

ARCHSTONE FOUNDATION

AND THE
GERONTOLOGICAL
HEALTH SECTION
OF THE
AMERICAN
PUBLIC HEALTH
ASSOCIATION
PRESENT

2000 AWARD FOR EXCELLENCE

IN PROGRAM INNOVATION



ARCHSTONE FOUNDATION

MISSION STATEMENT

The Archstone Foundation is a private grantmaking organization, whose mission is to contribute toward the preparation of society in meeting the needs of an aging population. Our resources are used to help all generations plan for the aging process and support programs addressing the needs of the elderly in three areas:

- healthy aging and independence
- quality of life within institutional settings
- end-of-life issues

The majority of the foundation's funds are directed to programs in the Southern California region, programs with regional impact, and demonstration projects will be considered from other parts of the country. Proposals are accepted throughout the year, with funding decisions being made by the Board in September, December, March and June. Please contact the Archstone Foundation for further information at:

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GERONTOLOGICAL HEALTH SECTION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

MISSION STATEMENT

The mission of the Gerontological Health Section is to stimulate public health actions to improve the health, functioning, and quality of life of older persons, and to call attention to their healthcare needs. Section members fulfill that mission through research and advocacy aimed at reforming governmental health care programs, particularly Medicare and Medicaid. Section members are also active in administration, direct service, research, and education in health promotion, consumer empowerment, community organizing, program development, and evaluation. We are constantly looking for new ways to bring public health innovations to older persons.

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Richard Fortinsky, Ph.D.

Program

Dana B. Mukamel, Ph.D.

Awards

Nancy A. Miller, Ph.D.

Archstone Foundation Award

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FOREWORD

This award was created in conjunction with the **Gerontological Health Section of the American Public Health Association**, and was established to recognize the best practice models in Gerontology and Geriatrics. Emphasis is given to those innovative programs that have effectively linked academic theory with applied practice in the field of public health and aging.

The 2000 Archstone Foundation Award recipients:

Experience Corps

Johns Hopkins Center on Aging and Health & Civic Ventures, Inc.
Baltimore, Maryland and San Francisco, California
Principal Investigators: Linda Fried and Marc Freedman

Assistive Equipment Demonstration Project

The Gerontology Institute at the University of Massachusetts Boston and the Executive Office of Elder Affairs
Boston, Massachusetts
Principal Investigator: Alison Gottlieb, Ph.D.

2000 Archstone Foundation Award — Honorable Mentions:

United Jewish Appeal (UJA)

Montifiore Aging and Memory Center
Bronx, New York

Pathfinders

Gerontology Center University of Utah
Salt Lake City, Utah

Chronic Disease Monitoring Team

Mountain-Pacific Quality Health Foundation & Montana Dept. of Public Health & Human Services
Helena, Montana

Medication Assistance Program

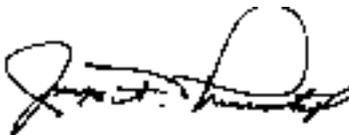
Senior Services, Mission St. Joseph's Hospital
Asheville, North Carolina

It is our hope that these model programs can be replicated in an effort to enhance services to the aging population throughout the U.S.

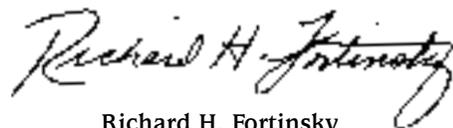
To Brenda Wamsley, M.S.W., Chair of the Archstone Foundation Award Selection Committee, and the other members of our selection advisory committee, we extend our deepest appreciation for their efforts in narrowing down the nominations and selecting the outstanding programs, which received this year's award and honorable mentions.

To Karla Morales of Archstone Foundation our greatest appreciation for her work and effort on preparing this program award booklet.

To the winners of the 2000 Archstone Foundation Award and to all who participated in the award process, we offer our best wishes for continued success in their commitment to develop service models to the field of aging and disability.



Joseph F. Prevratil
President and Chief Executive Officer
Archstone Foundation



Richard H. Fortinsky
Chair, Gerontological Health Section
American Public Health Association



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THE 2000 ARCHSTONE FOUNDATION
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The Experience Corps is a new model of senior service designed to simultaneously create new, generative and productive roles for older adults meeting unmet needs of public elementary schools, and to provide a social model for health promotion for older adults that could be taken to a national scale. It is designed to be attractive to the full diversity of community-dwelling older adults, with roles for people of all backgrounds.

The model was designed to place older adult volunteers in public elementary schools, in roles selected by the principal as the greatest needs for improving academic outcomes. The program was designed in the mid-1990's by Dr. Linda Fried at the Johns Hopkins Center on Aging and Health, and Marc Freedman at Civic Ventures, Inc. Its goal is to incorporate into one program exposure to a number of risk factors that research has shown to be beneficial to healthy aging. Its design was based on research evidence showing that:

1. Remaining physically active, even at low to moderate levels, improves well-being and protects against major chronic diseases of aging, depression, disability and mortality. Despite this evidence, interventions for older adults that solely target modification of health habits, such as exercise programs, thus far attract only a subset of older adults, and only a fraction of these are compliant over the long run;
2. Participating in structured, productive social activities, such as volunteering, decreases risk of disability and mortality and improves psychological health; notably, the number of hours per week in which older adults perform volunteer activities is associated, in linear fashion up to a threshold, with decreased disability risk;

3. Generativity (or leaving one's legacy), per Erick and Joan Erikson, is essential to successful psychological development in late life; it has been pointed out that there is significant structural lag in our society, such that, while people are retiring younger, generative opportunities are lacking for the large proportion of older adults that seek them;

4. Social networks and support are associated with decreased mortality in older adults, at the same time that they are likely to diminish as people age; and ,

5. Regular exposure to complex environments is associated with enhanced cognition and with corresponding increases in brain connections in the hippocampus. However, interventions to date that are designed for cognitive stimulation have impact but low generalizability and retention.

The designers of the Experience Corps hypothesized that a program that could attract large numbers of older adults based on meeting their personal needs to "give back" and to be socially engaged, but was simultaneously designed to be health promoting, might have greater long-term compliance and health benefit than, for example, interventions to date to increase physical and cognitive activity. This research evidence was merged with current knowledge about the most effective senior service programs into the design of the Experience Corps.

