose work had spanned both national stakeholder and community leader positions, discussed "how you translate your own work" in the following way:

> Translation is a huge thing so people who not only know what they do but how to convey what they do to others so that they will be able to work together. You can get folks in a room, and I have seen this happen many times, they do a great job talking at each other and after a couple of meetings they want to know why nothing is getting done. So this becomes being able to translate what you do. Also, it's understanding what the possible connections are between what you do and what others do (Participant A).

Related to translation was the task of educator about issues and strategies across disciplines described by a community leader participant who had staffed a community level approach:

> Another [role/task] is what we called an educator or champion trying to help our communities get a broader picture of what the issues [are]…that are facing our communities and our families and help champion strategies in the larger community planning [arena]. We've also identified a role for staff as trainers trying to share best practices and building community capacity (Participant P).

Disciplines/areas frequently mentioned in relation to the interdisciplinary role, in addition to aging, included public health/healthcare, housing/design, transportation/mobility, land use planning and economic development. A participant with ties to both aging and

planning encouraged "aging professionals" to recognize "that they have standing to be able to go and talk to people outside their arena":

> It's just that folks in land use planning and housing and transportation and workforce development need to hear from you because what you do is important to their work and critical to their success in the future. So part of it is in getting folks to recognize the different disciplines that intersect with aging…And then from that being able to look at the issue of aging from the perspective of somebody in a different discipline – that often means that people need to redirect a little bit their frame of reference (Participant L).

Also associated with this role was moving away from "siloed" approaches as expressed by one national stakeholder:

> So what I have seen happening is that people are coming from quite frankly a siloed approach in a discipline or an area…[but] what happens if on the ground engagement work is going well...[is] first their roles will expand because the light bulbs that will go off …so that they step out of their traditional roles and into a far more interdisciplinary role is how I would phrase it (Participant B).

Planning: Planning was a central role for targeted professionals indicated by 19 out of 20 participants. Participants used a variety of terms to summarize generic tasks such as community planning, community strategic planning, and strategic planning. The planning role and related tasks were associated with a planning process and connected to several other roles including the fundamental role of convening and facilitating as described by one participant: "Well, typically, what they do is either perform or facilitate a planning process of convening stakeholders – many stakeholders – and doing some kind of a needs assessment and coming up with some kind of a plan . . ." (Participant K). At least two participants specified that the role included planning tasks at different levels and movement into implementation:

> I think it requires someone who is expert in planning both from a strategic planning perspective – really big picture, what are we trying to accomplish here, how do we get there – and then also planning in terms of the logistics – putting something into implementation (Participant I).

> Part of it is somebody who is both process oriented to keep a planning process moving and planning as used specifically as well as loosely as convening stakeholders and moving into an action plan and then moving those action plan pieces to implementation… (Participant L).

A fourth participant emphasized the community dimensions of the planning role:

> I think being able to do strategic planning that we often call community strategic planning is very important… you can do strategic planning with three guys in a room that figure it all out but [rather this is] strategic planning in a community that comes up with priorities and helps work on the strategies…community planning (Participant A).

Nonprofit management: Most participants (18 out of 20) described a generic nonprofit management role related to supporting the core leadership group which often also encompassed developing and running the entity that fostered the community level approach to aging. Whether the community level approaches to aging were part of a nonprofit or government entity, most were organized in a manner similar to a nonprofit organization in that staff worked closely with a leadership group to manage the entity. Tasks associated with this role included logistical support, organizational development, financial management/budgets, resource development/sustainability, measurement/evaluation/assessment, human resources and implementation. One participant described this role for targeted professionals as "…just [basic] nonprofit management: How do you manage your board? How do you put accounting together? How do you fundraise? How do you do a lot with a little? Those things" (Participant R). Another participant coming

from a NORC/Village Model perspective that also included service provision summarized the nonprofit management role in this way:

> They have to create a governance structure that really does provide some accountability back to the community which you need if you want to keep them engaged. They need to hire and to provide and to competently supervise a staff and provide service to those in need of the service piece. They have to manage the day to day of running their shop…They need to manage budgets. They need to do fundraising. They need to make sure they have put into place an evaluation mechanism that is believable and valid – evaluation some of it is about process; some of it is both quantitative and qualitative. So they need to have incredibly good people skills because they need to be …willing to listen and hear a range of community players. They need skills in... how to outreach and engage the different players in the community. I could go on and on and on (Participant F).

Participants were prolific and detailed in their responses about the various tasks associated with the nonprofit management role. Examples of responses include:

- Financial management: "…having accounting skills and financial skills at some level – being able to read a financial and say hey we are in trouble or we're not…" (Participant R)
- Resource development/sustainability: "I've already mentioned grant writing…grant finding is another important development skill. There's also something about human development and being able to tap social capital and develop people who are involved in your project . . ." (Participant D)
- Measurement/evaluation: "We said we have these goals that we want to improve access and we want to improve quality…[but] how do we know if we have been

successful, so let's go back and look at this from the standpoint of evaluation." (Participant C)

- Human resources: "The members [of the core leadership group] are volunteers so that like any organization managing volunteers you have to keep the expectations of what volunteers can accomplish realistic, and then provide the staff support to make up the difference" (Participant A).

Resource connector: The role of resource connector, described by 18 out of 20 participants, involved connecting people and resources within a community to address issues related to the older adult population. A variety of terms were used to refer to it in addition to "resource connector" (Participant O) including "resource developer" (Participant P) and "connector of services" (Participant R). One participant from a generalist background described the role in this way: "I would say that almost essentially that we're a resource connector to convene the groups to provide an opportunity and a platform for community discussion" (Participant O). Another participant coming from a NORC/Village Model perspective indicated that the role included "…really getting to know what the community resources are. That's a lot of research. The community resources are absolutely critical because in our business – this particular business model – we're a link to all those. We're not trying to recreate. We're trying to link" (Participant S). The resource connector role included general coalition/partnership type activities that linked organizations and stakeholders.

Knowing the population: This role, described by 17 out of 20 participants, encompassed possessing and sharing expertise in aging including understanding individual,

community and societal aging. An interesting subtheme articulated by several participants within this category was the ability, as described by a national stakeholder participant who had also been a community leader, to go "beyond stereotypic images of aging to a more nuanced understanding" (Participant K) of older adults and aging in communities. That participant also characterized knowing the population as part of "understanding the evidence base" and went on to say it was important to understand "who the population is that you're talking about – whether it's more upstream in terms of helping people to age in a more healthy manner [or] whether it's more downstream in terms of taking people who are more at risk of having to move to a higher level of care and keeping them in place."

From another participant with ties to planning and aging came planners' perspectives:

> It's an interesting dance in looking at that from planners' perspectives…they know the processes but they don't have a feel for the people because they don't come from that world. So often times what happens is that you have people operating off of the stereotypes of what an older person is (Participant L).

A participant who "had been involved with older adult services in the community" for many years indicated that it was important that s/he:

> … could speak with a lot of authority on the experiences of older people and what life was like for older people…whom I knew well in a variety of circumstances and that…knowledge of the population I guess informed my awareness as to how to best communicate with older adult audiences as well and so I guess it's content knowledge in a way but it's also just direct experience (Participant D).

Policy/intergovernmental relations: Fourteen out of twenty participants delineated a role characterized by understanding the policy context and navigating the policy arena including intergovernmental relations at local, state and/or federal levels. This role included

advocating for policy change, external funding and systems building. A national stakeholder participant summarized: "How do we create an aging friendly community? There's some advocacy pieces that go along with that as well as the navigation of political structures [which] is pretty critical" (Participant R). Another participant stressed: "I really feel very strongly that most frontline people do not have a policy background and they need it. They need to understand why they are doing what they are doing and the context in which they are doing it" (Participant F).

Several participants also emphasized the need for professionals in this area of practice to have a sound understanding of how local policy development occurs and how local governments work particularly local planning functions. Participants discussed both public and private sector channels for policy development:

> The one thing that I think is really critical to the future success of this work is recognizing that there is a place at the table for the public sector. And in saying that I think, because a lot of the foundational points for transportation and housing and land use planning in all of these efforts are somewhat or completely housed or controlled by government, we need to be able to engage local elected officials. And somebody [with] some sensitivity to that process, the political process [is important] (Participant L).
>
> I call it savvy really. It's important also. How do things work in the community? What are the power structures? How do things get done? Is there a history of collaboration in the community? Or does change mostly occur as a consequence of charismatic leaders putting some resources into a project? What's the old boy network like? All those kinds of issues become important (Participant D).
>
> In our community people tend to think of advocacy just in terms of when are you going to [the state capital] next and when are you going to try and advocate for more dollars for services and that is an important set of relationships certainly…[but] we've always had this idea that what can happen locally is even much more important…We've been able I think to

> serve as advocates in places that aren't typically viewed as important spaces for aging advocacy (Participant N).

Community organizing: Related to several other roles particularly the convener/facilitator and planning roles, the community organizing role that emerged was defined by its connection to community change and grass roots activities/tasks. It included tasks such as being a community voice, knowing the community, assessing community readiness and community development. Half of participants (10 out of 20) specifically delineated such a role often also emphasizing its importance. For example:

- "Community organizing is very important that would be one of the top" (Participant E).
- "A very important role that these people take on is the role of community organizer" (Participant J).
- "When it comes to professional training for this kind of work I think if I were to give it a rubric it would have – it would probably – be called community organizing" (Participant D).
- "What's most important is understanding community change processes" (Participant K).

Responses from participants illustrating the community organizing role are summarized in Table 5:

Table 5: Participant Responses Describing the Community Organizer Role of Targeted Professionals

Participant	Response
B	Change agent in the community
D	When it comes to professional training for this kind of work, I think if I were to give it a rubric it would have—it would probably--be called community organizing.
E	Community organizing is very important, that would be one of the top.
F	They need some skills and actually background in community organizing.
J	A very important role that these people take on is the role of community organizer.
I	Community development focus.
K	What's most important is understanding community change processes.
K	The knowledge base of community organizing and community change.
M	It's much I think community development.
Q	Someone who is a community organizer would have been helpful so that was to some degree what my role was in the beginning of all this.
R	I don't think we put enough emphasis on community organizing as a skill but it really is.

Social entrepreneur: Six out of twenty participants explicitly described a social entrepreneurial role that encompassed innovation associated with business development and acumen. "Innovations drive the solutions," noted a national stakeholder participant (Participant R). This role included activity related to redesign and reorganization of service delivery and, for NORC/Village model approaches, member/resident services. One participant said of targeted professionals, "They need to be entrepreneurial and they need to be willing and able to think outside the box . . ." (Participant F). Another participant who

had both business and human services training indicated that his/her human services training did not take into the consideration "that some of us were going to be social entrepreneurs and what that meant – understanding business skills that you may need to try to get something off the ground, to grow the business and to just sustain the business . . ." (Participant S).

Service Provider (4 out of 20): This role included service provision to individual older adults (and their caregivers) including access and direct services. Most of the community level approaches to aging represented in this study were not initiated to provide direct services but did include service providers among their leadership/stakeholders. Most participants did not view this role as fundamental to the overall emerging area of practice of assisting community level approaches to aging, rather they described a connecting relationship to service provision. For some community level approaches, particularly the NORC/Village models, however, those connections were more integral and day to day.

General Themes: The Nature of the Work

In addition to the responses associated with specific roles, several general themes flowed from the interviews related to the *nature of the work* of this emerging area of practice that are relevant to competency development. Those themes included:

Relation to community level approach leadership: The professionals who help communities plan and mobilize do so in support of the work of a core leadership group of community stakeholders, and their relationship with that group has a strong influence on the nature of the work. One participant described the relationship as, "Who begins to focus and target the work tends to be the [core leadership], then taking care of the logistics – getting it

done – tends to be staff." That participant also noted, "A [community level approach] only works if it has momentum. That tends to be the primary task of staff to keep the momentum moving forward" (Participant A). Another participant indicated for targeted professionals that "It means being able to work with multiple stakeholders and to help both engage multiple stakeholders but create a process that is really not about you . . ." (Participant K). A participant who had been a core leader for several years had observed an evolution of the staff role over time: "These were professionals but [initially] it wasn't a role where staff took a leadership position, they mostly were recorders of what the [core leaders] were saying, and as it evolved we realized that staff needed to have a more professional role in terms of understanding the aspects of planning initiatives" (Participant C).

Relation to service provision/delivery: The nature of this work is different from service provision/delivery. This theme emerged in several threads throughout the interviews. Several participants noted that a service delivery background did not necessarily prepare you to do this work of helping communities plan, mobilize and implement approaches to address growing numbers of older adults. Even some participants whose own work had included or did include direct service provision noted the distinction and differences in required skill sets. One such participant emphasized, "If that's what you are interested in – direct service – then this is not your field and getting that difference …between direct service and changing systems and redeveloping neighborhoods on the ground is [important]" (Participant M). Along a similar thread, another participant drew a distinction between a "services mode…around the aging of the community" and a "community model" (Participant D). A participant coming from a NORC/Village Model perspective emphasized that a service

component was integral to that model, "I mean you can do planning and engagement without a service component, but that's not [our approach]. The whole point of the [model] is, because you've got concentration and density, it permits you to reorganize and redesign service delivery so by definition then you need to have…[the] planning, the community organizing and the service delivery." But that same participant also noted that professionals who "know service provision" often "really don't quite get the complexity of this model" (Participant F). Another participant from the NORC/Village Model perspective drew an additional distinction suggesting that professionals coming from the service side did not necessarily have the full complement of skills needed to implement such community level approaches:

> I get a lot of folks [interested in the model] …from social services and want to just help somebody, but first you have to raise money to do that and there are business pieces and infrastructure that go along with that and you just can't run out and help everybody and hope that it is sustainable (Participant R).

