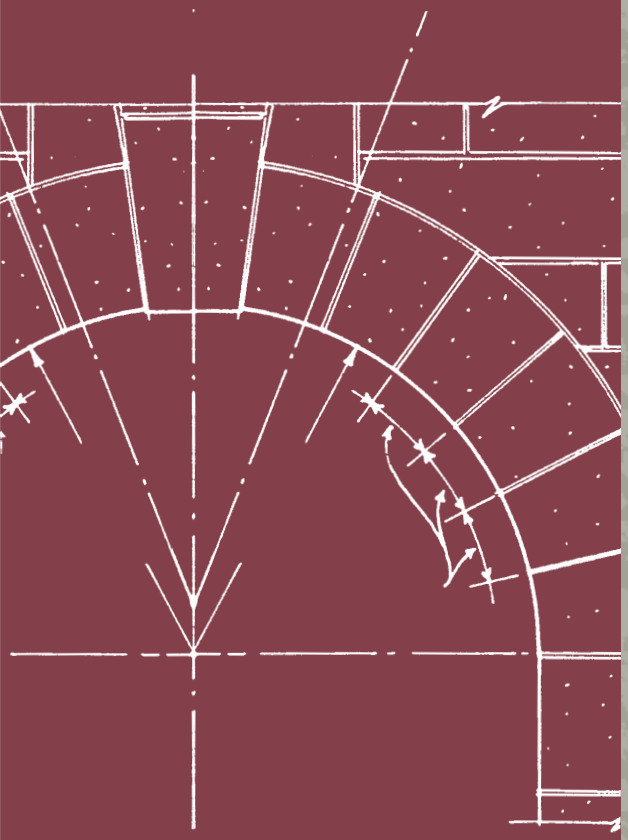
ARCHSTONE FOUNDATION

and the
Gerontological Health Section
of the
American Public Health Association
present . . .

1999 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
- at the end of life

The majority of the foundation's funds are directed to programs in the Southern California region. Demonstration projects and programs with regional or national impact 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:

Archstone Foundation
401 E. Ocean Blvd., Suite 1000
Long Beach, CA 90802
(562) 590-8655
(562) 495-0317 Fax
www.archstone.org

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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FOREWORD

Congratulations to this year's Recipient and Honorable Mentions of the
Archstone Foundation Award for Excellence in Program Innovation.

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 1999 Archstone Foundation Award recipient:

Senior Wellness Project
Senior Services of Seattle/King County
Northshore Center, Bothell, Washington
Principal Investigator: Edward Wagner, M.D., M.P.H.

1999 Archstone Foundation Award
Honorable Mentions:

Strengthening Geriatrics Training for Primary Care Medical Residents
Medical College of Wisconsin
Milwaukee, Wisconsin

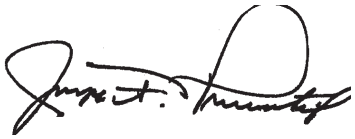
Genesis Older Adult Services Program
Los Angeles County Department of Mental Health
Los Angeles, California

Partners for Healthy Aging
Merck-Medco Managed Care, LLC
Montvale, New Jersey

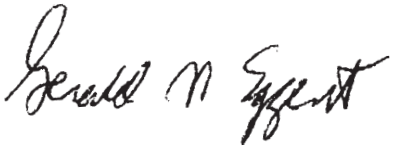
A Model in Community Organizing for Primary Prevention
Marin Commission on Aging Strength Training Task Force
San Rafael, California

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 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 the winners of the 1999 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



Gerald M. Eggert
Chair, Gerontological Health Section
American Public Health Association

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1999 Award for Excellence

IN PROGRAM INNOVATION

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SENIOR WELLNESS PROJECT

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Senior Services of Seattle/ King County
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Overview: The Northshore Senior Center (NSC) in Bothell, Washington, a unit of Senior Services of Seattle/King County, developed the Senior Wellness Project (SWP) to test the effectiveness of embedding interventions proven to decrease disability risk and/or improve function in older adults into one interconnected program. SWP aims to provide a cost-effective, high quality, comprehensive program with tangible efficacy results. The Senior Center environment complements the SWP because of the Center's potential to provide and strengthen social networks, with are associated with improved health outcomes. University-based researchers were invited to work with the NSC in unobtrusive ways that allowed the health promotion activities to be consumer-friendly but nonetheless collected rigorous data.

Background: Senior centers have long provided a place for social interaction and a variety of health-related programs, such as exercise activities and health screening. However, the diversity and efficacy of such programs have varied markedly across senior center sites. Often, the benefit of programs has not been well documented, thereby limiting the ability to cover program costs because potential funders often demand evidence of improved health outcomes and/or reduced health costs. The program initiated by NSC sought to implement *and* evaluate programs to ensure continuation of those activities that prove to be effective for seniors and cost-effective for providers. The SWP is a model of community-academic collaboration for pragmatic research.