The Experience Corps seeks to create new types of generative roles for older adults that will be attractive to a large proportion of the older population, decrease structural lag, increase social, cognitive and physical activity and confer health benefits for participants, while harnessing the largely untapped human capital of an aging society to help meet

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important social needs. The essential elements of the Experience Corps design creatively incorporate both maximizing health outcomes for adults 60 years of age and older, and the impact of the program on the schools. These elements include:

1. Roles that are meaningful for older adults, selected by the principal to make an important difference in children's outcomes. These roles were designed and standardized, and training developed, by Experience Corps investigators, and include literacy and math support, library programs, violence prevention programs, enrichment activities, and public health programs such as personal hygiene instruction and an asthma management club for children with asthma, run by older adults with asthma;
2. Volunteer 15 or more hours per week, to maximize outcomes;
3. Training and infrastructure support provided by program;
4. Experience Corps volunteers work in teams of 7-10; a critical mass of volunteers, as determined by the principal, are placed in each school; the number range from 15-60 per school;
5. Diversity of older adults: all backgrounds of individuals can participate;
6. Learning: program flexibility permits identification of additional needs and development of new Experience Corps programs;
7. Reimbursement for expenses: volunteers receive \$150/month to cover program expenses;
8. Leadership: volunteers evolve into leadership roles to make the program self-sustaining;

9. Evaluation: by volunteers, through journaling, and by the program developers.

Since 1996, this program has been a Demonstration Project funded by the Corporation for National Service, with programs in 10 U.S. cities. Programs in several other cities have been funded through foundations. Dr. Fried and colleagues have implemented a pilot for a randomized trial of the Experience Corps in Baltimore, beginning fall 1999 in six schools, which is jointly sponsored by the Johns Hopkins Center on Aging and Health and a community organization, the Greater Homewood Community Corporation. It is funded by the State of Maryland, the State Department of Education, the Baltimore City School Board, the Baltimore City Commission on Aging and Retirement Education, and the Corporation for National Service. Across all of these programs, adults 52-91 years of age have participated. They have been almost one-third male and 67-89% African American, with 24-35% married. Educational levels vary, with 32-80% having less than a high school education. In the previous year, 44-65% had not volunteered. The volunteers average 2.2 chronic conditions. In the national demonstration, early data suggest improvements in social, psychological, cognitive and physical function for the older adults, and deep satisfaction with the ability to "make a difference" through the Experience Corps. Principals, teachers, older adults and children are highly enthusiastic about the program. Teachers describe improvements in literacy by at-risk elementary age children as a function of the Experience Corps. The Baltimore program has had no dropouts among the volunteers with consistently high satisfaction with the program.

PARTICIPATING
IN STRUCTURED,
PRODUCTIVE
SOCIAL
ACTIVITIES,
SUCH AS
VOLUNTEERING,
DECREASES RISK
OF DISABILITY
AND MORTALITY
AND IMPROVES
PSYCHOLOGICAL
HEALTH . . .

GENERATIVITY,
OR LEAVING ONE'S
LEGACY, IS
ESSENTIAL TO
SUCCESSFUL
PSYCHOLOGICAL
DEVELOPMENT IN
LATE LIFE . . .



ASSISTIVE EQUIPMENT DEMONSTRATION

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Assistive Equipment Demonstration Project

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The Gerontology Institute at the University of Massachusetts Boston (UMB) and the Executive Office of Elder Affairs (EOEA) collaborated on a three year demonstration project, with evaluation research funded by the Robert Wood Johnson Foundation. This project disseminated low-cost assistive equipment through case managers to elderly clients of a publicly-funded home care program, with the aim of increasing elders' independence in personal care and household management. Although it has been documented that assistive equipment can be highly beneficial to functionality disabled older people, such equipment is typically underutilized by elders and has not been a routine service of the home care programs within Massachusetts, which serve over 30,000 frail elders. An informational manual and website were developed based on the demonstration findings, and the manual is being distributed to home care programs statewide.

Nearly 200 clients received assistive equipment through the demonstration. Project participants were typically female (87%), white (97%), and single (85%), with ages ranging from 61 to 101 (median, 81). Over half the participants had at least two ADL deficits and nearly all had at least four IADL deficits. Typically, participants received three or four formal services. Nearly all used homemaker services, with other commonly used services including home-delivered meals, home health aides, transportation, skilled nursing, and personal care attendants.

Based on self-report interviews, half the clients reported that preparing meals was difficult. Although the majority of clients had one or more bathing devices prior to the demonstration, a third reported bathing to be difficult, and a

quarter could not bathe at all without personal assistance. A third of the clients reported difficulty dressing or engaging in leisure activities.

Because case managers' cooperation was critical to achieving the projects' ultimate objective- increasing elders' use of low cost assistive equipment, the project included two complementary services, case management training and client equipment. The training and client screening materials were provided by occupational therapists from a rehabilitation hospital. A client screening tool was developed to assist case managers in identifying clients who might benefit from assistive equipment and in recommending equipment based on clients' functional limitations. During regularly scheduled home visits, case managers spoke with clients to decide on the assistive equipment items they wanted. The home care programs each developed their own procedures for ordering, delivering, and tracking the equipment. Case managers followed up the delivery of equipment with visits or phone calls to determine whether clients were using and satisfied with their equipment, and whether they needed demonstrations or other equipment.

The project employed a pretest/post-test experimental design to evaluate the impact of the intervention. Equipment delivery was delayed six months for one of the home care programs (the control group) to allow comparisons between clients who had received equipment and those who had not. Clients participated in in-home interviews at baseline, and were re-interviewed after six months. The control group completed a third interview six months after they received equipment. Baseline interviews addressed clients' perceived difficulty with tasks associated

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PROJECT

with meal preparation, bathing, dressing, and expressive activities. Clients were also asked about their use of and desire for assistive equipment. The second round of interviewing was similar, with additional questions for the experimental group that addressed specific items participants had received as part of the project, as well as clients' experiences around selecting and receiving equipment. In addition to the interviews, client background and services information was collected from client records at baseline and at the time of follow-up interviews.

The demonstration was carried out through two state-funded home care programs representing comparable client populations that permitted a quasi-experimental evaluation design. The project involved collaborations with a rehabilitation hospital that provided case manager training and a professional survey research center that conducted interviews with project participants. While the Robert Wood Johnson Foundation provided funding for research activities, the assistive devices (allocated at \$150 per client) per purchased with existing state home care funds, and the interventions was carried out with existing case management resources.

Thirty seven case managers from the two home care programs received training and distributed equipment to, on average, five clients. As a result of the project, clients received an average of four assistive devices at an average cost of \$76 per client. Nearly half the distributed items addressed meal preparation, followed by bathing or toileting, mobility, and dressing equipment. Most clients (88%) expressed satisfaction with their equipment and, according to case managers, 71% of the clients were using their equipment regularly after two weeks. There were also

indications that clients' capacity to perform tasks addressed by specific items was increased. For example, clients who received and reported using adaptive can or jar openers reported less difficulty opening cans or jars. Moreover, case managers reported increased awareness of the range and benefits of assistive equipment and were more likely to consider assistive equipment as a service option.

The project demonstrated the potential for case managers, with modest training, to recommend and encourage the use of low-cost assistive equipment for many frail elders experiencing difficulties with self-care activities. The overall cost of equipment was minimal and could be absorbed within existing home care budgets. At the same time, implementation and procedural challenges were identified. Based on the experiences of the demonstration, the research team developed resource materials that are being distributed to home care programs throughout Massachusetts. These materials along with additional resources are also available on the Gerontology Institute's website at the University of Massachusetts Boston. It is expected that these materials will assist home care programs state-wide as they consider incorporating assistive devices within their range of service options.

THIS PROJECT
DISSEMINATED
LOW-COST
ASSISTIVE
EQUIPMENT
THROUGH CASE
MANAGERS TO
ELDERLY CLIENTS
OF A PUBLICLY-
FUNDED HOME
CARE PROGRAM,
WITH THE AIM
OF INCREASING
ELDERS'
INDEPENDENCE
IN PERSONAL
CARE AND HOME
MANAGEMENT.