Relation to change: Another thread that ran through several interviews was that this work fundamentally relates to change in the manner and scale of how communities approach the aging of society. Participants who commented on this theme sometimes described it as different from simply encouraging a goal of adding more traditional aging services.

> If you're trying to increase services for older adults, it's a matter of some education, mostly planning and coordination, and some identification of resources to incentivize the changes and sustain them, but if you're trying to create real change in the context in which people are living then it's a bigger issue and one that requires rather different skills (Participant K).

> It [one part of the work] has to be a willingness to challenge assumptions. Aging in the community is a pretty radical idea these days when you look at

> the way we build our communities or setup our long term care system, so that you have to have folks who have a productive way of challenging existing ideas (Participant A).

Community matters: The deep community dimensions of this work also emerged as a theme. Those dimensions particularly were evident in the role of community organizing and associated tasks described by participants. "Where this [developing a community level approach] is a grass roots effort the more it is going to be a successful one – the opposite is I know what you need and let me tell you what it is," indicated a national stakeholder participant who had worked across communities (Participant B). Further, some participants encouraged a greater understanding of what actions communities could take and how advocacy for policy changes can relate to local governments as well as state and federal levels. "I think a lot of times local folks and local decision makers have seen aging as something that the federal government was going to take care of and haven't seen their role..." suggested one community leader participant who went on to add, "I think building capacity – part of it – is looking at what communities can do" (Participant P). Another participant, who came from a planning background, also emphasized "…that the aging perspective can enable/allow us to look at our communities very differently and identify and seize the opportunity to do things very differently in a positive way" (Participant H). For a community leader, who had developed a community level approach, the essential community dimension related to identifying and tapping community assets:

> If you begin with the assumption that a neighborhood or a community or a village in which older people live …[has] capacity here to make this better but we don't know what it is… so our job was to tap into – to find all that – with the basic understanding that it was there somewhere…(Participant M).

Interdisciplinary nature: The interdisciplinary (as well as cross disciplinary) nature of this work which participants frequently described as the opposite of "siloed" came through as a theme. One national stakeholder participant discussed the interdisciplinary nature of the work in relation to the challenge to fill these roles by community level approaches given the current training for professionals:

> I think in many ways it is really, really difficult to get people [to staff community level approaches] who have the full set of skills that I think are needed. And the reason I say that is because it is so interdisciplinary. I don't think anybody really functions like that whether they are a university program or a training institute or whatever. I don't think that quite gets communicated or is taught in the type of interdisciplinary manner that this needs to be – because there are just so many things that you need to know in order to implement these things and you know most of the time people don't have the funding to hire all the people with the individual expertise that they need, so it all gets wrapped up into one person or two people maybe …(Participant E).

Another national stakeholder participant noted that mobility/transportation, housing, healthcare and supportive services were important issues to community level approaches to aging and went on to emphasize the cross disciplinary nature of developing professional competencies:

> It is interesting to realize that many times it's not enough just to have the person from the area agency on aging who is the aging expert, but that aging lens somehow has to get built into "I'm a transportation planner and I know about aging," so I always feel a little uncomfortable with aging as a separate category. What I'd like to see is competencies built into people who are housing experts, people who are transportation experts – competencies and knowledge around the aging issue just not saying, "Oh, I don't have to do aging, I don't work with that" (Participant B).

Emerging area of practice issues: Another theme about the nature of the work related to the issues surrounding the definition and scope of this emerging area of practice. Overall, participants were very supportive of the purpose of this study and felt that it was timely to give attention to professionals in this area of practice. This theme encompassed discussion of how any one person could play all the associated roles. As one participant noted with amusement, "You need someone who can do everything and then you're fine," but went on to add that doing this work was about "having a pretty good understanding of what you don't know and being able to find that" (Participant R). One way that communities have expanded the expertise available to them is via hiring consultants: "I can think of a number of communities that hired outside consultants to come in where the consultant role was either as a planner or as an aging expert or as a community organizer" (Participant K). The need for some type of core staff, however, was noted over and over again by participants. A national stakeholder characterized this area of practice as "an emerging role" that in general "is not a job description that someone applied for and got. It is more like as they were working…the agency started to move, the community started to move. Someone needed to step up and guide the process and that's what they ended up doing" (Participant B).

B. Values and Community Capacity

Participants were also asked questions during the interviews about values with regard to the work of assisting community level approaches to aging and about the building blocks for community capacity. The responses to these questions were intended to help inform both competency development and discussion of the linkages between professional competency and the process of building community capacity.

Values Question: *With regard to this work [assisting community level approaches to aging], do you think values are important? If yes, how? If no, why not?*

There was overwhelming consensus among participants (20 out of 20) that values do matter with regard to this work and that values do influence the process of developing community level approaches. Participants saw the process as influenced both by values held in common and the self interests of stakeholders. A community leader participant indicated the importance of developing "guiding principles" at the onset of an initiative as a common "starting point" (Participant O). Another participant, who had been both staff to a community level approach and a national stakeholder, indicated the "there is more of a likelihood of…moving forward" if stakeholders "bring their own self interests to the table and are very open about what they want to get out of whatever approaches we are talking about…" (Participant J).

The most important individual values with regard to this work for participants were valuing older people and their contributions to the community and valuing equity, inclusion and participation in the process. This response from a national stakeholder participant illustrated what most participants expressed about "the value and importance of older people themselves – not only that they are going to benefit but what they give back to …communities and part of that [is the] participatory process of them helping to shape and influence [community level approaches]" (Participant G). One participant summarized what several others also indicated about inclusion and equity by emphasizing that it was "the role of staff people" not only to facilitate the participation of older people in the process but also "to ensure that voices are heard equitably especially for the most marginalized people

who might not necessarily be heard without the extra efforts of trying to find them" (Participant J).

Participants also highlighted the importance of shared power/leadership and change/openness to change within the process. A participant who had worked with a number of community level approaches emphasized both shared power and openness to change:

> They have to be willing to share, if it's the spotlight or resources or ideas…they have to be willing to do that. I think they have to have an open mind…You have to be very nimble and willing to adjust because conditions are always changing. I think you have to be collaborative and feel that no one organization can do everything, and it actually benefits everyone if people work together (Participant E).

A community leader participant underscored that valuing shared leadership in both identifying problems and working on solutions was critical to sustainability:

> A community level approach to aging has got to have sustainability at the very front, so you've got to be thinking if there's a connector, if there's a systems gap. This cannot be done in isolation – if we have worked together in community to identify the problem then we've got to work on the problem together and the reason for that is whatever we do, we want it to live on (Participant N).

Further, nine participants noted the interdisciplinary value of working across disciplines including respect for what the other disciplines bring to the table. One of those participants described the interdisciplinary value in this way:

> When I was thinking about values, one is the importance in this field of interdisciplinary work and really appreciating what other disciplines can bring. I have only mentioned public health and aging but that would include social work, nursing -- you know many of the very transdisciplinary approaches – and really being able to understand the value of what other groups bring (Participant G).

Community Capacity Question: *How would you define community capacity with regard to this work? [Probe: What, in your opinion, are the 3 or 4 essential building blocks of community capacity?]*

Five themes emerged related to the building blocks for community capacity: core leadership; a community willingness to learn about itself; openness to change; cooperative broad support; and resources within the community.

Fundamental building blocks for a majority of participants included core leadership, a community's willingness to learn about it itself and openness to change based on what was learned. "Community responsiveness or culture shifts to aging" was how one community leader participant described indicators of community capacity building related to aging. That participant went on to list three building blocks that resonated with themes from other participants: "It's about leadership, it's about learning and it's about – hopefully – developing the necessary resources to address the problem" (Participant N). Participants used such terms as "able leaders," "nucleus of committed individuals," and "indigenous leadership in the community" to refer to the core leadership as a building block for community capacity. Learning about the community meant for participants an acknowledgement that there were things to learn about the community that the core leadership did not already know and that learning those things together was worthwhile. Several participants went on to emphasize that capacity not only meant being willing to learn together about the community but also open to making changes based on what was learned.

Learning about the community included research and data gathering efforts as well as the basic capacity to listen to and learn from one another's stories:

> You have to have people who have the ability to talk with each other and willingness to have the patience to listen – to listen to different stories. You have to foster and in some cases you have to build that capacity because it may not exist (Participant H).

Cooperative broad support within the community beyond the core leadership was emphasized as an important building block by half of participants. "You need broad community support for the work you are doing," noted one participant who was both a community leader and national stakeholder (Participant A).

Participants frequently (17 out of 20) mentioned the theme of resources within the community as a building block, but there was no consensus on how financial resources influenced capacity. Some participants stressed that financial resources were not synonymous with community capacity; others felt financial support was an essential building block. There was more consensus around human resources as an important component of resources within the community. Several participants used assets based language to "frame" capacity building in a manner similar to this participant's response related to capacity:

> I think we can easily deteriorate into assuming capacity equals dollars. That is a tragic flaw in reasoning because I think it will thwart you ever getting from zero to step one, so I think you have to frame the understanding of community capacity about what are the assets that all parts of this community can bring…(Participant B).

C. Recommendations for Curriculum Applications

Curriculum Research Questions: *How should this information be applied to curriculum development? At the master's program level? At the interdisciplinary certificate level? At the continuing education level?*

Themes related to recommendations for *curriculum applications* for learning experiences associated with this emerging area of practice generally fell into one of six categories: experiential learning; continuing education; infusion of material; certificates; specializations; and content and other curriculum issues.

Experiential learning was the most frequent curriculum recommendation. Participants making this recommendation (14 out of 20) strongly felt that to learn about this work it was necessary to engage at the community level in internships, practicum, shadowing or volunteer experiences. Examples of participant responses related to support for experiential learning included:

- "I think people would absolutely benefit from experiential opportunities: practicum, internships, volunteering. I think there is no substitute for the real world" (Participant B).
- "I think internships are great to just get a sense of how do I [do this] work if this is going to be a community role…working with communities is very different from the rest of my professional life..." (Participant S).

- "I do think that anybody who is interested in community change ought to be doing internships...where they begin to integrate and synthesize some of what they are learning in the classroom" (Participant F).
- "I mean internships, fellowships...really worked. People really understood this by being on the ground" (Participant M).

A participant who has been both a community leader and a national stakeholder proffered this rationale for experiential learning:

> I would recommend that students get connected into real work as quickly as possible through probably a series of ways. Whether you bring people into speak to the class who are actively doing the work or ask students to participate in some of the meetings or do formal internships…Here's why. This work tends to go up and down. [In working with community level approaches] you can have everything going great and then everything not going great. You have to learn how to stick with it, redirect when needed; organize in a different way; rephrase when possible – whatever it is going to be in order to keep it going. I would say those who are not used to seeing it happen [will not make it]. If you have seen how it happens you probably can make it (Participant A).

Another participant who has been both a community leader and a national stakeholder indicated that it was possible to structure experiential learning to be respectful of community dynamics and integrity by starting with "learning about the community particularly about older adults in the community" and "staying far away from any prescriptive work" (Participant D).

Continuing education was considered important by 12 participants because of the number of professionals already engaged in this work in communities and the number that will become so over the near term. As would be expected, participants discussed how to

make such information accessible via the web and other distance models as well as through professional development. Some participants also emphasized the potential for peer learning whether it was through peer mentors or community to community initiatives.

Themes of infusion of material, certificates and specializations described how material related to this area of practice should be included in academic curricula. The consensus among participants commenting on these themes was that infusing content about community level approaches to aging throughout curricula was a desirable goal. Seven participants explicitly recommended infusion and most participants encouraged interdisciplinary/cross disciplinary knowledge (18 of 20) as a related theme. One participant was a proponent of infusion across several disciplines:

> I think infusing all disciplines [is important] so infusing some type of gerontological content in maybe public administration programs or planning programs because of the growth of the older adult population would be important and then also in other programs like gerontology programs or maybe social work programs infusing some kind of either planning or evaluation or policy [content]…(Participant J)

A participant with a planning background noted, "It would be nice if we could find ways of mainstreaming [content about community planning for aging] so that everybody gets exposed not just the enlightened." That same participant also made the case for infusion into planning:

> I frankly think, and again it's a gross generalization, that the initiatives that we are seeing when we do a search on the internet are being led predominately by social service providers or aging advocates and not by planning specialists. And I would really like to see planning professionals step up to the plate and really understand at a gut level what this is all about so that we can get this aging perspective infused into mainstream planning (Participant H).

Additionally, several participants (6 out of 20) felt one way to encourage "cross pollination" among practitioners was to encourage students to seek certificates in disciplines that would add complementary knowledge and skills. For example, students in public administration might pursue a certificate in aging or students in gerontology might pursue one in nonprofit management or public health. Some participants had experience with certificate programs including one community leader who gave an example of a local government official with a certificate in aging who had had a positive impact on their community level approach.

