Outcomes	Objectives	Performance Measures	Targets	Strategic Initiatives	Commentary/Notes
Across Colorado older adults achieve better health and wellness through access to, better understanding of, and increased utilization/ engagement related to:					
1. Ensure access to quality, affordable, coordinated, person-centered care. **Health Care includes but is not limited to physical (primary and specialty), behavioral, oral, vision, and other services as identified to achieve and maintain health and wellness*	**1a**. Older adults have access to a regular health care provider/ a medical home. **1b**. Individuals that need it have access to case management and care coordination. **1c**. Transitions of care occur safely. **1d**. Medical care is delivered in a way that aligns with patient preferences and values (e.g. the right care, at the right time, for the right person).	**1a.** Percent of older adults that have one (or more) person(s) they think of as their personal healthcare provider. **1b.** Percent of older adults who felt comfortable and supported to go home after a care transition **1c**. Decrease in 30-day readmission rates		**a.** Leverage opportunities (SIM surveys, ACC 2.0) to better understand and measure consumer satisfaction and consumer centeredness, across care settings **b.** Increase scope of practice for people serving older adults (geriatric trained providers, EMT/paramedics, community health workers, navigators) **c.** Increased use of technology to provide care/ increase access to care --In home technology --Telehealth --ECHO Colorado – geriatrics and palliative care **d.** Providing opportunities for communities to co-create programs and services. Engaging with local community groups advocating for elders and health. **e.** Utilizing social media to gather key concerns and create greater awareness. f. Health Literacy to understand transitions into Medicare (including prescriptions) - expansions, better knowledge of SHIP g. Develop a statewide resource (211 like, or 1-800 number) for older adult services/ and state-wide website online, zip code with services (tied to no wrong door efforts of Colorado). Use this resource to leverage and promote existing community services like SNAP, Economic Check-up, Benefits Check up, LEAP, Senior Source. h. Increase the use of healthcare teams that are trained to care for those with complex geriatric medical needs (integrated involvement of multiple disciplines, including social workers, pharmacist) i. More support for care transitions/ care transition teams as older adults are leaving an ER to reduce readmission j. Different payment Global (payments / bundled) as a way to achieve patient centered medical home for older adults – movement away from fee for service k. Improve coordination of benefits for individuals, across Medicare, Medicaid, Older American Act programs, and Veterans Administration benefits	

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2. Utilize resources which support informed health and wellness decision-making.	**2.a**. Increase the understanding of older adults and their caregivers about the options available when selecting health care services. **2.b.** Employ evidence-based programs that support healthcare decision-making and advanced care planning. **2.c**. Ensure availability of educational resources at the time of decision-making delivered in an individual's preferred approach.	**2a.** Increase in appropriate use of community-based home services,especially after hospitalization (i.e. home visits, home health, palliative care, hospice) **2a.** Utilize appropriate community-based home services particularly during transitions of care (e.g. after hospitalization) accessing home visits, home health, palliative care, hospice. **2b**. Increase the number of decision making tools that are available (need to figure out the right "unit") 2c.Increase percentage of older adults that participate in advance care planning **2**c. Increase percentage of older adults with a surrogate medical decision-maker		**2a**. Develop a statewide advance care planning website for individuals (and professionals), that includes available decision making tools (example: http://coalitionccc.org/# - A statewide collaborative of healthcare practitioners, consumers, and regulatory agencies to advance palliative medicine and end-of-life care in California) **2a**. Create incentives to promote hospitals and insurers use of home delivered means after a hospital admission **2b.** Develop a state registry for advance care planning documents [documents are up-to-date; accessible in multiple settings; ex) Oregon POLST registry]	
3. Foster programs, environments, and behaviors known to maintain health and well-being.	**3a.** Promote lifestyles which incorporate such components as physical exercise, mental exercise, nutrition and social interaction **3b.** Ensure availability of community programs to promote healthy lifestyles. **3c.** Optimize physical, mental, and behvioral functions as needs change across the lifespan **3d.** Ensure availability of services and programs to manage chronic disease	**3a**. Increase in the percentages of older adults who participate in evidence based health and wellness programs **3a**. Rates of fall related ER visits and hospital admissions (decrease) **3a**. Percent of older adults connected to community (related to isolation) **3a**. Increase the number of Colorado counties that provide evidence-based, health-related prevention programs, from X number and locations in 2015 to Y by 2030. **3a.** Percent of older adults reported eight or more days of limited activity in the past month due to poor physical or mental health. (decrease) **3b.** Percent of health care providers screening for older adult wellness **3b.** Increases in funding for health and wellness (because a ROI is shown) **3c.** Percentage of older adults with immunizations **3c.** Percentage of older adults who are current smokers (decrease) **3c**. Percent of people who have access to nutritious meals **3c**. Percentage of older adults who participated in physical activity in the past 30 days (increase) **3c**. Rates of suicide related death, hospitalization ER visits, hospital admissions, (decrease) **3c.** Percent of older adults reported that their mental health was not good for eight or more days in the past month/ Best depression measure for older adults **3c.** substance abuse/ misuse measure*		**3a.** Evaluate the return on investment for promising, evidence-based interventions for health and wellness programs (Chronic Disease Self-Management Programs; STEADI/Fall Prevention Programs; Coalition for Older Adult Wellness; Nutrition programs; SBIRT, etc) **3b.** Encourage implementation of prevention, health and wellness related to healthy aging and disease management activities and services into health insurance plans **3c.** Home Health Agencies, Transitions of care programs, outpatient rehab centers, and skilled nursing facilities will offer wellness and preventive programs. **3d.** Encourage use of Medicare Annual wellness visits as a referral source for community programs **3e.** Increase knowledge of and funding for suicide prevention programs **3f.** Medicare reimbursement for fall prevention	

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4. Provide person centered care for older adults with decreasing functional status.	**4a.** Increase participation in comprehensive care coordination programs (disease support, wellness coordination, hospital discharge, inter-facility transfer, nutrition, living situation, transportation, caregivers) **4b**. Increase utilization of opportunities and programs that promote quality of life for individuals with short or long-term functional limitations **4c**. Increase awareness and timely use of palliative care across care settings **4d**. Increase the use of caregivers in the care team	**4a.** Number of pallative care training curriculum **4b.** Percentage of individuals who are referred for palliative care in the last 12 months of life **4b**. Percentage of individuals who utilize hospice care at the time of death **4b.** Palliative care programs are available in X% of Colorado health care settings (hospital; ambulatory; home; nursing facility) **4c**. Percentage of Colorado counties with programs that promote social connection and meaning		**4a.** Add gerontological training to curriculum and continuing education across disciplines 4a.i. Ensure rural and underserved areas are covered **4a**. Develop and implement training for dementia (leverage exisiting organizations, e.g. Alzheimer's Association) 4a.ii. Provide training for direct care providers and health care professionals 4a.iii.Provide orientation or training for associated staff and personnel working in programs related to older adults **4b.** Increase knowledge of Program of All-inclusive Care for the Elderly (PACE) and the focus within that program of person-centered care and quality of life metrics **4b.** Streamline Medicaid waiver options, to better serve older adults **4b**. Utilize the National Core Indicator (NCI) Adult Consumer Survey as one tool to assess system-wide performance in the state, for providing older adults with Access to Services, Choices, Respect/Rights and Community Inclusion **4c**. Adopt or apply for federal or state opportunities to integrate clinical training across disciplines to support people with decreasing functional status, including appropriate palliative care training (MDs, nursing, physician assistant, social worker, chaplain/clergy) **4d**. Increase caregiver resources (websites, support groups, counseling, respite)	