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UNITED JEWISH APPEAL (UJA)

Montefiore Aging and Memory Center

For more information
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For frail elders in Co-op City, New York in 1997, the difficulty of travel compounded by the stigma of mental illness and the fragmentation of services, effectively barred access to mental health care. There are 11,251 adults aged 65 years or older in Co-op City making it a Naturally Occurring Retirement Community (NORC) and qualifying it for New York State NORC Project support to provide social services. The state aid is dependent on matching funds from the private housing entity. The Co-op NORC Project is funded by the New York State Office for Aging and the Co-op City Riverbay Housing Corporation and is administered by the Coordinating Council of Co-op City Senior Citizens. The NORC Project offered a unique opportunity to reduce the fragmentation of mental health efforts by linking community agencies and primary care providers with geriatric specialists.

The design for this project pooled resources to provide specialized care for seniors who had unmet mental health needs and who found existing services stigmatizing or inaccessible. To make care more convenient, psychiatric services are provided by trainees in primary care offices or in the resident's home rather than referring them to an out-of-area mental health clinic. Philanthropic grants from the United Jewish Appeal and the Irving Weinstein Foundation provided the seed money to add full time staff to the program beyond the geriatric psychiatrists in training. The Montefiore Medical Group made space available at no cost to the program. Screening programs, lunch time talks at senior centers, case finder

training, and health fairs are used to detect depression and memory impairment, provide assistance to make a living will or appoint a health care proxy. The result is a virtual geriatric mental health center with 3 full time staff plus fellows in geriatric medicine and psychiatry who are not confined by the conventional boundaries of care. The program is community based and interdisciplinary in the true sense of the terms.

The benefits of the program are reflected in the clinical statistics through the first 59 weeks of operation at the Bay Plaza site and 25 weeks at Pelham Parkway. At Bay Plaza, new patients evaluated numbered 129 of whom 13 were seen in their homes or apartments. There were 378 follow-up visits of which 13 were house calls. At the Pelham Parkway site, 32 new patients were evaluated. There were 87 follow-up visits of which 6 were house calls.

Geriatric specialists were established in an underserved population by basing the services in existing primary care sites and forging alliances with community agencies. A significant number of referrals came from community agencies, almost two thirds of patients were aged 75 or older, dementia and depression made up the majority of diagnoses, and a substantial number of persons served came from disadvantaged minority groups. The linkage between academic centers and social service agencies to serve older adults in NORC sites offers an economy of scale and critical mass for a sustainable program for these underserved populations.



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PATHFINDERS

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Pathfinders

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Pathfinders is a self-care and health education program for older widows and widowers, funded as a three-year demonstration project by the Ben B. and Iris M. Margolis Foundation. The primary purpose *Pathfinders* is to provide the participants important health and wellness information in a supportive environment where they can develop self-care skills and learn how to access other relevant community resources for information and support. Understanding and coping with grief also is included in the intervention. The development of the program was informed by previous research on spousal bereavement in later life and guided by several conceptual foundations relevant to health promotion programming. Although the program is primarily designed for those who are recently widowed (within the past 18 months), it is open to any widow or widower age 50 and older.

The program consists of 11 weekly classes (offered twice a year), each led by professionals with expertise in a specific self-care or health education content area. These presenters come from a variety of settings in the community, including faculty at the University of Utah, the local area agency on aging, the state's land grant university extension service, and those in private practice- including the human services and business. An advisory council provides input throughout all phases of the project's development and facilitates recruitment of participants into the program.

The conceptual foundations for *Pathfinders* are derived from social network and support concepts, and the application of self-management techniques and lifelong learning principles. Life transitions like bereavement require

the acquisition of new information and/or skills for effective adaptation.

Social networks can directly facilitate positive health behaviors by providing information, resources, and an environment supportive of a lifestyle conducive to health and wellness. The *Pathfinders* program creates a sense of belonging and network among the participants by providing a supportive environment in which they learn from each other as well as from the presenters. Over time, many participants form supportive relationships outside the weekly sessions that often extend beyond the conclusion of the program where learning continues.

Self-management strategies are encouraged through contracting. Each workbook contains contracts that the participants complete as they develop short- and long-term goals related to that week's content. Each contract requires the participants to specify a plan of action to meet their goals and describe how they will reward themselves once the goals are attained. They also identify sources of support that can help them succeed as well as potential barriers and their solutions.

The ongoing evaluation of the project consists of a baseline and three follow-up assessments (two months apart). Thus far participants have reported improvements over baseline in the following self-care competencies: reading and understanding food labels, managing one's household, filing insurance and tax forms, performing physical activities, identifying and accessing needed community resources, time management, coping with stress, meeting leisure needs, and timely arrangement of important medical exams and immunizations.



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CHRONIC DISEASE MONITORING TEAM

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The work for the *Chronic Disease Monitoring Team* was accomplished by a team from a peer review organization and a state health department, using funds awarded by the Health Care Financing Administration and by the Centers for Disease Control and Prevention. The project supports the efforts of physicians and nurses to provide the highest possible level of evidence-based care to persons with diabetes. The benefits of this project have been repeatedly demonstrated at participating clinics.

The Chronic Disease Monitoring System (CDMS) is a computer-based system that was designed and developed by the Mountain-Pacific Quality Health Foundation and the Montana Department of Public Health and Human Services. The system provides participating clinicians with a simple tool to monitor care for individual patients with diabetes, as well as for patient population. The CDMS software is available free of charge to participating clinics and is simple to learn, use and maintain. It provides action-oriented, pre-programmed reports that can be used to identify patients in need of preventive care services as well as important clinical follow-up services. It is an outstanding example of putting academic theory (regarding recall-reminder systems) into practice.

The CDMS team has installed the software in more than 35 physicians' offices in Guam/Saipan, Hawaii, Montana and Wyoming. The system allows physicians to efficiently and continuously monitor evidence-based indicators of diabetes care. The system provides a one-page current status report for each patient which is kept in individual medical records and regularly updated. It also allows participating

physicians, at any time, to describe care provided to their patient population, including easy identification of patients who are due for key diabetes care services. The system monitors blood pressure, blood sugar and lipid levels, urine protein status, eye care, foot care, adult immunization status and important treatment steps for some of these indicators of diabetes care.

The most important innovation of this program is the successful implementation of an electronic diabetes care monitoring system in individual physicians' offices in remote, rural areas and in small towns. Physicians recognize the importance of "managing" care and are demonstrating a successful method to do this.

The CDMS system was initiated in October 1997. By February 2000, there were thirty-six participating offices. At the time this nomination was prepared, installations were scheduled for more offices that have requested to participate in this program.

The project team provides a quarterly newsletter to all participating sites. Each issue of this newsletter, entitled the "Chronic Disease Monitoring System Quality Improvement Report" (CDMS-QIR), includes a "Successful Quality Improvement" column which documents evidence of improved care at participating offices. In addition, some offices have demonstrated how the systematic use of the project's software is associated with a variety of clinical performance measures for diabetes care.

Because more than 40% of patients with diabetes are aged 60 years or more, this type of office-based care monitoring makes an important contribution to gerontological health.