Three participants also noted that there would need to be some academic specialization related to this work but that most people who do the work would not be trained at the specialist level. One participant touched on themes of infusion and specialization, as well as continuing education, in a response to the question on curriculum recommendations:

> My simple response is that there needs to be maybe three different things: One is that everybody who's getting a degree in planning or who's going to be in one of these kinds of roles needs to have some basic understanding of aging issues. [Two] to the extent possible there ought to be some folks who are trained as specialists who have the opportunity to really specialize in their discipline in the needs of older adults and [three] that probably the most productive short run [option] is for continuing education and finding ways to build in educational opportunities for people who are already out there (Participant K).

Another participant's response addressed curriculum applications in a similar manner:

> I guess my bias at this point is that…the starting point is to do this as infusion into existing programs and existing curricula and continuing education…but that ultimately community planning – building community capacity for aging populations – maybe, in fact, an interdisciplinary kind of specialty (Participant I).

Content comments: Some participants' responses to the curriculum question included information on content which was appropriate to incorporate into the competency development process.

D. Competencies and Associated Knowledge and Skill Areas

Knowledge Research Question: *What knowledge should targeted professionals possess?*

Skills Research Question: *What skills should targeted professionals possess*?

Competencies Research Question: *What competencies do such knowledge and skills suggest as useful for the targeted professionals to possess?*

Findings that directly addressed these three research questions associated with competencies for targeted professionals came from analysis of two sources: participant interviews and documents/web content that summarized characteristics of community level approaches to aging. Hence, this section of the chapter is divided into three parts to present findings from both of those sources and, finally, in part three, a discussion of the synthesis of the overall findings related to competencies.

From Participant Interviews

Participants were asked directly three questions related to competencies for targeted professionals during the phone interviews, and they provided very detailed responses. In general, they were asked what the targeted professionals should know, what they should be able to do and what competencies were suggested from those areas (see Interview Guide in Appendix II). Because, as noted in Chapter III in the description of the analysis of

participant interviews, participant responses frequently blended discussion of knowledge, skill and competency areas, open coding was conducted across all the responses related to the knowledge and skills that targeted professionals should possess and the associated competencies. That coding generated extensive lists that were then grouped into meaningful categories for further coding.

The categories to be used in the qualitative coding process were central to expressing an important overall product of this research: the suggested competency set for this emerging area of practice. It was impossible to develop a categorization framework that fit all the competency rubrics of the related disciplines (gerontology, public health, planning, public administration/policy and social work). The work of Gebbie on how to develop competencies provided guidance on developing a rubric for competency categories. She described competency domains "that have been used by a number of the groups developing new public health competency sets" (2004) and adopted by the Council on Linkages between Academia and Public Health Practice (mostly recently in May 2010). These domains were used to group "core competencies" that are "designed to serve as a starting point for academic and practice organizations to understand, assess and meet education, training and workforce needs" (Council on Linkages, 2010). The domains are:

- Community dimension of practice skills
- Leadership and systems thinking skills
- Policy development/program planning skills
- Analytic/assessment skills
- Public health sciences skills

- Cultural competency skills
- Communication skills
- Financial planning and management skills

For the purposes of this research, four of those domains (communication skills, analytic/assessment skills, cultural competency skills and community dimensions of practice) from the Council on Linkages groupings have been adopted directly for use. Another six domains have been created through adaptations/additions that help connect the domains to the roles played by the targeted professionals: financial planning/nonprofit management skills, planning skills, aging knowledge base, public policy/intergovernmental, social entrepreneurial skills and interdisciplinary knowledge and skills.

Table 6 provides a summary of the ten competency domains and indicates the number of participants that included the domain their response. In general, there was a great deal of consensus around competency domains by participants. At least 14 out of 20, or 70%, of participants identified 9 out of 10 domains. The specific domains of community dimensions of practice, aging knowledge base and interdisciplinary knowledge/skills were identified by at least 18 of 20 participants. Only six participants explicitly identified social entrepreneurial skills but that domain has some overlap with financial planning/nonprofit management.

Table 6: Competency Domains from Participant Interviews

Domain	Participant number	Percentage responding
Communication Skills	14	70
Analytic Assessment Skills	16	80
Cultural Competency Skills	16	80
Community Dimensions of Practice	18	90
Financial Planning/Nonprofit Management	15	75
Planning	17	85
Aging Knowledge Base	19	95
Public Policy/Intergovernmental	14	70
Social Entrepreneurial Skills	6	30
Interdisciplinary Knowledge/Skills	18	90
Public Health/Healthcare	12	60
Transportation/Mobility	9	45
Housing/Design	9	45
Economic	6	30
Land Use Planning	5	25

A more detailed summary from the participant interviews of the knowledge/skill areas associated with each competency domains appears in Table 8. For example, knowledge/understanding of community and community life, stakeholder analysis and convening and engaging stakeholders appear as knowledge/skill areas which are associated with the domain of community dimensions of practice. For the domain of interdisciplinary knowledge and skills, there are knowledge/skill areas associated with the domain itself as well as with the related knowledge areas of public health/healthcare, housing/design, land use planning, transportation/mobility and economic development.

When reviewing the competency domains and associated knowledge/skill areas, it is important to keep in mind that they relate to competencies that "cross-cut" disciplines rather than "core" competencies for any one discipline. The intended product of this research is a

suggested interdisciplinary competency set and related curriculum recommendations for professionals engaged in this emerging area of practice (as described by Gebbie, 2004). It is not intended to give birth to a new discipline or profession. An analogy from public health would be the work around an interdisciplinary competency set for professionals engaged in emergency preparedness and response (Subbarao, Lyznicki, Hsu, Gebbie, Markensen, et al, 2008). Thus, the items within the resulting competency domains focus on the roles and tasks associated with the emerging area of practice. They should not be thought of as a complete set of competencies for any one discipline.

From Document Analysis

As noted earlier, the research for this exploration of cross-cutting competencies included information gleaned from key informant interviews as well as analysis of document/web content. As described in Chapter III related to the methods used for document analysis, sources for documents/web content originated from two processes: the original literature review for this research and from resources to inform the study recommended by participants in response to an interview question. To meet the criteria for analysis, documents/web resources had to summarize characteristics of community level approaches to aging and have multi-site, national relevance. (See Table 2 for a summary of documents/web resources that were analyzed.) Other resources that were identified during these processes were used to expand the general literature available to this research. Analysis of the competencies suggested by characteristics of community level approaches to aging provided another perspective on the knowledge and skill areas needed by targeted professionals.

For the purposes of this study, the summaries of those characteristics of community level approaches were linked to knowledge and skill areas needed by targeted professionals via a qualitative coding process. For example, as described in Chapter III, a characteristic such as "a wide variety of appropriate housing options" reported by Alley et al (2007) as indicative of elder-friendly communities was linked with knowledge areas such as living arrangements, housing, disability, housing options for older adults, universal design, and the Americans with Disabilities Act.

Table 7 provides a summary of association between the ten competency domains (described above) and the characteristics of community level approaches across the documents/web resources that were analyzed. In order for an association to be coded as indicated, the association had to be direct. So the example characteristic of "a wide variety of appropriate housing options" (Alley et al 2007) would be linked to the housing/design area of the interdisciplinary domain but not to the financial planning/nonprofit management domain even though knowledge and skills from that domain would probably be used when developing housing options. Even using such fairly restrictive coding guidelines, the ten competency domains are associated broadly with the desired characteristics of community level approaches to aging as illustrated in Table 7. For eight out of ten domains, over half of the summaries of characteristics reflect those domains. The remaining two domains, financial planning/nonprofit management and social entrepreneurial skills, were identified in the document analysis less frequently. That simply may be because domains related to management skills are considered to be inherent in a characteristic and less likely, in general, to be articulated by the processes that promulgate characteristics. The "Unifying Principles"

of CPFOA and the "Guiding Principles" of the NORC Blueprint that did reflect both those management domains were less like the other summaries of characteristics. For instance, they were part of web-presences specifically designed to enhance the knowledge and skills of community leadership who were developing approaches.

Table 7: Competency Domains Associated with Characteristics of Community Level Approach to Aging (from document analysis characteristics review).

	AdvantAge Feldman / Oberlink, 2003	Alley et al, 2007	n4a, 2006	Arizona State AARP, 2005	Kochera for AARP, 2005	CPOA, Unifying Principles	AARP, Oberlink, 2008	UHF, NORC Blueprint	n4a, 2007
Domains:									
Communication Skills					■	■	■	■	■
Analytic Assessment Skills			■	■	■	■	■	■	■
Cultural Competency Skills		■	■	■	■	■	■	■	■
Community Dimensions of Practice	■	■	■	■	■	■	■	■	■
Financial Planning/Nonprofit Management						■		■	■
Planning	■	■	■	■	■	■	■	■	■
Aging Knowledge Base	■	■	■	■	■	■	■	■	■
Public Policy/Intergovernmental	■	■	■	■	■	■	■	■	■
Social Entrepreneurial Skills						■		■	
Interdisciplinary Knowledge/Skills	■	■	■	■	■	■	■	■	■
Public Health/Healthcare	■	■	■	■	■				■
Transportation/Mobility	■	■	■	■	■		■		■
Housing/Design	■	■	■	■	■		■		■
Economic	■		■	■			■		■
Land-use/Planning		■	■	■	■		■		■
Additional Interdisciplinary areas:									
Safety/Security	■	■	■	■	■				■
Culture/Recreation/Education	■	■	■	■	■				■

A more detailed summary from the analysis of characteristics of community level approaches of the knowledge/skill areas associated with each competency domains appears in Table 8. Knowledge/skill areas that were identified during the document/web content analysis that had not already been identified during the analysis of participant interviews are shown in *italics*. For example, under the public policy/intergovernmental domain, *local policy agenda development* was added to the knowledge/skill areas as result of the document analysis. Further, within the interdisciplinary domain, two additional knowledge area categories, *safety/security* and *culture/recreation/education* were added to reflect categories that were identified during document analysis.

Discussion of the Synthesis of Participant Analysis and Document Analysis:

By synthesizing the results of participant analysis and document analysis as illustrated in Table 8, "a more complete picture" (Farmer et al, 2006) emerges of a potential competency set for the targeted professionals who assist community level approaches to aging. If only the document analysis of characteristics had been conducted, the management domains, of financial planning/nonprofit management and social entrepreneurial skills, may not have been included. On the other hand, if only the participant analysis had been conducted, some of the detail of knowledge/skill areas would have been missing particularly with regard to the interdisciplinary knowledge areas.

In addition to completeness, Farmer and colleagues (2006) encouraged using such triangulation of methods and sources to assess convergence and dissonance as a part of qualitative analysis. Overall, there was a great deal of convergence of findings and little

dissonance within and among the participant analysis and document analysis. There was strong convergence around the domains of communication skills, cultural competency skills, community dimensions of practice, planning, aging knowledge base, public policy/intergovernmental skills and interdisciplinary knowledge and skills. Where there were differences, those differences were almost always about degree of emphasis rather than inclusion. For example, some participants stressed community dimensions of practice; others put more emphasis on analytic/assessment skills. Most participants, however, included knowledge/skills areas from both those domains in their overall response about what targeted professionals should know and be able to do. The one area where there was more dissonance was around service provision. As discussed in Section in A of this chapter under the nature of the work, most participants did not see service provision as a part of this emerging area of practice. For the NORC/Village model participants, however, service provision was more integral to their day to day practice. Hence, it is important to note that service provision to older adults was not included in the development of competencies in this research but may need to be addressed in future applications for professionals who will serve NORC/Village model community level approaches to aging.

Table 8: Competency Domains with Associated Knowledge/Skills Areas
(from Participant Interviews)
(*from Document/Web Content Analysis*)

Communication Skills (COMU)

- Interpersonal communication skills
- Writing
- Speaking/presenting
- Web/media presence
- Developing and implementing communication plan
- Internal/external communication skills
- Networking skills
- Specialized writing skills: Business correspondence, reports, grant proposals

Analytic Assessment Skills (ALYT)

- Understanding research and evaluation methodologies
- Analysis of community problems/issues
- Needs assessment techniques
- Environmental scan/asset mapping
- Development of logic models
- Information/technology literacy
- Data collection and analysis/research methods (qualitative and quantitative)
    - Interview skills
    - Survey research
    - Focus groups
- Measurement/evaluation (process/outcome/contracting for external)
- Understanding cost/benefit analysis

Cultural Competency Skills (CULC)

- Engaging with diverse groups
- Listening to community voices
- Helping underrepresented to be heard
- Life experiences of diverse older adults aging in community
- Cultural context of aging
- *Understanding of culturally responsive services*
- *Recognizing and responding to the unique needs of older adults*

Community Dimensions of Practice Skills (COMM)

- Knowledge/understanding of community and community life
- Stakeholder analysis
- Convening and engaging stakeholders
- Facilitating groups/running meetings
- Volunteer coordination
- Knowledge base of community organizing and community change process

Understanding community development
Assessing community readiness
Knowledge of community services and supports
Engaging with community leaders
Community leadership development (including older adult leadership)

Financial Planning and Nonprofit Management Skills (FPNM)

Organizational development
    Board development and governance
    Group/organizational dynamics
Development of agreements among entities
    (including partnerships/coalitions)
Finance/budgeting/accounting
Resource development/sustainability
    Grant finding/writing
    Tapping social capital
Implementation/operations
Human resources
Contracting
Project management skills

Planning Skills (PLAN)

Strategic planning
Community planning
Program planning
Implementation planning

Aging Knowledge Base (AGEB)

Psychological, social and physical aspects of aging
Demographics of individual, community and societal aging
Challenges/barriers associated with aging in place/in community
Changing demographics of communities related to boomer cohort
Aging policy and the Aging Services Network
Aging services and supports
Organization and trends in home and community-based services
Organization and trends in long term care services
Philosophy of person-centered care
Medicare/Medicaid policy
Understanding benefits available to older adults
Adult learning principles/lifelong learning
Civic engagement of older adults including volunteerism
Contributions of older adults to communities
Knowledge of evidence-based aging programs
Implications of transitions in late life

Understanding of basic needs of older adults
Family caregiving issues and services

Public Policy and Intergovernmental (PPIG)

Understanding the role that government plays in lives of older adults
Understanding the broad policy context
Framing issues/initiatives
Navigation in the policy arena across levels
Working with government officials
Policy advocacy
Local government organization and function
Local policy agenda development

Social Entrepreneurial Skills (ENTR)

Business planning and development
Membership/customer service
Vetting providers
Understanding the innovation process

Interdisciplinary Knowledge and Skills (INTE)

Identifying/understanding/assessing/applying evidence
Understanding language of related disciplines
Translational/training skills
Knowledge of health and human service systems
Identifying/engaging with knowledgeable people across disciplines
Knowledge of people's needs across the lifespan

Key interdisciplinary knowledge areas (in addition to aging):

Public Health/Healthcare (PHH):

Health care policy
Organization and financing of service delivery
Population-based health
Chronic disease issues
Healthy aging/value of health promotion
HIPAA
Preventive health services
Palliative care services
Mental health services
Services for people with dementia and their caregivers

Housing/Design (HOU):

Housing types/living arrangements options
(including affordability)
Relation of housing to service and supports
Accessory dwelling units
ADA
Universal design
Visitability
New Urbanism
Livable communities
Dynamics of moving vs. nonmoving
HUD housing programs
Senior housing's relation to zoning issues
Home modification/repair options

Land Use Planning (LAN):
Implications of an aging society for built environment
Mixed land use
Zoning/codes/ordinances
Local nature of land use planning
Smart Growth
Integration of residential/service uses
Impact on availability of options

Transportation/Mobility (MOB):
Mobility issues among older adults
(including accessibility and affordability of options)
Pedestrian travel
Needs of older drivers
Transportation to medical services
Road design/signage issues
Traffic control issues
Walkability
Complete Streets
Transit oriented development
Paratransit

Economic Development (ECN):
Economic development impact of an aging society
(including economic well being of older adults)
Older worker issues
Frontline worker issues
Housing market issues

Energy use and assistance
Taxation issues (including property tax relief)
Financial fraud/predatory lending
Older adults as consumers within communities

Additional Interdisciplinary Areas from Community Characteristics Analysis:

Safety/Security:
Personal Safety Issues
Neighborhood/community safety
Home safety
Elder abuse issues
Emergency preparedness/evacuation planning issues
Community design features that promote safety

Culture/recreation/education:
Healthy living (including wellness programs)
Tailoring exercise classes to health concerns
Age-appropriate equipment and facilities (including walking/biking trails)
Availability/accessibility of cultural/educations services (including libraries)
Senior center development: current and future

Chapter V
Conclusions and Recommendations

This chapter presents the conclusions from the findings of this research from both conceptual and applied practice perspectives and recommendations based on those findings and conclusions. It is organized into three parts: (A.) Support for Conceptual Framework; (B.) Conclusions about this Applied Area of Practice; and (C.) Recommendations.

A. Support for Conceptual Framework

The introduction to this dissertation began with the premise that communities are the frontline of response to the challenges and opportunities of an aging society. It went on to specify that the ultimate aim of this applied research is to enhance community capacity to address the issues of an aging society through competency development for professionals working in communities. Community capacity was defined as:

> The commitment, resources, and skills that a community can mobilize and use to address community issues and problems and strengthen community assets; the characteristics of communities that affect their ability to identify and address social and economic health issues; the cultivation and use of transferable knowledge, skills, systems, and other resources to affect community—and individual—level change (Baker, Davis, Gallerani, Sanchez & Viadro, 2000).

Using that definition and the work of Foster-Fishman and colleagues (2001) who linked "collaborative capacity" to competencies within communities, the conceptual framework

related building community capacity to address the aging of communities to developing competencies in the professionals who assist community level approaches to aging. The findings supported such a relationship. Participants identified core leadership as a building block for community capacity. They described in detail how the professionals facilitated the work of that core leadership particularly through convening and engaging community stakeholders. Further, some participants linked another building block of community capacity, the community's openness to change, to support of a community change process by these professionals via the professionals' community organizing role. Professionals were also seen as helping to foster broad cooperative support and to develop resources within the community to help communities learn about themselves and their options for change.

Many of the knowledge and skills areas identified in this research were common to those identified by Foster-Fishman and colleagues (2001) including ones related to communications, implementation, evaluation and community change. Additionally, Foster-Fishman et al (2001) found the need for competence in understanding "the problem domain," "targeted problem," and "target community" (Foster-Fishman, et al, 2001). In the case of this research, the community issue/problem domain is the aging of communities and the sets of competencies (knowledge and skills) relate to the professionals who are helping community members use information and other assets to design solutions (McKnight, 1994) related to community level approaches to aging; thus, building community capacity. Participants in this research described the deep community dimensions of the nature of the work of the professionals and their need for knowledge and skills about community practice (Weil, 2005) as well competence in analysis and assessment of community issues. Further,

participants identified the need for professionals to know the older adult population in ways that go beyond the "stereotypes" of old age and to be able to "translate" that knowledge across disciplines.

The conceptual model for this research also linked enhanced capacity in communities to address aging with the long-term outcomes of elder-friendly communities; available, accessible, affordable care for frail older people; and more livable communities for all ages. (See visual representation in the logic model found in Figure 3 in Chapter II.) Goodman et al (1998) summarized an expert consensus process on community capacity that concluded: "The level of community capacity may be lower in the absence of skills to produce and implement quality plans." This research identified roles of planning and nonprofit management and related competency domains for professionals that should enhance skills for planning and implementing innovative community level approaches to aging. The ultimate gauge of those long term outcomes, however, is not what plans have been developed or even what plans have been implemented but whether enhanced capacity will lead to positive and sustained community level change with respect to the aging of communities.

B. Conclusions about this Applied Area of Practice

Faculty and trainers who are involved in educating professionals for applied areas of practice often assume that we know what to teach to enhance such practice. Competency-based education, however, encourages us to be more deliberate about connecting what professionals do with the knowledge and skills they need to perform in those roles. That is a challenging undertaking, however, when the area of practice is very new. The findings from

this research help to inform such deliberations around the emerging area of practice of assisting community level approaches to aging.

Participants, who have either performed in this area of practice or worked closely with those who do, described in detail the professionals roles associated with it, other aspects of the nature of the work and the knowledge/skills (competencies) needed to perform such work. One participant indicated that as stakeholders who work closely with community level approaches to aging, participants will probably already be aware of many of its findings, but the "due diligence" of this research is important to systematically record and share such information more broadly.

What can be concluded from this research about the emerging area of practice of assisting community level approaches to aging?

- *Diverse roles*: Professionals who engage in this area of practice play a number of diverse roles typically including convener/facilitator, translator across disciplines, planner, nonprofit manager and resource connector. Further, their roles relate to knowing the population of older adults and navigating the policy/intergovernmental arena. They also may play community organizer, social entrepreneur or service provider roles.
- *Process and community characteristics matter*: Participants emphasized the *process* of developing community level approaches to aging and what competencies professionals needed to effectively assist that process. The results of the analysis of the characteristics of community level approaches to aging helped to describe the potential outcomes of such a process.

- *Interdisciplinary:* Participants emphasized that this area of practice is truly interdisciplinary and that few individuals are likely to have the full complement of competencies required as a result of graduate education programs from the targeted disciplines as currently configured.

C. Recommendations

The cross-cutting competency set from this applied research is presented here as a starting point for further discussion and development within and among the targeted disciplines and more broadly in the policy arena. Developing a cross-cutting competency set for an emerging area of practice is not a solitary endeavor. No competency set such as the one presented here should come into use more widely without being fully vetted through an interdisciplinary consensus process. Chapter VI presents an implementation plan that may lead to such a process.

While such a process takes shape, this research contributes to a foundation of information available to faculty and trainers who are encouraged to use it to better understand the roles played by professionals who assist community level approaches and to develop learning experiences for such professionals. There are myriad opportunities to begin or continue infusion of knowledge and skills relevant to community level approaches to aging across disciplines.

Chapter VI
IMPLICATIONS FOR POLICY AND PRACTICE: BEYOND STEREOTYPES AND ACROSS SILOS

Participants in this qualitative study made a compelling case for interdisciplinary training for the professionals who help America's communities plan and mobilize to address the aging of society. They emphasized that the very nature of the work is interdisciplinary and complex: Sustainable outcomes on the scale required depend on working across the "silos" of disciplines and beyond the "stereotypes" of old age to create innovations with deep community dimensions within the larger policy context.

My plan for change related to the implementation of the findings of this research focuses on its policy and practice implications. Three bodies of scholarship from my study of public health leadership have had a major influence on the path of my work and will continue to guide its implementation: Kingdon on the theory of policy making (2002; 2003); Rogers on the diffusion of innovation (2002); and Bowles and Gintis (2002) on the complementary nature of communities, governments and markets.

A "policy window" as described by Kingdon (2002; 2003) is open around community level approaches to aging: As the implementation of national health care reform continues to unfold, communities remain the setting where older adults and their caregivers prefer to receive care and support (Bayer & Harper, 2000; Kane & Kane, 2001) and where services

can effectively be delivered (e.g. Mollica, Kassner, Walker & Houser, 2009). Recent federal initiatives, including AoA's Community Innovations for Aging in Place (AoA, 2009), CMS's Medical Home Demonstration Program (CMS, 2009a), the Medicare Health Care Quality Demonstration Programs (CMS, 2009b), CDC's Healthy Aging Programs (CDC, 2009) and the joint AoA/CMS Aging and Disability Resource Centers Program (HHS, 2009) focus on community linkages. Most recently, the Patient Protection and Affordable Care Act (2010) expanded funding for ADRC's and emphasized, in a "Sense of the Senate" statement, community settings for the provision of long term services and supports. Further, health care and built environment issues intersect at the community level (Scharlach, 2009a and 2009b) in efforts to encourage livable communities which promote healthy aging and the prevention and management of chronic conditions (e.g. AoA, 2005; CDC, 2009; Kochera, Straight & Guterbock, 2005; n4a, 2007). Four examples from around the United States illustrate those intersections. The Lifelong Communities initiative of the Atlanta Regional Commission has addressed goals to promote housing and transportation options and to encourage healthy lifestyles through community planning and design efforts (Lawler & Berger, 2009; Ory, Liles & Lawler, 2009-2010). In the community of Manchester, New Hampshire, a recent policy initiative has linked a community level approach to aging to priority goals for caregiver support, livable communities and the creation of medical homes for older adults (Seniors Count, 2009). Smith, Tingle and Twiss (2010) of the Center for Civic Partnerships of the Public Health Institute have introduced a new toolkit for "aging well in communities" in the ICMA publication, *Public Management.* In that toolkit, the Center for Civic Partnerships, which hosts both California Healthy Cities and Communities and Healthy Aging initiatives,

encourages local governments to act as "convener and facilitator" for planning efforts focused on aging well (Center for Civic Partnership, 2010). In North Carolina, current "senior-friendly" state planning initiatives have gubernatorial and legislative support which encourages cooperation among gerontologists and planners at the university level to provide information to local governments on "model local planning efforts" (State of North Carolina, Office of the Governor, 2010; NC Session Law 2009-407). These examples illustrate in various stages the elements of problem definition, policy options and political will that Kingdon (2002; 2003) indicates are necessary for a policy window to open. Comprehensive policy development around communities and aging, however, is still in early stages and spread among local, state and national initiatives.

Rogers (2002) defined implementation simply as "when an individual (or other decision-making unit) puts an innovation to use." This applied research focused on the practice side of policy formulation: developing competencies in professionals across disciplines to assist community initiatives. It has the potential to inform an interdisciplinary research and training agenda that can help community level approaches to aging to move beyond the "stereotypes" and the "silos" described by participants. First, however, decision-makers have to learn about the findings and decide to act on them in some manner.

My initial action plan is to share my findings with three key audiences:

- The first audience is professionals who identify with the field of aging. Such professionals may be gerontologists or professionals from other disciplines such as public health and social work who have specializations in aging. They

form a base group of interest and support for the importance of this emerging area of practice. Additionally, because gerontologists, in general, emphasize the interdisciplinary nature of the study of aging, there is an interdisciplinary base from which to build.

- The second audience is professionals among the relevant disciplines who do not identify currently with the field of aging including professionals from public health, planning, public administration and social work. It will be critical to take the information to such professionals and not expect them to reach out to retrieve it from aging-oriented sources.