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MEDICATION ASSISTANCE PROGRAM

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Medication Assistance Program (MAP) was established by Mission St. Joseph's Hospital in 1997. The purpose of the program is to provide medications, education, and disease state management for low income, Medicare recipients. The staff is comprised of two clinical pharmacists and a program coordinator. Hospital discharge planners facilitate the proper referral of these patients who are identified during hospital admissions. Patients enrolled in this program receive the services at no cost to them. Currently, the program is solely supported by Mission St. Joseph's Hospital.

Patients who are eligible for enrollment into MAP must be Medicare beneficiaries at or below 130% of the Federal Poverty Level with no other prescription coverage or Medicaid.

1. Financial review and referrals: The program coordinator is responsible for conducting financial interview and ensuring that patients are referred to the appropriate assistance agency. In addition, the program coordinator informs geriatric patients of other financial resources available in the community.

2. Medication Assistance and Education: The pharmacists are responsible for the medication management and education of each patient enrolled in the program. The program coordinator is responsible for obtaining the needed medications through the drug manufacturers' indigent care programs.

Pharmacists conduct a comprehensive medication review, including monitoring for alternative therapies and over the counter medication use. Special attention is also placed on questioning patients about problematic side effects. Medication regimes are evaluated for appropriateness in the geriatric population and any suggestions are faxed to the prescribing physician. Education focuses on in-home monitoring of diseases, use of medications as well as lifestyle modifications such as diet and exercise. The pharmacists also coordinate the sharing of information between the various health care providers for these

patients. Due to the complexity of their medication regimens and multiple disease states, this coordination is extremely vital to the patients.

3. Preventative Health Screening: In addition to providing patients with medications and education, pharmacists also question patients about cancer screenings and vaccinations. As part of the medication review process, patients are routinely questioned about preventative screenings for breast, colon, and prostate cancer. Pharmacists also counsel female patients about the importance of breast self exams and provide information on how to do breast self exams. Every year patients are questioned about flu shots, and if they have not received one their primary care physician is contacted. Other vaccinations such as tetanus and pneumococcal are also encouraged and discussed with the patients.

There are currently 87 patients enrolled in the Medication Assistance Program. In 1999, the Medication Assistance Program achieved a 95% retrieval rate on applications submitted through drug manufacturers' programs. The dollar value of those medications obtained was \$353,590.00.

One of the realizations since the inception of the program is that there is a tremendous need for more programs. As a result, the pharmacists and program coordinator have been instrumental in developing similar programs in the region. They have provided the training and support for new programs to develop and provide services for patients in the outlying rural areas of Western North Carolina. The most established program is in the Hominy Valley community, which is located west of Asheville. This program is staffed by church volunteers and uses a Mission St. Joseph's pharmacy resident to provide patient education and medications reviews. The pharmacy resident is supervised by the MAP pharmacists. The program addresses not only the financial needs of the patient, but encourages patients to become active participants in their health care through education about medications and diseases.



2000 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

OTHER
NOMINATIONS

AS A MATTER OF FACT: FITNESS MATTERS

**As a Matter of Fact:
Fitness Matters**

*Older Adult
Fitness Programming
Allegheny County Area
Agency on Aging
441 Smithfield Street
Pittsburgh, PA 15222*

Contact:
*Lorie J. Scrabis, J.D., A.G.E.
(412) 350-4071
(412) 350-4330 Fax
KBishirjian@county.allegheny.pa.us*

Allegheny County Area Agency on Aging, Pennsylvania, launched a new fitness program for older adults with cooperative funding from Allegheny County and Prime Time Health. Targeted consumers are identified as adults, 60 years of age or older, who are healthy or working on renewed health.

The goals for the program are as follows:

- Provide effective, high quality fitness programming that encompasses cardiovascular health through aerobic conditioning, musculoskeletal health through strengthening activities, flexibility work, relaxation activities, and sound wellness counseling.
- Utilize a qualified fitness trainer who can properly teach, motivate and communicate successful, effective fitness programming as well as the ability to assess and manage emergency situations.

- Make the appropriate technical decisions addressing class frequency and duration, execution of varied training formats (seated, standing and floor), with proper adaptations regarding physical and mental restrictions related to health risk factors and/or associated medications.

- Provide for accurate, concise, timely written assessments for outcome evaluations.

The Fitness Matters program's results have been positive to date and do illustrate that older adults like to exercise in a group. They are very interested in strengthening and flexibility exercises; they are receptive to instructors and are interested and extremely dedicated in improving or maintaining good health through exercise and social contact.

SIT AND BE FIT™

SIT AND BE FIT™

*P.O. Box 8033
Spokane, WA
99203-0033*

Contact:
*Mary Ann Wilson, R.N.
(509) 448-9438
(509) 448-5078 Fax
sit.and.be.fit@sisna.com*

SIT AND BE FIT™ is an exercise program targeted primarily for seniors and people with chronic and/or physical limitations. It's focus is to provide a safe, medically sound exercise program so that everyone, at every income level, can improve their quality of life by remaining functionally fit. The program also targets people who have been intimidated by other exercise programs that have not met their special needs.

SIT AND BE FIT™ airs on almost 100 public television stations and is also used in a variety of nursing home settings. Produced by a local PBS station the program is widely accessible and reaches diverse cultural backgrounds. If local PBS stations don't air the program, then 19 videotapes are available for a variety of fitness levels and medical conditions; one is in Spanish. This program is the only means for many homebound persons to participate in an

age-appropriate exercise program, enhancing independence.

By addressing the need for specially designed exercises for seniors with limitations, this program has performed an invaluable service for millions all over the world.



2000 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

OTHER
NOMINATIONS

SAVE YOUR SIGHT

Save Your Sight

Virginia Health Quality
Center
P.O. Box K70
Richmond, Virginia
23288-0070

Principal Investigator:
Diana G. Westbrook,
M.A., A.B.C.
Phone: (804) 289-5320
Fax: (804) 289-5324

The Virginia Health Quality Center (VHQC) is a federal contractor, paid by Medicare to assure that the state's Medicare beneficiaries receive high-quality health care, which includes educating them about preventive care. It's objective is to increase the rate of dilated retinal examinations among Medicare beneficiaries with diabetes in the targeted areas. The role of the VHQC is to promote, not to perform, eye exam services among Virginia's seniors with diabetes and among family physicians and pharmacists, reminding them to encourage their senior patients and customers to schedule the exam.

Virginia's seniors with diabetes were identified through the VHQC's analysis of claims data. Analysis indicated that nearly 120,000 seniors in Virginia have diabetes, or about 14% of the state's senior

population. The secondary audience for the campaign was ophthalmologists, optometrists, family physicians, and pharmacists who practiced in the targeted areas. Consults with ophthalmologists and optometrists indicated that family physicians and pharmacists are important partners in promoting eye exams for diabetic seniors.