- The third audience is the professionals who are the experts associated with this emerging area of practice including the national stakeholders and community leaders who were participants in this study and their colleagues.

The methods of communicating with all three audiences will be similar and include presentations at conferences, publications in practice-oriented literature and personal communications with opinion leaders within each discipline. The goal will be to create a synergy among the three audiences from which a process to consider interdisciplinary education and training, including competency development, will emerge. Using Rogers (2002) concept of diffusion of innovation, the third audience is in the position to become both "early knowers" about the innovation and "early adopters" of it and to help to "diffuse" information about it to the other audiences who are then more likely to "adopt" or use the information later. Rogers (2002) also describes the process of "reinvention" where adopters

take an innovation and modify it to make it more useful to them. My research has been at such an early stage in the development of a body of knowledge around community level approaches to aging that I fully expect it will be only one piece to inform a competency development process that goes through several stages of reinvention.

In the meantime, widespread dissemination efforts will also provide information to individual faculty and trainers to be used in infusing content related to community level approaches to aging in coursework and experiential learning. Those individuals can make their own choices about whether to adopt information from my findings that is useful to their teaching. I plan to seek support to develop and maintain web-based curriculum development resources related to practitioners who are working with community level approaches to aging. In addition to this dissertation, a report summarizing results and featuring the suggested set of competencies will be prepared for web-based distribution. Further, other resources that were identified during this research that will be useful to faculty and trainers doing curriculum development will be annotated and organized into a website that is visibly placed, strategically linked and well-publicized among the three key audiences noted above.

The model for this site will be the Gero-Ed Center site of the Council on Social Work Education (www.cswe.org). The Council on Social Work Education through its National Center for Gerontological Social Work has had a detailed effort aimed at infusing aging content across social work curricula. The CSWE Gero-Ed Center with funding from John A. Hartford Foundation is deeply engaged in promoting social work education related to aging based on articulated competencies. The work of the CSWE initiative and its web-based resource center suggest a number of creative modalities for sharing innovative curriculum

recommendations. The development of the Gero-Ed Center was a large and multi-site initiative, which this research cannot replicate directly, but the web-based curriculum sharing, including definitions of competencies that resulted from the work of the CSWE, provides a model for sharing the results of this research. (National Center for Gerontological Social Work Education, n.d.; Special Issue, *Journal of Gerontological Social Work*, Volume 48: 1-2, 2007).

Finally, my role in implementing these findings as well as my career path is influenced by the work of political economists Bowles and Gintis (2002) on communities. They describe the complementary nature of communities, markets and central governments. For them, communities are not utopian units where only good can be done but entities that complement what markets and central governments can do. Neither one of the three is necessarily bad or good, according to Bowles and Gintis, each simply has different potential to address aspects of human needs (Bowles & Gintis, 2002). Participants in this research made a similar case when they encouraged us to imagine what communities can do to address the aging of society.

APPENDIX I: DEFINITIONS

Baby Boom cohort: The demographic cohort representing individuals born between 1946 and 1964.

Built environment: Alley et al (2007) define *built environment*, using the National Institute of Environmental Health Sciences (www.niehs.nih.gov) definition as "Those aspects of our environment that are human modified such as homes, schools, workplaces, parks, industrial areas, farms, roads and highways." Srinivassan, et al (2003), writing in the *American Journal of Public Health* on a research agenda for the built environment and public health in relation to the Healthy Communities movement, modified Health Canada's definition of the built environment to include the following: "The built environment encompasses all buildings, spaces and products that are created or modified by people. It impacts indoor and outdoor physical environments (e.g. climatic conditions and indoor/outdoor air quality), as well as social environments (e.g. civic participation, community capacity and investment) and subsequently our health and quality of life."

Chronic disability: Manton (2008) defines the chronic disability "threshold" as impairment in activities of daily living (e.g. bathing, dressing, eating) or instrumental activities of daily living (e.g. meal preparation, managing money, using transportation) lasting 90 days or more. Chronic disability is different than a chronic illness, such as cardiovascular disease, diabetes or hypertension. Chronic illnesses may, or may not, lead to limitations in activities in daily living.

Collaborative capacity: "Conditions needed for coalitions to promote effective collaboration and build sustainable community change" (Foster-Fishman, Berkowitz, Lounsbury, Jacobson & Allen, 2001).

Community: For the applied purposes of this research, community will be defined simply drawing on the definition of the AARP Beyond 50 series: "People living within a specific area, sharing common ties, and interacting with others." Practically, this definition will frequently lead to a community being equivalent to a town, city or county. While there are many possible ways to define community, some of which transcend geopolitical boundaries, for the purposes of this research this definition is in sync with the way in which communities are mobilizing to address aging issues at the local level across the United States.

Community capacity: The Center for the Advancement of Community Based Public Health (Baker, Davis, Gallerani, Sanchez & Viadro, 2000) CDC funded guide to evaluation of community health programs defines community capacity as: "The commitment, resources, and skills that a community can mobilize and use to address community issues and problems and strengthen community assets; the characteristics of communities affect their ability to identify and address social and economic health issues; the cultivation and use of transferable knowledge, skills, systems, and other resources to affect community—and individual—level change."

Community leaders: For the purpose of this research, a community leader (who will be interviewed) is a leader from a frontrunner community who has either been in a staff leadership role or worked closely with staff as a voluntary leader while a community

approach to aging was planned, developed and/or implemented. The role may have been either compensated or uncompensated and may have been acquired via employment, appointment or civic engagement. It is anticipated that such community leaders (interviewees) may include (but not be limited to) council on aging board members, council on aging directors, city council members or aldermen, county commissioners, city or county managers and planners, public health directors, business persons, United Way executives, civic club leaders, clergy, health system leaders, etc.

Community level approach to aging: For the purposes of this research, a community level approach to aging occurs when there is collaborative planning and mobilization to address the aging of a community across settings, services and organizations, clearly, going beyond the staff efforts of one organization or entity. Many different terms are used at the local level to label such approaches including partnerships, coalitions, collaboratives, initiatives, task forces, etc. Additionally, approaches may be associated with broader initiatives such as naturally occurring retirement communities, livable communities or senior or elder friendly communities.

Competency: This research will use the definition of competency (with respect to curriculum development) employed by the Council of the National Postsecondary Education Cooperative (Jones, Voorhees, & Paulson, 2002) adopted by other groups including the Council on Education in Public Health: "[T]he combination of skills, abilities, knowledge needed to perform a specific task." The NPEC further notes that: "Competencies are the result of integrative learning experiences in which skills, abilities, and knowledge interact to

form bundles that have currency in relation to the task for which they are assembled" (Jones, Voorhees, & Paulson, 2002).

Competency-based education: An educational experience where learning outcomes are specified for students in relation to the competencies they should be able to demonstrate after completing the experience.

Competency sets: A related group of educational competencies which may be organized around degree requirements, position requirements or the requirements for specific areas/tasks. For example, in public health there are competencies sets for for MPH programs (degree), health educators (position) and emergency preparedness (specific area/task).

Core competencies: Competency sets which are generally associated with the basic requirements for a degree or a position.

Elder-friendly community: "Generally refers to a place where older people are actively involved, valued and supported with infrastructure and services that effectively accommodate their needs" (Alley, Liebig, Pynoos, Banerjee & Choi, 2007). Alley and colleagues (2007), however, note that there is no uniform definition of the term. Further, several other similar terms are used frequently in the literature including "senior friendly" and "elder-ready." "Senior-friendly" is often used to describe communities which have features that make them "friendly" to current older residents. Being "elder-ready" implies a degree of planning and preparedness for coming waves of older adults. But these terms and other similar ones are often used interchangeably.

Frontrunner community*:* For this research, a community that has been recognized by a national initiative as having planned and mobilized to take a community level approach to aging.

Key national stakeholders: For this research, key national stakeholders will include practice and academic leaders who have assisted or encouraged community level approaches to aging across multiple communities and states.

Livable community*:* The AARP Beyond 50 series defines "livable community" as "one that has affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life." (Kochera et al, 2005). Discussion around the livable communities movement frequently notes that such communities are good for people across the age spectrum leading to such terms as "ageless communities" or "communities for all ages."

Naturally occurring retirement communities (NORCs): Housing complexes or neighborhoods where residents are aging over time resulting in a relatively high proportion of older adult residents. Term originally introduced by Hunt and Gunter-Hunt (1985).

Social capital: From Kawachi and Berkman (2000), social capital can be defined "as the resources available to individuals and groups through their social connections in their communities."

Targeted professionals: For this research, professionals who act in staff (or similar consultative) roles to community level approaches to aging. Examples of such professionals

include staff of councils on aging or area agencies on aging, city/county planning staff, public health planners and program directors, city/county management staff and United Way planners and program directors. Note: It is anticipated that in most communities there will be overlap between the pool of community leaders and targeted professionals.

Village model of naturally occurring retirement communities: NORCs where residents have organized through grass roots/self-help type activities to arrange for the services and activities that will help members to continue to stay in their homes.

APPENDIX II: MATERIALS RELATED TO KEY INFORMANT INTERVIEWS

A. Scripts of Email and Phone Recruitment Messages

B. Factsheet on Study

C. Interview Guide for Key Informant Interviews

A. SCRIPTS OF EMAIL & PHONE RECRUITMENT MESSAGES

[Informational note: Below are the scripts for messages (original and follow-up) that will be used to recruit participants for this study. At any point at which the potential participant declines to participate no further contact will be made.]

[First email contact message.]
Date: [Insert date sent]

To: [Potential participant's email address]

From: Sandra Crawford Leak, MHA
DrPH Candidate
Health Policy and Management
Gillings Global School of Public Health
The University of North Carolina at Chapel Hill

Re: Community Level Approaches to Aging Study: Developing Educational Competencies for Professionals. UNC DrPH Candidate Research.

Attachment: Factsheet for Potential Participants

By way of introduction, my name is Sandy Crawford Leak, and I am a doctoral student in Health Policy and Management at the Gillings Global School of Public Health at The University of North Carolina at Chapel Hill. I am contacting you regarding a study I am conducting related to helping build community capacity to approach the aging of society. The specific aim is to explore the knowledge and the skills needed by professionals who help communities plan, develop and implement ways to address growing numbers of older residents. Information about the knowledge and skills will be used to suggest educational competencies for such professionals as a starting point for interdisciplinary curriculum development.
Because of the work you have done related to community level approaches to aging, I would like to set up an interview with you to help inform this study. Interviews will be by phone and take approximately 45 to 60 minutes. For your reference, I am attaching a two-page fact sheet to provide you with more information about the study.

Please let me know by response to this email whether you do or do not agree to participate by [insert date one week hence]. If you do agree to participate, please include your contact information for my use in scheduling a time for the interview. Additionally, if you have any questions related to participating in the study, please feel free to contact me via email or by phone at 919.630.2597.

The insights of stakeholders like you, who have worked with community level approaches to aging, are important to include in this study. Many thanks for your consideration.

******

[Phone Contact Messages if no response to first email contact after one week.]

[If potential participant answers:] Hello, my name is Sandy Crawford Leak and I am doctoral student in public health at the University of North Carolina at Chapel Hill. I contacted you by email about a week ago with regard to a research study I am conducting on developing educational competencies for professionals who assist community level approaches to aging. Because of the work you have done related to community level approaches to aging, I would like to set up an interview with you to help inform this study. Interviews will be by phone and take approximately 45 to 60 minutes. The email that I sent had a factsheet attached that gives additional important information about the study and your potential participation in it. Have you read the factsheet? [If yes] do you agree to be interviewed? [If no] would you like me to resend that factsheet to you by email? Or another method? Are you prepared to schedule an interview at this time? Or would you like me to contact you again? What would be the best method to contact you? Do you have any questions for me at this time?

[If potential participant does not answer, and there is a voicemail option:] Hello, my name is Sandy Crawford Leak and I am doctoral student in public health at the University of North Carolina at Chapel Hill. I contacted you by email about a week ago with regard to a research study I am conducting on developing educational competencies for professionals who assist community level approaches to aging. Because of the work you have done related to community level approaches to aging, I would like to set up an interview with you to help inform this study. Interviews will be by phone and take approximately 45 to 60 minutes. The email that I sent had a factsheet attached that gives additional important information about the study and your potential participation in it. I will send out another email message to you within the next week. In the meantime, if you have questions, or to schedule an interview, please feel free to call me at 919.630.2597.

*****

[Second Email Contact Message if no response to first message.]

Date: [Insert date sent]
To: [Potential participant's email address]

From: Sandra Crawford Leak, MHA
DrPH Candidate
Health Policy and Management
Gillings Global School of Public Health
The University of North Carolina at Chapel Hill

Re: Second Request: Community Level Approaches to Aging Study: Developing Educational Competencies for Professionals. UNC DrPH Candidate Research.

Attachment: Factsheet for Potential Participants

About two weeks ago, I sent the email message below to you. The purpose of that message was to invite you to participate in a study that I am conducting related to developing educational competencies for professionals who assist community level approaches to aging. The insights of stakeholders like you, who have worked with community level approaches to aging, are important to include in this study. Please consider participating.

If you do agree to participate, please reply to this message by [insert date one week hence]. Please include in that message your contact information for my use in scheduling a time for the interview. Additionally, if you have any questions related to participating in the study, please feel free to contact me via email or by phone at 919.630.2597. Many thanks.

INFORMATION FROM ORIGINAL MESSAGE: By way of introduction, my name is Sandy Crawford Leak, and I am a doctoral student in Health Policy and Management at the Gillings Global School of Public Health at The University of North Carolina at Chapel Hill. I am contacting you regarding a study I am conducting related to helping build community capacity to approach the aging of society. The specific aim is to explore the knowledge and the skills needed by professionals who help communities plan, develop and implement ways to address growing numbers of older residents. Information about the knowledge and skills will be used to suggest educational competencies for such professionals as a starting point for interdisciplinary curriculum development.

Because of the work you have done related to community level approaches to aging, I would like to set up an interview with you to help inform this study. Interviews will be by phone and take approximately 45 to 60 minutes. For your reference, I am attaching a two-page fact sheet to provide you with more information about the study.

*****

[If no response to second email attempt, final attempt will be made to contact participant by phone:]

[If potential participant answers:] Hello, my name is Sandy Crawford Leak and I am doctoral student in public health at the University of North Carolina at Chapel Hill. I have contacted you by email recently with regard to a research study I am conducting on developing educational competencies for professionals who assist community level approaches to aging. Because of the work you have done related to community level approaches to aging, I would like to set up an interview with you to help inform this study. Interviews will be by phone and take approximately 45 to 60 minutes. The email that I sent had a factsheet attached that gives additional important information about the study and your potential participation in it. Have you read the factsheet? [If yes] do you agree to be interviewed? [If no] would you like me to resend that factsheet to you by email? Or another method? Are you prepared to schedule an interview at this time? Or would you like me to contact you again? What would be the best method to contact you? Do you have any questions for me at this time?

[If potential participant does not answer, and there is a voicemail option:] Hello, my name is Sandy Crawford Leak and I am doctoral student in public health at the University of North Carolina at Chapel Hill. I have been attempting to contact you with regard to a research study I am conducting on developing educational competencies for professionals who assist community level approaches to aging. Because of the work you have done related to community level approaches to aging, I would like to set up an interview with you to help inform this study. Interviews will be by phone and take approximately 45 to 60 minutes. The email message that I sent to you had a factsheet attached that gives additional important information about the study and your potential participation in it. I will be glad to resend that message to you and answer any questions you may have, but I need to hear from you within the next week if you wish to consider participating in this study. Please respond to the email message or call me at 919.630.2597.

B. FACTSHEET ON STUDY

FACTSHEET FOR POTENTIAL PARTICIPANTS

Study Title: Building community capacity to meet the needs of our aging society: Interdisciplinary competency development for professionals.

Sample document follows.

UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

DEPARTMENT OF HEALTH POLICY AND MANAGEMENT
1101 MCGAVRAN-GREENBERG HALL
CAMPUS BOX 7411
CHAPEL HILL, 27599-7411

T 919.966.7350
F 919.966.6961
www.sph.unc.edu/hpm

PEGGY LEATT, PhD
Chair

LAUREL FILES, PhD, MBA
Associate Chair

IRB Study #: 09-1476

Title of Study: Building Community Capacity to Meet the Needs of Our Aging Society: Interdisciplinary Competency Development for Professionals

Principal Investigator: Sandra Crawford Leak, MHA (scleak@email.unc.edu)

UNC-Chapel Hill Department: Health Policy and Management/School of Public Health

Faculty Advisor: Pam Silberman, JD, DrPH (pam_silberman@unc.edu)

Study Contact Telephone Number: 919.630.2597

Study Email Contact: scleak@email.unc.edu

FACTSHEET FOR POTENTIAL PARTICIPANTS

Summary: The purpose of this research study is to help build community capacity to approach the aging of society. The specific aim is to explore the knowledge and the skills needed by professionals who help communities plan, develop and implement ways to address growing numbers of older residents. Information about the knowledge and skills will be used to suggest educational competencies for such professionals as a starting point for interdisciplinary curriculum development (including the disciplines of gerontology, public health, planning, public administration and social work). Data will be collected from three sources: interviews with national stakeholders; interviews with leaders from communities that have already taken steps to address growing numbers of older adults; and documents/web-based resources. About 20 people will be interviewed for this study. The results of this study will be shared widely through presentations, publications and web-based resources.

Definition of educational competency: "The combination of skills, abilities, knowledge needed to perform a specific task." From the Council of the National Postsecondary Education Cooperative (Jones, Voorhees, & Paulson, 2002).

Who is conducting this study: Sandra Crawford Leak, MHA, is the principal investigator for this study. She is a candidate for a doctorate of public health degree (DrPH) in the Department of Health Policy and Management, Gillings School of Global Public Health, University of North Carolina at Chapel Hill. This research is part of her dissertation process in fulfillment of that degree. Pam Silberman, JD, DrPH, Clinical Associate Professor, is her faculty advisor and committee chair

(pam_silberman@unc.edu). Other members of her doctoral committee include Suzanne Havala Hobbs, DrPH, Clinical Associate Professor, and Peggye Dilworth-Anderson, PhD, Professor, and adjunct faculty members Elise J. Bolda, PhD, and Dennis Streets, MPH.

Funding: This study is self-funded by the principal investigator.

Participant Selection: You were selected to be interviewed for this research because of your position as a national stakeholder in the education of professionals who assist community level approaches or because of your position as a leader in a community that has taken steps to address growing numbers of older adults.

More about what it means to participate: Interviews will be conducted by phone and take approximately 45 to 60 minutes. At the time of your interview, you will be asked for verbal consent to be interviewed and to record the session. Transcriptions will be made of recorded interviews and analyzed using software designed for such purposes. All recordings, transcriptions and other electronic or hardcopy storage of data will be designed to assure the integrity of the data. Participation is completely voluntary. If you agree to be interviewed, you may withdraw your consent at any time for any reason.

Risk related to participating in this study: Because of the educational/curriculum development nature of the information being collected in this study, participants are expected to encounter no more than nominal risk. Risk is expected to be no more than you would encounter in the course of your normal professional activities.

Benefits related to participating in this study: As a participant in this study you will not receive any compensation for your time or any other specific benefit as an individual. In general, this study is expected to be of benefit to society by building the capacity of community level approaches to aging through enhanced competencies in the professionals who assist those approaches.

Confidentiality: Both your name as a participant and the name of any organizations with which you are affiliated or communities with which you work will be held confidential. It is, however, important to this study to give the audience for its results information about the range of stakeholders who participated. General aggregate information about the categories of participants (e.g. gerontologists, planners, etc.) and the categories of their organizational affiliations (e.g. governmental, nonprofit, academic, etc.) will be presented as results are disseminated. In addition, very general information about the range of communities represented in terms of geographic region (e.g. North, West, South, Midwest, etc.) and size (metro vs. non-metro) will be shared.

What if you have questions about this study? You have the right to ask, and have answered, any questions you may have about this research. If you have questions, or concerns, you should contact me at 919.630.2597 or scleak@email.unc.edu. You may also contact my advisor, Pam Silberman, JD, DrPH, at pam_silberman@unc.edu.

What if you have questions about your rights as a research participant? All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject you may contact, anonymously if you wish, the Institutional Review Board at 919.966.3113 or by email to IRB_subjects@unc.edu.

Last updated: August 5, 2009

C. INTERVIEW GUIDE FOR KEY INFORMANT INTERVIEWS

Introduction: Thank you for agreeing to talk with me. As I indicated when we scheduled this interview, I am a doctoral student at the School of Public Health at the University of North Carolina in Chapel Hill, NC. My research interests focus on communities that are planning and mobilizing to address the aging of their populations and the professionals who help them with such efforts. The aim of this study is to explore the knowledge and skills needed by such professionals. The results of my work will include a suggested set of educational competencies for professionals working in this area. It might be helpful for you to know that I use the term community level approaches to aging to describe a variety of community responses including elder or senior friendly community initiatives, livable communities and naturally occurring retirement communities.

Consent questions: (1) Did you receive the factsheet about the study? (2) Do you have any questions for me about the study or your participation in it? (3) Do you agree to participate by being interviewed? (4) Do you agree for this interview to be recorded?

[Once taping has begun]: For the record: (1) Did you receive the factsheet about this study? (2) Did you have an opportunity for any questions you might have about the study or your participation in it to be answered? (3) Do you agree to participate by being interviewed? (4) Do you agree for this interview to be recorded?

Main Questions

1: Please describe **how you and _____ [organization if relevant] have been involved with the development of community level approaches to aging**? Examples of community level approaches to aging include elder friendly community initiatives, livable communities and naturally occurring retirement communities. [Probe:] Developed approach at the community level; offered technical assistance to approaches; provided financial support; collected info/wrote report, otherwise served as a leader or staff for a national or local initiative.

2: a. Please discuss, in general, **what you know about how these community level approaches to aging are "staffed."** In other words, who helps get the detailed work done, particularly with regard to planning, developing and implementing?

b. Have you ever been in a "staff" role to a community level approach to aging? Please describe.

c. If yes, **how did you acquire your role**? [Probe:] Were you hired specifically to it? Were you assigned the role as part of other duties? Were you "loaned" to it from your organization? Did you volunteer for it? Other?

3: Please **tell me what professionals in staff roles do to help communities** plan, develop or implement community level approaches to aging. Can you give me **concrete examples of the roles they play**? Please describe.

4. Still thinking about what such professionals do to help communities plan, develop or implement community level approaches to aging, can you give me **concrete examples of the tasks they perform**? Please describe.

5: From your experience, **what should professionals in such roles know** to help facilitate this work? [Probe:] Are there specific **content areas** that come to mind? Such as housing, transportation or health and aging.]

a. Are there specific aspects of these content areas that are particularly important for staff to know (for example, if housing is important, should staff know about ADA and accessibility, affordability, etc.)

6: From your experience, **what should professionals in such roles be able to do (skills)** in order to facilitate this work? [Probe:] Are there **specific skills** that come to mind? Such as financial, evaluation, planning or facilitation skills.

7: Do you have **suggestions for competencies** for such professionals? For the purposes of this research we are defining competency as "The combination of skills, abilities, knowledge needed to perform a specific task." [From the Council of the National Postsecondary Education Cooperative (Jones, Voorhees, & Paulson, 2002.)] [Probe:] For example, competency in strategic planning for older populations.

8. With regard to this work [assisting community level approaches to aging], do you think values are important? If yes, how? If no, why not?

9. How would you define community capacity with regard to this work? [Probe: What, in your opinion, are the 3 or 4 essential building blocks of community capacity?]

10. Do you have **curriculum recommendations** related to how such competencies should be acquired through learning experiences? [Probe:] Coursework? Internships? Continuing education?

11: Are there **documents and/or web content** that would be useful for me to review related to these topics? [Probe:] Published by your organization? Others?

12: Have you or your organization been involved with **training/educating professionals** related to community approaches to aging? Please tell me more. [Probe:] Continuing education, higher education, other. Type of involvement: teaching a course; site for course projects; site for internships?

13. Have you or your organization been involved with **a partnership, or similar relationship, between an academic entity and a community approach level approach to aging**? Please describe. [Probe:] Type of activities: evaluation, planning, information technology, approach design, other technical assistance?

14: It would be helpful for me to know more about the **range of educational backgrounds of the people who have been interviewed:**

a: In general, would you describe your **professional affiliation** as public health, gerontology, planning or public administration? Or another affiliation?
b: Did you **attend college**? If so, what was your **undergraduate major**?
c: Did you attend **graduate school**? If so, what was your **graduate discipline**?
d: **Any other certificates or licensures**? (Such as a public health or gerontology certificate or nursing home administrator license.)
e. Has **your educational background related to your role** in community level approaches to aging, and if so, how?

15. It would also be helpful for me to know about **the range of organizational affiliations of the people who have been interviewed.**

a. What is your **primary organizational affiliation**? Would you categorize that entity as governmental, nonprofit, academic, consultant or interest group?
b. Do you have **additional organizational connections** relevant to community level approaches to aging? For example, have you done consulting or other contract work for other organizations related to community level approaches to aging? Would you categorize that organization as governmental, nonprofit, academic, consultant or interest group?
c. Have you been involved with **a professional or trade association that is related to community level approaches to aging**? If so, what is the professional or trade association?

16: Is there **any other information you think I should know** as I develop a suggested set of competencies for professionals who staff community level approaches to aging?

17. May I contact you again, if needed, as my research progresses?

18: In closing, do you have any **questions for me**?