REAWAKENINGS

**Reawakenings:
Restoring Cognitive and
Physical Function
Through Music Therapy**

Beth Abraham
Health Services
612 Allerton Avenue
Bronx, New York 10467

Contact:
Peter M. Sanna,
P.A.-C., M.P.H., L.N.H.A.
Phone: (718) 519-4004;
Fax (718) 519-4010

Restoring Cognitive and Physical Function Through Music Therapy

The *REAWAKENINGS* initiative at Beth Abraham Health Services is a six-year old multi-faceted music therapy program implemented by the Music Therapy Department and designed to restore cognitive and physical function to skilled nursing home residents and adult day care participants. Residents/patients are assessed by certified music therapists who design a prescriptive program which allows stimulation of seemingly lost brain function in persons with dementia and neuro-physiologic disease. Music Therapy services provided include small group therapy utilizing all the components of music—rhythm, sound and melody.

What makes the Music Therapy program unique is its focus on exploring the specific ways music can Reawaken cognitive

and physical function through the inherent properties of music and its effects on the human nervous system. Through the innovative base of music therapy coupled with scientific applications of music, the Reawakenings initiative has made significant progress in restoring cognitive and physical function in the patients.



2000 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

OTHER
NOMINATIONS

COMMITTEE TO END ELDER HOMELESSNESS

*Committee to End
Elder Homelessness*

Massachusetts
Public Health Association
305 South Street
Jamaica Plain, MA 02130

Contact: K.R. Kaffenberger
Phone (617) 524-6696
Fax (617) 624-5075
Rick.Kaffenberger@state.ma.us

Alarmed by the rapidly increasing numbers of homeless older people in the Boston community, seven women with extensive professional experience in housing, health, mental health and social services founded the *Committee to End Elder Homelessness, Inc. (CEEH)* in 1991. The primary mission of CEEH is the eradication of elder homelessness through the provision of permanent housing and supportive services. The goals of the project are to create case management, critical pathways and Care Maps® to quantify, delineate, teach, evaluate and disseminate effective case management strategies for the homeless elder population.

CEEH recognized early in its development that finding a physical place for homeless elders to live is just the beginning of their journey out of homelessness, and that what happens

before and after placement is critical to each older adult's path to growth and stability. Along each step in the journey, CEEH has been creating a system of integrated supported services which enables former homeless residents to form the skills, connections and relationships that will guide them to the next, stable level of autonomy, and allow these men and women to become reconnected to their community.

SIT UP PROGRAM

SIT UP Program

ElderServe
411 E. Muhammad Ali
Blvd.
Louisville, KY 40202

Contact:
Linda Murray
Project Director
Phone: (502) 587-8673
Fax: (502) 587-0222

The Supporting Independence Through Unity and Pride Project (SIT-UP) is an integrated program of case management, adult day center, counseling, household management and recreation services for the residents of Dosker Manor, Kentucky's largest elderly/disabled public housing facility. The primary objective is to implement expanded services on-site at Dosker Manor that are determined necessary and essential to enable elderly and non-elderly/disabled to live independently and to prevent premature or unnecessary institutionalization.

The SIT-UP Program components include the following:

- Recreation Services: Two centers provide an opportunity for elderly and non-elderly residents to socialize together in a positive environment.
- Adult Day Center: A social model adult day program, provides elderly residents activities, socialization and assistance for its participants.
- Chore Service: Chore service is provided on a time limited basis to residents who are at risk of eviction due to the condition of their apartments, or who are unable to do their housework because of temporary illness or disability.
- Case Management: SIT-UP was designed to provide non-intrusive services that come to the individual and provide help that is perceived as positive.



2000 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

OTHER
NOMINATIONS

AN IPRO HEALTH CARE QUALITY IMPROVEMENT PROGRAM

IPRO

1979 Marcus Avenue
Lake Success, NY
11042-1002

Contact:
Charles Stimler,
M.D., Ph.D.
(516) 326-7767
(516) 328-2310 Fax
nypro.twill@sdps.org

As part of its on-going quality improvement activity under contract to the federal Health Care Financing Administration (HCFA), **IPRO** has undertaken a series of studies, which focus on improving care and health outcomes for Medicare beneficiaries with Congestive Heart Failure (CHF).

IPRO's initial CHF study focused on whether patients were assessed for CHF and whether eligible CHF patients received treatment with ACEI and to a lesser degree, other cardiac agents. A second study, was designed to promote awareness among health care providers regarding the importance of patient education as a major component of good quality care of congestive heart failure, and focused on whether there was documentation of patient

education in five categories during each admission for CHF. The current CHF initiative focuses on all hospitals in New York, requiring them to improve their processes regarding the diagnosis and treatment of CHF. The project also focuses on physicians and health care providers providing outpatient care for CHF. Findings have resulted in the development of a patient education booklet, the production of a clinical pathway template for the inpatient management of CHF and a continuing education program.

FLORIDA FLU FIGHTERS

Florida Flu Fighters

Florida Medical
Quality Assurance, Inc.
4350 West Cypress St.
Suite 900
Tampa, Florida 33607

Contact:
Michele Brodsky
(813) 354-9111
(813) 354-0737 Fax
mbrodsky@SDPS.org

Florida Medical Quality Assurance, Inc. (FMQAI), spearheaded the **Florida Flu Fighters Coalition** in designing a message for Medicare beneficiaries to increase influenza immunization rates in Florida.

Materials were created in Spanish and English to meet language and cultural barriers and written at a literacy level for the target population to understand. Health care providers were involved as a secondary audience for the message because they would ultimately support the behavior change and respond to consumer questions. Informational Materials, and Free Flu Shot coupons in English and Spanish were sent to providers, pharmacies, churches and libraries.

Utilizing a multi-media approach, press kits were sent to health care reporters of television, radio and newspaper. Radio interviews as well as television interviews were conducted. In collaboration with the American Lung Association, an informational toll-free line was promoted to assist Medicare beneficiaries in their search for flu shot locations.

As a result, FMQAI and the Florida Flu Fighters Coalition successfully raised awareness of the need for influenza immunizations among senior agencies and beneficiaries.



2000 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

OTHER
NOMINATIONS

SENIOR FOCUS

Senior Focus Radio

with hosts
Carole Marks and
Dale Callahan

3 Pondsides Court
Mystic, CT 06355
(860) 535-1322
(860) 535-1328
Asoscia01@snet.net

Senior Focus, is the first nationally syndicated radio talk show for seniors. The program was created to dispel the myths of aging, and to help all generations plan for the aging process. The hosts are Carole Marks and Dale Callahan, and the show is heard on the Talk America Radio Network. *Senior Focus* is about all the things everyone is interested in, but with the “seasoned citizen” flavor.

A recent survey revealed that 84% of seniors listen to the radio on a weekly basis, another survey indicates the average daily time spent listening to the radio by the 65+ market is three hours and nine minutes each day. That makes the purpose of *Senior Focus* important: inform, educate and entertain.

The show is dedicated to enriching the lives of seniors through education about community resources, medical breakthroughs, political issues such as Social Security, Medicare and Prescription Drug, while encouraging the aging people of America to be more productive and to enjoy life to the fullest.

PNEUMONIA PREVENTION
THROUGH IMMUNIZATION

**Pneumonia Prevention
Through Immunization**

HealthInsight
500 S. Rancho Drive
Suite C-17
Las Vegas, NV 89106
(702) 385-9933
(702) 385-4586 Fax
dhuber@healthinsight.org

The aim of the *Pneumonia Prevention Through Immunization* project was to facilitate the implementation of the inpatient immunization programs in Nevada’s acute care hospitals. This program, funded by Nevada Medicaid, linked the results of numerous studies and national recommendations with current medical practice in the state. An important benefit of the project was to create a statewide network of acute care hospitals.