Appendix III

A. Codebook Summary by Tree View

COMMCAP:	Community Capacity
CHANGEC:	Openness to change
COBRSPC:	Cooperative broad support
CORLEAC:	Core leadership
LEARNCC:	Learning community
RESOURC:	Resources within the community
COMPPRO:	Competencies suggested
AGEBCMP:	Aging Knowledge Base Competencies
ALYTCMP:	Analytic Assessment Competencies
COMMCMP:	Community Dimensions Competencies
COMUCMP:	Communications competencies
CULCCMP:	Cultural Competencies
ENTRCMP:	Social Entrepreneurial Competencies
FPNMCMP:	Financial/Nonprofit Management Competencies
INTECMP:	Interdisciplinary competencies domain
COMPECN:	Interdis Economic Development Competencies
COMPHOU:	Interdis Housing/Design Competencies
COMPLAN:	Interdis Land Use Planning Competencies
COMPMOB:	Interdis Transportation/Mobility Competencies
COMPPHH:	Interdis Public Health/Healthcare Competencies
PLANCMP:	Planning Competencies
PPIGCMP:	Public Policy/Intergovernmental Competencies
CURRICR:	Curriculum recommendations
CERTCUR:	Certificates
CNEDCUR:	Continuing education
CONTCUR:	Curriculum content
EXPRCUR:	Experiential learning
INFSCUR:	Infusion of material
SPECCUR:	Specializations
KNOWPRO:	Knowledge needed by professionals
AGEBKNW:	Aging Knowledge Base
ALYTKNW:	Analytic Assessment Knowledge
COMMKNW:	Community Dimensions Knowledge
COMUKNW:	Communications Knowledge
CULCKNW:	Cultural Competency Knowledge
ENTRKNW:	Social Entrepreneurial Knowledge
FPNMKNW:	Financial/Nonprofit Management Knowledge
INTEKNW:	Interdisciplinary knowledge domain
KNOWECN:	Interdis Economic Development Knowledge

KNOWHOU:	Interdis Housing/Design Knowledge
KNOWLAN:	Interdis Land Use Planning Knowledge
KNOWMOB:	Interdis Transportation/Mobility Knowledge
KNOWPHH:	Interdis Public Health/Healthcare Knowledge
PLANKNW:	Planning Knowledge
PPIGKNW:	Public Policy/Intergovernmental Knowledge
NATUREW:	Nature of the work
COMMATW:	Community matters
EMGPRCW:	Emerging area of practice issues
INTDISW:	Interdisciplinary nature
RELCHGW:	Relation to change
RELEADW:	Relation to community level approach to leadership
RELSERW:	Relation to service provision
ROLEPRO:	Professional roles
COMORGZ:	Community organizing
FUNDMNT:	Convener/Facilitator
INTEVID:	Translator across Disciplines
KNOWPOP:	Knowing the population
NPMAGMT:	Nonprofit management
PLANNER:	Planning
POLIGOV:	Policy/Intergovernmental relations
RCONNEC:	Resource connector
SERVICE:	Service Provider
SOCENTR:	Social Entrepreneur
SKILPRO:	Skills needed by professionals
AGEBSKL:	Aging Base Skills
ALYTSKL:	Analytic Assessment Skills
COMMSKL:	Community Dimensions Skills
COMUSKL:	Communication Skills
CULCSKL:	Cultural Competency Skills
ENTRSKL:	Social Entrepreneur Skills
FPNMSKL:	Financial/Management Skills
INTESKL:	Interdisciplinary Skills
SKILECN:	Interdis Economic Development Skills
SKILHOU:	Interdis Housing/Design Skills
SKILLAN:	Interdis Land Use Planning Skills
SKILMOB:	Interdis Transportation/Mobility Skills
SKILPHH:	Interdis Public Health/Healthcare Skills
PLANSKL:	Planning skills
PPIGSKL:	Public Policy/Intergovernmental Skills
VALUEPC:	Values
CHANGEV:	Valuing change
EQINPAV:	Equity, inclusion and participation

INTDISV:	Interdisciplinary value
OLDPEOV:	Valuing older people
PROCESV:	Values influence process
SHAREDV:	Shared power

B. Full Codebook Report

Code:	AGEBCMP
Short Desc.:	Aging Knowledge Base Competencies
Full Desc.:	Competencies related to aging knowledge and skills.

Code:	AGEBKNW
Short Desc.:	Aging Knowledge Base
Full Desc.:	Knowledge area related to understanding aging.

Code:	AGEBSKL
Short Desc.:	Aging Base Skills
Full Desc.:	Skill area related to aging knowledge base

Code:	ALYTCMP
Short Desc.:	Analytic Assessment Competencies
Full Desc.:	Competencies related to analytic assessment knowledge skills

Code:	ALYTKNW
Short Desc.:	Analytic Assessment Knowledge
Full Desc.:	Knowledge base for analytic assessment

Code:	ALYTSKL
Short Desc.:	Analytic Assessment Skills

Code:	CERTCUR
Short Desc.:	Certificates
Full Desc.:	Curriculum recommendations related to use of certificate programs related to this emerging area of practice.
Use For:	Responses to Q10 and other material specifically related to curriculum recommendations.
Don't Use For:	More broadly for infusion. See INFSCUR
Example:	Gerontology certificate, planning certificate, nonprofit management certificate, public health certificate.

Code:	CHANGEC
Short Desc.:	Openness to change
Full Desc.:	Themes related to a community's openness and willingness to make changes in terms of how the community addresses aging as a building block for community capacity. Include visioning.
Use For:	Primarily responses to Q9. Culture change.
Don't Use	For straightforward goal of increasing traditional aging services

For:	
Example:	Can do spirit. Articulating a vision.

Code:	CHANGEV
Short Desc.:	Valuing change
Full Desc.:	Themes on open-mindedness/openness to change as a value within the process of developing a community level approach to aging.
Use For:	Q8 responses and others that specifically denote a value with regard to change.
Don't Use For:	Q9 responses and others that relate to change as a component of community capacity. Consider CHANGEC
Example:	Open minded.

Code:	CNEDCUR
Short Desc.:	Continuing education
Full Desc.:	Curriculum recommendations related to continuing education for this emerging area of practice.
Use For:	Responses to Q10 and other material specifically related to curriculum recommendations
Don't Use For:	Material that is more appropriately related to content. Consider CONTCUR
Example:	Training options.

Code:	COBRSPC
Short Desc.:	Cooperative broad support
Full Desc.:	Themes related to cooperative broad support for the community level approach to aging as a building block for community capacity including engagement of a wide range of stakeholders. Also, for a process that achieves cooperation and buy-in.
Use For:	Primarily responses to Q9. Inclusion of diverse stakeholders, entities and sectors.
Don't Use For:	For openness to change (see CHANGEC)
Example:	Respondents will use phrases like ability to work together.

Code:	COMMATW
Short Desc.:	Community matters
Full Desc.:	Theme related to the deep community dimensions of this work.

Code:	COMMCAP
Short Desc.:	Community capacity
Full Desc.:	Parent codes for themes related to building community capacity to address the issues of an aging society.
Use For:	Primarily for responses to Q9 on community capacity. Additionally, for

	material throughout interview that specifically and primarily relates to community capacity.
Don't Use For:	Be careful not to use this too broadly. Much of the material throughout interviews could be construed as relating in some way to community capacity. Reserve the use of this parent code and its child codes for specific, direct material.
Example:	Child codes: CHANGEC, COBRSPC, CORLEAC, LEARNCC, and RESOURC

Code:	COMMCMP
Short Desc.:	Community Dimensions Competencies
Full Desc.:	Competencies related to community dimensions knowledge and skills.

Code:	COMMKNW
Short Desc.:	Community Dimensions Knowledge
Full Desc.:	Knowledge base for community dimensions of practice.

Code:	COMMSKL
Short Desc.:	Community Dimensions Skill
Full Desc.:	Skills related to community dimensions of practice.

Code:	COMORGZ
Short Desc.:	Community organizing
Full Desc.:	Role connected with grass roots activities/tasks that go beyond planning, developing (or expanding), and implementing traditional services and supports for older adults in the community to encourage community change.
Use For:	Community development and grass roots activities in communities and neighborhoods.
Don't Use For:	Separate from individual advocacy for older adults.
Example:	Keywords and phrases associated with the roll of community organizing include change agent, community voice, accountability to the community, voice for older adults, empowerment of older adults, knowledge of the community, assessing community readiness, mobilization, community development, community leadership and representing stakeholders.

Code:	COMPECN
Short Desc.:	Interdis Economic Development Competencies
Full Desc.:	Competencies related to the knowledge and skills for the interdisciplinary area of economic development.

Code:	COMPHOU
Short Desc.:	Interdis Housing/Design Competencies
Full Desc.:	Competencies related to the knowledge and skills for the interdisciplinary

area of housing/design.

Code:	COMPLAN
Short Desc.:	Interdis Land Use Planning Competencies
Full Desc.:	Competencies related to the knowledge and skills for the interdisciplinary area of land use planning.

Code:	COMPMOB
Short Desc.:	Interdis Transportation/Mobility Competencies
Full Desc.:	Competencies related to the knowledge and skills for the interdisciplinary area of transportation/mobility.

Code:	COMPPHH
Short Desc.:	Interdis Public Health/Healthcare Competencies
Full Desc.:	Competencies related to the knowledge and skills for the interdisciplinary area of public health/healthcare.

Code:	COMPPRO
Short Desc.:	Competencies suggested
Full Desc.:	Competencies suggested by participants particularly in response to Q7

Code:	COMUCMP
Short Desc.:	Communications competencies
Full Desc.:	Competencies related to the knowledge and skills areas for communications.

Code:	COMUKNW
Short Desc.:	Communications knowledge
Full Desc.:	Knowledge base for communications

Code:	COMUSKL
Short Desc.:	Communications Skills
Full Desc.:	Skill areas related to communications.

Code:	CONTCUR
Short Desc.:	Curriculum content
Full Desc.:	Curriculum recommendations for specific subject related content as opposed to methods.
Use For:	Responses to Q10. Similar information will be coded under KNOWPRO, SKILPRO and COMPPRO as responses to other questions.
Don't Use For:	Distinguish insofar as possible from competency recommendations.
Example:	Communications, aging, health policy, etc.

Code: CORLEAC

Short Desc.:	Core leadership
Full Desc.:	Themes related to the core leaders that initiate community level approaches to aging as a building block for community capacity. Includes concept of critical mass of support.
Use For:	Founding members, initial boards or workgroups. Also champions.
Don't Use For:	For broad cooperative support (see COBRSPC).
Example:	See above.

Code:	CULCCMP
Short Desc.:	Cultural Competencies
Full Desc.:	Competencies related to cultural and diversity.

Code:	CULCKNW
Short Desc.:	Cultural Competency Knowledge
Full Desc.:	Knowledge base related to culture and diversity.

Code:	CULCSKL
Short Desc.:	Cultural Competency Skills
Full Desc.:	Skills related to cultural competency.

Code:	CURRICR
Short Desc.:	Curriculum recommendations
Full Desc.:	Curriculum recommendations related to this emerging area of practice.
Use For:	Parent code for range of responses to Q10 and other material specifically related to curriculum recommendations.
Don't Use For:	Responses related to specific knowledge and skills. See KNOWPRO and SKILPRO.
Example:	Child codes: CERTCUR, CNEDCUR, CONTCUR, EXPRCUR, INFSCUR, SPECCUR.

Code:	EMGPRCW
Short Desc.:	Emerging area of practice issues
Full Desc.:	Themes related to the definition and scope of this emerging area of practice.

Code:	ENTRCMP
Short Desc.:	Social Entrepreneurial Competencies
Full Desc.:	Competencies related to the knowledge and skill areas of social entrepreneurship.

Code:	ENTRKNW
Short Desc.:	Social Entrepreneurial Knowledge
Full Desc.:	Knowledge base for social entrepreneurship.

Code:	ENTRSKL
Short Desc.:	Social Entrepreneurial Skills
Full Desc.:	Skills related to social entrepreneurship.

Code:	EQINPAV
Short Desc.:	Equity, inclusion and participation
Full Desc.:	Valuing making the process and goals of community level approaches to aging equitable, inclusive and participatory. Includes listening to all voices within community and helping voices be heard.
Use For:	Q8 responses and other responses that specifically associate this behavior to values.
Don't Use For:	Valuing older people. Consider OLDPEOV.
Example:	Hearing all the voices and helping underrepresented groups be part of the process.

Code:	EXPRCUR
Short Desc.:	Experiential learning
Full Desc.:	Curriculum recommendations related to experiential learning. Includes internships, practica, shadowing and volunteering.
Use For:	Responses to Q10 and other material specifically related to curriculum recommendations
Don't Use For:	Volunteering or engagement by people not in a formal learning mode.
Example:	See above.

Code:	FPNMCMP
Short Desc.:	Financial/Nonprofit Management Competencies
Full Desc.:	Competencies related to the knowledge and skill areas of financial/nonprofit management.

Code:	FPNMKNW
Short Desc.:	Financial/Nonprofit Management Knowledge
Full Desc.:	Knowledge base for financial/nonprofit management.

Code:	FPNMSKL
Short Desc.:	Financial/Management Skills
Full Desc.:	Skills related to financial/nonprofit management

Code:	FUNDMNT
Short Desc.:	Convener/Facilitator
Full Desc.:	Defined by descriptors of the convener/facilitator role related to this emerging area of practice.
Use For:	Consider using where activities/tasks span more than two of the other role

	categories
Don't Use For:	Separate from generic nonprofit management
Example:	Keywords and phrases associated with the fundamental role for this emerging area of practice include facilitating, convening, networking/building relationships, collaborating, engaging stakeholders, communicating, team building, working with groups, motivating, finding common ground, building consensus and educating. Also, mobilization, stakeholder analysis, holistic/comprehensive approach, vision, creative/conceptual thinking, momentum/forward progress and action/follow through.