The program targeted patients, hospitalized in Nevada acute care hospitals, who were 1) over age 65, 2) chronically ill, 3) immunocompromised, 4) lived in group settings. This initiative utilized a Rapid Results Quality Improvement model. This

model shortens improvement cycles by encouraging organizations to work collaboratively on common themes, share tools, and support one another in improvement.

The project resulted in a significant increase in the percentage of at-risk patients assessed for vaccination status over the 10-month data collection period (November 1998 to August 1999). The percentage ranged from a low of 6.5% to a high of 28.5%.



**2000 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION**

**OTHER
NOMINATIONS**

PROJECT HEALTHY BONES

Project Healthy Bones

*New Jersey Department of
Health and
Senior Services*

*P.O. Box 807
Trenton, NJ 08625-0807*

*Contact:
Gerry Mackenzie
(609) 588-3468 Telephone
(609) 588-3601 Fax
gmackenzie@doh.state.nj.us*

Project Healthy Bones is a twenty-four week exercise and education program for older women and men at risk for, or who have osteoporosis. The twenty-four week curriculum educates participants on the importance of exercise, nutrition, safety, drug therapy and lifestyle factors as they relate to osteoporosis. The education portion of the class is interactive, with the Peer Leaders facilitating the exchange of information. This supports Project Healthy Bones' wellness focus which builds upon the ideas that self-esteem, peer support and incremental successes are necessary in order to change behavior. It also supports the concept that the program must be a positive and fun experience in order to maintain the commitment of participants.

The success of Project Healthy Bones can be attributed directly to the unique partnership among the New Jersey

Department of Health and Senior Services, the Association of Retired and Senior Volunteer Program Directors, Inc. (RSVP), and the Saint Barnabas Health Care System.

Ninety-five percent of those participants completing the 24-week program advanced from "level one" to "level two" in the balance exercises. In regard to calcium intake, 68% of those participants who completed a minimum of 12 weeks of the program increase their daily calcium intake.

PROJECT OPEN

Project OPEN

*Arizona Center on Aging
College of Medicine
University of Arizona
1807 E. Elm Street
Tucson, Arizona 85719*

*Contact:
Theodore H. Koff, Ed.D.,
Director
(520) 318-7234 Telephone
(520) 318-7237 Fax
koff@u.arizona.edu*

Project OPEN (the Older Person's Emergency Network) enables a community to heighten its emergency response to older persons and other vulnerable populations through the more effective transfer of life-sustaining information in a crisis situation.

Project OPEN consists of several key components: 1) an existing public telephone network which could transport information at little or no cost, 2) an existing 911 emergency communication system with enhanced computer capability, 3) responding to unmet emergency assistance needs of frail older persons who live alone and are at high risk of having to use emergency care, 4) expanding monitoring (call-in or visiting) services to persons who do not need daily monitoring but are still at high risk of using emergency services, and

5) providing emergency responders with advance knowledge of the health and social needs of an older person experiencing a crisis situation.

Preliminary findings indicate that Project OPEN enhances emergency responders decision making capability in a crisis, reduces uncertainty and property damage in their emergency response to older persons, and serves as a referral mechanism for emergency responders who identify older persons in need of health and social services assistance.



**2000 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION**

**OTHER
NOMINATIONS**

GERONTOLOGICAL NURSING CLINICS

***The Gerontological
Nursing Clinics***

*Minnesota State
University, Mankato
School of Nursing
360 Wissink Hall
Mankato, MN 56001*

*Contact:
Regina P. Smith
R.N., M.S.N., C.S.
(507) 389-6022 Telephone
(507) 389-6516 Fax
regina.smith@mankato.msus.edu*

The Gerontological Nursing Clinics provide basic health care consisting of services to the older adult in designated geographical areas throughout Mankato. These clinics are unique to this southern Minnesota community in that services provided are free to any older adult living in the area.

Services offered are blood pressure assessments, weight monitoring, foot care and ear cleaning. Skin assessment for skin cancer and other changes, macular degeneration screening, and "Brown Bag" medication reviews are some of the preventative programs offered at periodic intervals. In the Spring of 2000, the School of Dental Hygiene joined the clinic at both of these established sites. Services they

provide include assessment or screening for oral cancer and gum disease, and teaching good dental and oral health practices. The Gerontological Nursing Clinics provide students with "hands on" interventions that assist the older adult to maintain his/her independence.

**CONSORTIUM FOR ELDERLY AND
YOUTH IN THE ARTS (CEYA)**

***The Consortium for
Elders and Youth in the
Arts (CEYA)***

*Goldman Institute
on Aging
3330 Geary Blvd.
San Francisco, CA 94118*

*Contact:
Judy Loura
Development Director
(415) 750-4180 Telephone*

The Consortium for Elders and Youth in the Arts (CEYA) is a group of San Francisco Bay Area elder and youth service agencies collaborating on the development and implementation of cross-generational arts programming. CEYA is a program of Artworks which is an Artists-In-Residence program that provides workshops, instruction and performance opportunities to over 500 older adults annually who are either homebound or attend one of San Francisco's many Adult Day Health Centers or residential homes for the elderly.

CEYA was developed to address the high level of isolation that elders experience in contemporary American life. CEYA's program model, which involved long-term,

in-depth cross-generational programming, provides a conduit where elder's experiences, skills, and stories can be passed via the generation chain.

Each CEYA project is offered for 43 weeks and includes two sessions with participants each week. Each project typically involves 15-25 youth and 15-30 elders.



2000 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

OTHER
NOMINATIONS

SILVER SNEAKERS® FITNESS PROGRAM

**SilverSneakers®
Fitness Program**

HealthCare Dimensions
Incorporated
9280 S. Kyrene Road
Suite 134
Tempe, Arizona 85284

Contact:
Brigita M. Fody-Urias
(480) 783-9555 Telephone
(480) 598-3540 Fax
brigita.fodyurias@hcdimensions.com

HealthCare Dimensions Incorporated (HCD), developed the *SilverSneakers® Fitness Program* for the purpose of reducing/eliminating the main areas of disease and disability in the Medicare population. Like traditional public health programs, SilverSneakers® works toward identifying and serving the needs of “at-risk” seniors to reduce morbidity and mortality while also reducing health care expenditures within the senior population.

All eligible Medicare persons within partnered Medicare MCOs are offered the SilverSneakers® program. SilverSneakers® is a senior-focused fitness program that includes unlimited access to any contracted fitness facility in the local area, nationally accredited SilverSneakers® classes,

socialization activities, nutrition education, and targeted health campaigns. Data collection processes throughout the life of the program accurately measure the program’s impact on the following areas: 1) physical health, 2) mental health, 3) Health Plan Employer Data and Information Set (HEDIS®) measurements, and 4) health care consumption.