Code:	INFSCUR
Short Desc.:	Infusion of material
Full Desc.:	Curriculum recommendation related to infusion of material across disciplines to relate to this emerging area of practice.
Use For:	Responses to Q10 and other material specifically related to curriculum recommendations.
Don't Use For:	Certificate programs. See CERTCUR
Example:	Infusion of aging content into planning curricula. Infusion of community organizing content into other disciplines such as social work or planning.

Code:	INTDISV
Short Desc.:	Interdisciplinary value
Full Desc.:	Value in working across disciplines. Opposite of siloed.
Use For:	Q8 responses and other responses that specifically denote as a value interdisciplinary, multidisciplinary, crossdisciplinary and/or transdisciplinary activity.
Don't Use For:	Broadly for discussion of such activity across the board.
Example:	See above.

Code:	INTDISW
Short Desc.:	Interdisciplinary nature
Full Desc.:	Theme related to the interdisciplinary/cross disciplinary nature of this work.

Code:	INTECMP
Short Desc.:	Interdisciplinary competencies domain
Full Desc.:	Competencies related to the interdisciplinary evidence base.

Code:	INTEKNW
Short Desc.:	Interdisciplinary knowledge domain
Full Desc.:	Knowledge related to the interdisciplinary evidence base.

Code:	INTESKL
Short Desc.:	Interdisciplinary skills
Full Desc.:	Skills related to the interdisciplinary evidence base.

Code:	INTEVID
Short Desc.:	Translator across Disciplines
Full Desc.:	Understanding and/or applying the evidence base for community level approaches to aging that is interdisciplinary/multidisciplinary/cross-disciplinary. Broader than expertise in aging.
Use For:	Knowing the language of related disciplines
Don't Use For:	For simple sharing of information among agencies where no other factors of interdisciplinary or cross disciplinary activity are present.
Example:	Keywords and phrases associated with the role of understanding/applying the interdisciplinary evidence base include training, technical assistance, and translation. Also, learning to speak the language of related disciplines, understanding/applying research and moving away from siloed approaches.

Code:	KNOWECN
Short Desc.:	Interdis Economic Development Knowledge
Full Desc.:	Knowledge related to the interdisciplinary area of economic development.

Code:	KNOWHOU
Short Desc.:	Interdis Housing/Design Knowledge
Full Desc.:	Knowledge related to the interdisciplinary area of housing/design.

Code:	KNOWLAN
Short Desc.:	Interdis Land Use Planning Knowledge
Full Desc.:	Knowledge related to the interdisciplinary area of land use planning.

Code:	KNOWMOB
Short Desc.:	Interdis Transportation/Mobility Knowledge
Full Desc.:	Knowledge related to the interdisciplinary area of transportation/mobility

Code:	KNOWPHH
Short Desc.:	Interdis Public Health/Healthcare Knowledge
Full Desc.:	Knowledge related to the interdisciplinary area of public health/healthcare

Code:	KNOWPOP
Short Desc.:	Knowing the population
Full Desc.:	Expertise in aging including knowledge of current and future older adult populations. Role associated with understanding of individual, community and societal aging. Includes sharing expertise.
Use For:	Demographic information on older adults including information on boomers.
Don't Use	Separate from service provision

For:	
Example:	Keywords and phrases associated with the role of knowing the population include adult learning principles, learning from older adults, going beyond stereotypes of what older adults are thought to want, understanding needs across the lifespan.

Code:	KNOWPRO
Short Desc.:	Knowledge needed by professionals
Full Desc.:	Knowledge needed by professionals in this emerging area of practice
Use For:	Parent code for knowledge areas.

Code:	LEARNCC
Short Desc.:	Learning community
Full Desc.:	Themes related to communities willingness to learn about themselves in terms of how they do or can address the issues of an aging society as a building block for community capacity.
Use For:	Primarily Q9 responses and use of information resources including data and research to inform planning
Don't Use For:	All resources. Consider a RESOURC code. Separate from openness to change (CHANGEC). A community could learn a great deal about itself but still not be open to using that information to make changes.
Example:	Community integrating learning about past, present and future.

Code:	NATUREW
Short Desc.:	Nature of the work
Full Desc.:	Overarching themes related to the nature of the work for this emerging area of practice.
Use For:	Parent code for themes related to nature of the work.
Don't Use For:	Themes that can be more specifically related to a question on the interview guide.
Example:	Child codes: RELEADW, RELSERW, RELCHGW, COMMATW, INTDISW, EMGPRCW.

Code:	NPMAGMT
Short Desc.:	Nonprofit management
Full Desc.:	Activities/tasks associated with a generic nonprofit management role. Not specific to this emerging area of practice.
Use For:	In general, when the activity/task could be associated with a nonprofit management role related to a broad number of practice areas including but not limited to this emerging area.
Don't Use For:	Separate from fundamental. Do not include planning related tasks/activities.
Example:	Keywords and phrases associated with the role of nonprofit management include logistical support, leadership, sustainability, resource development,

organizational development, creating governance structures, succession planning, human resources, financial management/budgeting, contracting, policy and program development, strategic development and implementation and operations. Also assessing programs, measurement and evaluation.

Code:	OLDPEOV
Short Desc.:	Valuing older people
Full Desc.:	Valuing older people and their contributions to the community. Includes understanding and respecting older people's desire to contribute to the community and their desire to live in the community.
Use For:	Q8 responses primarily.
Don't Use For:	Providing service to older adults. Consider SERVICE code.
Example:	See above.

Code:	PLANCMP
Short Desc.:	Planning Competencies
Full Desc.:	Competencies related to the knowledge and skill areas for planning.

Code:	PLANKNW
Short Desc.:	Planning Knowledge
Full Desc.:	Knowledge base for planning.

Code:	PLANNER
Short Desc.:	Planning
Full Desc.:	Activities/tasks associated with a generic planning role.
Use For:	Includes activities/tasks traditionally associated with planning within a community as well as identifying service and needs gaps including through needs assessment.
Don't Use For:	Separate from convener/facilitator. Do not include broader nonprofit management. Do not use for land use planning see INTEVID instead.
Example:	Keywords and phrases associated with the role of planning include community strategic planning, community planning, facilitating a planning process and community assessment/analysis. Also encompasses applying techniques such as asset mapping and environmental scanning.

Code:	PLANSKL
Short Desc.:	Planning skills
Full Desc.:	Generic planning skills

Code:	POLIGOV
Short Desc.:	Policy/Intergovernmental relations
Full Desc.:	Understanding the policy context and navigating in the policy arena including intergovernmental relations at local, state, and/or federal levels.

Use For:	For public policy type activities.
Don't Use For:	Separate from policy related to discrete organizational or program development as in policy and procedures.
Example:	Keywords and phrases associated with the role of policy and intergovernmental relations include framing the issue, working with governmental officials, navigation of political structures and landscape. Includes advocacy as it relates to policy change, external funding and systems building.

Code:	PPIGCMP
Short Desc.:	Public Policy/Intergovernmental Competencies
Full Desc.:	Competencies related to the knowledge and skills areas of public policy and intergovernmental relations.

Code:	PPIGCMP
Short Desc.:	Public Policy/Intergovernmental Competencies
Full Desc.:	Competencies related to the knowledge and skills areas of public policy and intergovernmental relations.

Code:	PPIGKNW
Short Desc.:	Public Policy/Intergovernmental Knowledge
Full Desc.:	Knowledge related to public policy and intergovernmental relations

Code:	PPIGSKL
Short Desc.:	Public Policy/Intergovernmental Skills
Full Desc.:	Skills related to public policy and intergovernmental relations.

Code:	PROCESV
Short Desc.:	Values influence process
Full Desc.:	Themes related to how values influence the process particularly the development process of community level approaches to aging. Includes understanding values brought into the process.
Use For:	Responses to Q8 and other very specific material related to how values influence process.
Don't Use For:	Specific values.
Example:	Development of guiding principles for community level approach to aging.

Code:	RECONNEC
Short Desc.:	Resource connector
Full Desc.:	Connecting people and resources within a community to address issues related to older adult population. Includes developing information, referral and assistance and other type access services across organizations.
Use For:	Coalition/partnership type activity that connects people and resources.

Don't Use For:	For actual provisions of information and referral to individual older adults or their caregivers. Consider SERVICE code instead.
Example:	Keywords and phrases associated with the role of being a resource connector include information resources, resource connecting, connector of services, connecting organizations locally and informing from the experience of others.

Code:	RELCHGW
Short Desc.:	Relation to change.
Full Desc.:	Theme that this work fundamentally relates to change in the manner and scale of how communities approach the aging of society.

Code:	RELEADW
Short Desc.:	Relation to community level approach leadership
Full Desc.:	Theme that professionals who help communities plan and mobilize do so in support of core leadership group from the community.

Code:	RELSERW
Short Desc.:	Relation to service provision
Full Desc.:	Theme that the nature of this work is different from service provision
Don't Use For:	Separate from SERVICE

Code:	RESOURC
Short Desc.:	Resources within community.
Full Desc.:	Themes related to the perspective on how communities describe available resources and how resources impact community capacity.
Use For:	Funding, organizations and people resources. Perspectives may vary in terms of how critical a type of resource is to capacity. Include both assets and needs related to responses.
Don't Use For:	Directly for data and research resources (see LEARNCC code). Comments on stakeholders (see COBRSPC) or leadership (see CORLEAC).
Example:	Some respondents indicate that funding is key; others indicate that capacity goes beyond funding. In both cases, code responses in this category. Also, include general comments about human resources.

Code:	ROLEPRO
Short Desc.:	Professional roles
Full Desc.:	Range of professional roles associated with this emerging area of practice.
Use For:	Parent code for range of roles
Don't Use For:	Competency and curriculum related coding.
Example:	Child codes include: COMORGZ, FUNDMNT, INTEVID, KNOWPOP, NPMAGMT, PLANNER, POLIGOV, RCONNEC, SERVICE, SOCENTR.

Code:	SERVICE
Short Desc.:	Service provider
Full Desc.:	Provision of traditional services to older adults (and their caregivers) including access and direct services as well as care management.
Use For:	Direct service provision
Don't Use For:	Role separate from knowing the population or engagement and coordination of older adult volunteers. Also separate from the more general role of resource connector among people.
Example:	Keywords and phrases associated with the role of serving older adults includes providing services, service provision, problem solving for older adults, social work, navigating the system for older adults, providing information and referral and advocacy for individuals.

Code:	SHAREDV
Short Desc.:	Shared power
Full Desc.:	Value of shared power. Includes shared leadership, collaboration and cooperation.
Use For:	Q8 responses and other responses that specifically denote such sharing as a value.
Don't Use For:	Other references and other responses that specifically denote such sharing as a value.
Example:	See above.

Code:	SKILECN
Short Desc.:	Interdis Economic Development Skills
Full Desc.:	Skills related to the interdisciplinary area of economic development.

Code:	SKILHOU
Short Desc.:	Interdis Housing/Design Skills
Full Desc.:	Skills related to the interdisciplinary area of housing/design.

Code:	SKILLAN
Short Desc.:	Interdis Land Use Planning Skills
Full Desc.:	Skills related to the interdisciplinary area of land use planning.

Code:	SKILMOB
Short Desc.:	Interdis Transportation/Mobility Skills
Full Desc.:	Skills related to the interdisciplinary area of transportation/mobility.

Code:	SKILPHH
Short Desc.:	Interdis Public Health/Healthcare Skills
Full Desc.:	Skills related to the interdisciplinary area of public health/healthcare skills.

Code:	SKILPRO
Short Desc.:	Skills needed by professionals.
Full Desc.:	Skills needed by professionals in this emerging area of practice.
Use For:	Parent code for skills.

Code:	SOCENTR
Short Desc.:	Social Entrepreneur
Full Desc.:	Social entrepreneurial role that encompasses innovation associated with business development and acumen. Includes activity related to redesign and reorganization of service delivery.
Use For:	Activities related to business development.
Don't Use For:	Separate from generic nonprofit management activity. Also separate from traditional service provision.
Example:	Keywords and phrases associated with the role of social entrepreneur include marketing, market research, customer service, business development, running/operating business, vetting providers, member services and accounting/billing systems.

Code:	SPECCUR
Short Desc.:	Specializations
Full Desc.:	Curriculum recommendations related to the creation of academic specializations associated with this emerging area of practice.
Use For:	Responses to Q10 and other material specifically related to curriculum recommendations.
Don't Use For:	Certificate programs. See CERTCUR.
Example:	Specialization within a discipline or interdisciplinary specialization.

Code:	VALUEPC
Short Desc.:	Values
Full Desc.:	Range of values described by respondents as related to working with community level approaches to aging.
Use For:	Parent code for values.
Don't Use For:	Responses specifically related to community capacity. See COMMCAP.
Example:	Child codes: CHANGEV, EQINPAV, INTDISV, OLDPEOV, PROCESV, SHAREDV.

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Web Resources

Civic Ventures www.civicventures.org

Council on Social Work Education www.cswe.org

National Institute of Environmental Health Sciences www.niehs.nih.org

Villages model websites: www.beaconhillvillage.org , www.cambridgeathome.org ,

www.stayingputnc.org , www.capitolhillvillage.org

Village to Village Network at http://vtvnetwork.clubexpress.com/