COMPUTERS FOR HOMEBOUND AND ISOLATED PERSONS (CHIPS)

**Computers for
Homebound and Isolated
Persons (CHIPS)**

Knoxville-Oak Ridge
Regional Network
Conference Center
Building
600 Henley Street
Suite 313
Knoxville, Tennessee
37996-4137

Contact:
Natalie Bradley
(865) 974-2909 Telephone
(865) 974-6508 Fax
natalieb@korrnet.org

CHIPS is a program of KORRnet, a nonprofit community electronic network, that provides a computer and internet connectivity to persons who are homebound and isolated, to increase their community ties and decrease their sense of isolation. The participants in CHIPS are typically homebound because of infirmity, disability, or because of the responsibility of being a caretaker for someone.

Initially, one of the most unique aspects of the CHIPS program, is that it first began as a grassroots project initiated and managed solely by volunteers from the Office of Aging. With KORRnet providing the internet access, they combined their resources with donated computers from

Covenant Health, in order to provide online computer access to the elderly people. KORRnet and its CHIPS partners then were awarded a grant by the Technology Opportunities Program of the United States Department of Commerce.



2000 ARCHSTONE FOUNDATION AWARD FOR EXCELLENCE IN PROGRAM INNOVATION

OTHER NOMINATIONS

THE F.I.L.E.®

The F.I.L.E.®

Baltimore County
Department of Aging
611 Central Avenue
Towson, Maryland 21204

Contact:
Charles L. Fisher, Jr.
Director
(410) 887-2107 Telephone
(410) 887-2159 Fax
www.co.ba.md.us

In an endeavor to validate the theory that being prepared for the future is essential for both financial and psychological reasons, the Baltimore County Department on Aging, the Area Agency on Aging, developed the idea of a folder to help senior and their families organize their important documents. The Department of Aging developed, produced and marketed an innovative product to accomplish this, called **The F.I.L.E.**, (Financial, Investments, Legal and Estate). The F.I.L.E., a copyrighted document, is a bright yellow folder, designed for the collection and organization of important documents.

The F.I.L.E. was marketed not only locally, but all Area Agencies on Aging in the United States received copies with letters offering them the opportunity to buy camera-ready artwork, with the money going to a Fund for Needy Seniors. To date, the artwork has been purchased by 15 localities in nine states throughout the country.

PATIENT MEDICATION ASSISTANCE PROGRAM

Patient Medication Assistance Program

Christus Jasper
Memorial Hospital
1275 Marvin Hancock Dr.
Jasper, Texas 75951

Contact:
Willie J. Brown
(409) 384-5461 Telephone
(409) 383-0622 Fax
GNMJR@aol.com

Christus Jasper Memorial Hospital the only health care provider in their service area, is an 81-bed community hospital located in Jasper, Texas.

The current population is over 80,000 with a significantly high average rural market of 65 years and older. For many elderly people in Southeast Texas, the cost of monthly medications exceeds their total income. Recognizing that need, Christus Jasper Memorial Hospital sponsored a medication assistance program to aid eligible patients in obtaining free of charge maintenance medications. The program aids patients in obtaining free medications from pharmaceutical manufacturers and is implemented and overseen by the Social Services Department of Christus Jasper Memorial Hospital.

The program allows 150 people to take all their medications as prescribed for a cost of \$1 per month, per medication. This program is strongly supported by the physicians, who state it reduces hospital stays and strengthens the medical management of their patients' conditions.



IN-HOME AIDE TRAINING PROGRAM

***In-Home Aide
Training Program***

*Housing Authority of
the City of Asheville
Buncombe County
Department of Social
Services*

and

*Mission St. Joseph's
Health System
165 S. French Broad Ave.
Asheville, NC 28801*

*Contact:
Ms. Spike Gram
(828) 257-2638 Telephone
(828) 254-2276 Fax*

The In-Home Aide Training Program (IHATP) is a collaborative effort of the Housing Authority of the City of Asheville, Mission St. Joseph's Health System, and the Buncombe County Department of Social Services. Originally designed to address the needs of two "at-risk" populations- women transitioning from welfare (via the Work First Program) into the workforce, and low-income elderly in need of assistance in aging-in-place- the Program has evolved to include trainees from the Older Worker Program at the Area Agency on Aging, the Mary Benson House for pregnant women in drug/alcohol rehabilitation, local high schools, JTPA, and other agencies.

The curriculum encompasses the first two of the four levels of the state-mandated competencies for nursing assistants, plus units on the aging process, communication

skills, the role of the in-home aide in assisting elders' functional abilities. After two weeks of classroom learning, the trainees work in pairs to assist low-income elderly residents in a public housing high-rise in their activities of daily living. Also, the trainees provide social contact for residents who become isolated because of physical or mental challenges.

HEALTHY AGING PROGRAM

Healthy Aging Program

*University of Texas
Medical Branch, Galveston
301 University Boulevard
Galveston, TX 77555-1028*

*Contact:
David Haber, Ph.D.
(409) 772-3038 Telephone
(409) 747-1610 Fax*

The Healthy Aging Program is based on three principles: 1) empowering older adults, 2) applying social learning theory, and 3) implementing community-based programs with health science students and health providers. The components of the program are:

1. Exercise and Health Education: These 7 or 10-week programs are taught by health science students in a variety of community settings. The 40-minute exercise component consists of aerobics, stretching and strength-building. The target group has been sedentary older adults. The remaining 20 minutes of each class consists of health education on a variety of topics of interest to the older adults.
2. Health Assessment and Intervention: Over a 40-minute period, primary and

secondary prevention behavior changes are reviewed with each older adult by health science students and health providers. During the remaining 20 minutes, the student or provider collaborates with the older adult on choosing a health goal and plan of action to achieve that goal.

Students benefit from the program by increasing their knowledge in geriatrics. Older adults benefit by making dramatic progress toward achieving their health goals.



EL PORTAL: LATINO ALZHEIMER'S PROJECT

**El Portal:
Latino Alzheimer's
Project**

Alzheimer's Association
of Los Angeles
5900 Wilshire Blvd.
Suite 1700
Los Angeles, CA 90036

Contact:
Jeannette Hilgert
(323) 938-3379 Telephone
(323) 938-1036 Fax

El Portal: Latino Alzheimer's Project targets Latino family members of dementia-affected individuals and was developed as a creative response to the barriers facing this community. Sensitive to language, customs and other cultural values, the program's services and resources make it possible for family members to continue to provide care at home.

El Portal provides a range of social and supportive services to help families handle the burdens associated with caregiving. One of the creative design features of the project is its use of bilingual/bicultural personnel who advocate for the needs of families enrolled in the program. Additionally, as a culturally sensitive model, El Portal Project creatively employs input from clients and caregivers.

This culturally appropriate response to Latino caregivers, use of Care Advocates, and reliance on client participation has resulted in high service utilization, making the project one that truly meets the needs of its constituents.

CERTIFIED NURSE ASSISTANT RECRUITMENT AND RETENTION PROJECT

**Certified Nurse Assistant
Recruitment and
Retention Project**

Iowa Caregivers
Association
1117 Pleasant Street
Suite 221
Des Moines, IA 50309

Contact:
Diana Findley
(515) 241-8697 Telephone
(515) 241-8587 Fax
iowacga@aol.com

The purpose of the *CNA Recruitment and Retention Pilot Project* was to assess the needs of CNAs and respond to those needs through programming in order to reduce CNA turnover in nursing facilities. The philosophy of the Iowa CareGivers Association (an innovative professional association for CNAs) is central to the project:

1. enlist CNAs to be part of the solution and decision making;
2. the issues are multi-dimensional (cultural, social, economic, educational, and quality of life/quality of care).

A comprehensive approach was taken which included needs assessment, recruitment and training, and evaluation.

Both facility and community-based programs were developed and implemented.

At the end of the year one, three nursing facilities realized a reduction in their CNA turnover.

Project results have been disseminated to more than 2,000 health care providers, caregivers, legislators, state agencies, educators, advocates and consumers. With a more stable pool of caregivers who deliver 80-90% of the most fundamental care, the residents, providers, and caregivers all benefit.



2000 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

OTHER
NOMINATIONS

COMMUNITY NURSING ORGANIZATION / THE HEALTHY SENIORS PROGRAM

**Community Nursing
Organization/
The Healthy Seniors
Program**

Carondelet Health Network
5316 N. Via La Doncella
Tucson, AZ 85750

Contact:
Rebecca Dahl, R.N., Ph.D.
(520) 299-8504 Telephone
(520) 748-8790 Fax

The Carondelet Community Nursing Organization (CNO) is a national Medicare demonstration sponsored by the Health Care Financing Administration (HCFA). The goal of the CNO is to design and test a new model of home and community-based care for Medicare members. The CNOs feature Nurse Partners, health promotion/prevention, chronic illness management and individualized matching of health and community services to member need. Each program component also includes a Wellness Plan that includes a lifestyle prescription and appropriate referrals to health care providers, health seminars and community services.

The CNO has demonstrated effective care for seniors in a community-based setting. Measurable benefits of the CNO on the health of seniors and the efficient utilization of provider services were demonstrated. Program results include overall health status outcomes, show that members significantly improved in both mental and physical health status. Health screenings results showed significant improvement among high risk members in areas such as blood pressure, stress, and physical activity.

THE CANCER SURVIVAL TOOLBOX

**The Cancer Survival
Toolbox**

National Coalition for
Cancer Survivorship
1010 Wayne Avenue
Suite 770
Silver Spring, MD 20910

Contact:
Courtney Workman
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The National Coalition for Cancer Survivorship (NCCS), the Oncology Nursing Society (ONS), and the Association of Oncology Social Work (AOSW) through a grant from Genentech BioOncology, have collaborated on the development of *The Cancer Survival Toolbox™. . . Building Skills that Work for You*. The work has been the result of years of research and collaboration among the country's cancer experts to create highly effective and relevant audiotapes that teach, through interactive exercises and role-playing, the critical life and decision-making skills deemed necessary for obtaining the best care possible.

Programs around skills identified through extensive research were scripted and developed into 30-minute audiotapes

complete with case studies, interactive exercises and role-playing. A comprehensive resource booklet accompanied tapes, with references and referrals. The Cancer Survival Toolbox has become an indispensable staple in cancer centers and on survivors' tables nationwide and is widely recognized as one of the most effective educational tools for cancer patients available today.



HOME-BASED AND COMMUNITY-BASED CARE DEMONSTRATION

**Home-Based and
Community-Based
Care Demonstration**

*Kaiser Permanente
Center for Health Research
3800 N. Kaiser Center Dr.
Portland, Oregon
97227-1098*

*Contact:
Walter N. Leutz
(503) 499-5794 Telephone
(503) 335-2428 Fax
Lucy.Nonnenkamp@KP.org*

In 1997, Kaiser Permanente (KP) Interregional Committee on Aging (IRCOA) began a system-wide demonstration of home- and community-based (HCB) long-term care. The 33 sites participating were chosen from nearly 200 applicants. They represent a broad range of models for integrating HCB services into the KP system of care. Examples include:

- Enrolling the SSI Medicaid population and linking KP providers with these new members and the variety of HCB services they use (VT).
- Providing KP pediatricians with stronger ties to HCB services, schools, and family caregivers for children with developmental disabilities (OH).
- Developing new HCB supports and service linkages for KP care coordinators

and clinicians in serving disabled members, including:

- Home care aides for those with temporary disabilities (HI)
- Referral and access protocols with selected HCB providers (CA)
- Consultation and easy access to adaptive and supportive equipment (OR)
- Community health workers on care teams (CA)
- Increased coordination with adult foster homes (OR)
- Service coordinators in naturally occurring retirement communities (HI)
- An alliance with housing providers for older and disabled persons (CA).

“ALZHEIMER’S DISEASE: WHAT CAREGIVERS NEED TO KNOW”

**“Alzheimer’s Disease:
What Caregivers Need
to Know”**

*University of South Florida
Suncoast Gerontology
Center
12901 Bruce B. Downs Blvd.
MDC 50
Tampa, Florida 33612-4799*

*Contact:
Eileen Poiley, M.S.
(813) 974-4355 Telephone*

“Alzheimer’s Disease: What Caregivers Need to Know” is a video program developed as a result of caregiver classes conducted by the University of South Florida Suncoast Gerontology Center. The caregiver classes have consistently received excellent evaluation from over 200 caregivers. To make this information available to a national audience, the key information from six classes was produced into a 21-minute video and accompanying pamphlet.

The video features clips of actual Alzheimer’s caregivers and provides critical information on the following six topics: What to do after the Diagnosis is made; Successful Caregiving; Community services; What’s New in Alzheimer’s disease research; Dealing with problem behaviors; and Legal and financial issues. More than 100 individuals have viewed the video and the evaluations and feedback clearly shows that the video and pamphlet are very helpful to caregivers and professionals who work with Alzheimer’s caregivers.



THE 2001 ARCHSTONE FOUNDATION AWARD FOR EXCELLENCE IN PROGRAM INNOVATION

CALL FOR NOMINATIONS

The Gerontological Health Section of the American Public Health Association will accept nominations for its **2001 Archstone Foundation Award for Excellence in Program Innovation** effective November 1, 2000. This award has been established to identify best practice models in the field of aging and health. Emphasis will be given to those programs (in operation 10 years or less, but long enough to have documented results) that have effectively linked academic theory with applied practice in the field of public health and aging. An independent panel will review all nominations.

The criteria for award selection will include:

- Creativity in project design;
- Documented outcomes and benefits of the program;
- Replication potential; and,
- Dissemination strategy.

In two typewritten pages, please describe the program you wish to nominate. Your narrative should include information about the project's design, funding, partnerships or collaboration, staffing, types of services provided, population served, and measurable benefits and outcomes. A copy on a disk readable in MSWord or Word Perfect is requested. You may attach new articles, videos, manuals, etc., in support of the nomination. Only one program may be nominated per agency or organization.

The winner is expected to attend the 129th Annual meeting of the American Public Health Association in Atlanta, GA, on October 22, 2001, and make a presentation in a special Gerontological Health Section Award Session. Honorable Mention to other finalists may be awarded.

In recognition of this achievement, and to assist with travel expenses, the winner will receive a \$1,000 cash award. Each honorable mention will receive a \$250 cash award.

Nominations are to be postmarked by April 1, 2001.

Nomination materials for the 2001 Archstone Foundation Award for Excellence in Program Innovation can be obtained from:

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2000 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

NOTES



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