Target Audience: Older adults living in and near Bothell and, through replications projects, throughout the State of Washington

Program Components:

The Senior Wellness Project includes four distinct components for seniors. Each was developed and evaluated separately.

Lifetime Fitness is a comprehensive disability/fall reduction program that includes exercise for independent older adults. It was begun in 1993 as a collaborative effort of the NSC, University of Washington, and Group Health Cooperative Center for Health Studies. Participants have shown improvements in measures of physical function, including walking, strength and flexibility measures, and reduction in symptoms of depression.

Health Enhancement Program (HEP) is an intervention to prevent functional limitations and reduce health care use. It relies upon collaboration between community agencies and medical care providers to offer appropriate health promotion activities for older adults with substantial health problems. HEP enrollees receive a nursing assessment and comprehensive health review by a registered nurse and a social worker. The enrollee, with the assistance of the nurse, develops a Health Action Plan that details areas in which the person would like to make improvements. The nurse provides ongoing support, health education, problem solving, and referrals. The social worker provides individual counseling, assistance in developing an action plan to manage symptoms of depression/anxiety, and support groups. HEP seeks to complement the work of the primary care physician. The physician is notified when their patient is enrolled in the program, and is considered part of the program team working with the enrollee.

Award for Excellence in Program Innovation

Senior Services of Seattle/King County Northshore Center, Bothell, Washington

Chronic Disease Self-Management Program (CDSMP) is a seven-week course taught by lay leaders that enhances participant skills in living with a chronic illness. CDSMP was first developed and tested by Dr. Kate Lorig and colleagues at Stanford University.

The Health Mentor Program matches HEP clients to trained peer mentors. Mentors provide follow-up calls, companionship, and links to professional staff. Evaluation has found the program to be beneficial to both mentors and mentees.

Individual or Combined Activities. Seniors may participate in one of the four Senior Wellness programs, then be referred to the others.

Research and Evaluation. All of the programs have been designed based on a careful review of scientific evidence to date. Moreover, researchers, primarily from the University of Washington, have conducted ongoing evaluations of the SWP programs. In addition to being a focus of academic research, SWP provides quality control by requiring regular reports and careful training of those who implement activities. SWP also continues to incorporate evidence-based updates from community agencies and researchers.

Funding: The Senior Wellness program is sponsored by Senior Services of Seattle/King County, the largest non-profit agency serving seniors in Washington State. Funding for replication and dissemination of the project has been received from a wide range of organizations, including the local Are Agencies on Aging, physician service networks, hospitals, the public Health Department, and the Centers for Disease Control and Prevention (CDC) Prevention Research Center Program. These partnerships form a system of care that covers the Puget Sound area. Senior Centers provide office space, equipment, volunteers, and program staff. Funding for registered nurses and social workers comes from a variety of sources, including in-kind staff support from hospitals and clinics.

Outcomes: The Senior Wellness Program demonstrates how local agencies can practice evidence-based public health. An effective model for collaborating with university researchers were developed. As a result, measurable benefits of the SWP on the health of individuals and the efficient use of resources have been demonstrated. Each of the four component programs has been evaluated for its effectiveness. Because of its success, the Lifetime Fitness program began to be replicated by other senior centers as early as 1995. A randomized trial of HEP for which staff had the ability to refer patients to Lifetime Fitness, CDSMP, and the Health Mentor program showed a 72 percent reduction in hospital days, a reduced use of psychotropic medications, greater physical activity, and improved functional status. Based on these results, the complete program package of Lifetime Fitness, CDSMP, HEP, and the Health Mentor Program has been extended to over sixteen sites through the State of Washington. Individual program components have been replicated in an additional eighteen sites in the State of Washington and Virginia. Northshore Senior Center has recently received a grant from the Robert Wood Johnson Foundation to provide the full set of Senior Wellness Program activities in ethnically diverse low-income housing.

Marianne LoGerfo, MSW
Project Director

STRENGTHENING GERIATRICS TRAINING FOR PRIMARY CARE MEDICAL RESIDENTS, *Medical College of Wisconsin, Milwaukee, Wisconsin*

This program was funded by HRSA GEC #5D31 AH70009-05, the Helen Bader Foundation, the Wisconsin Area Health Education Centers, Veteran's Administration Medical Center, and the Medical College of Wisconsin.

Strengthening Geriatrics Training For Primary Care Medical Residents

Medical College of Wisconsin
Wisconsin Geriatric Education Center
Milwaukee, Wisconsin

Project Directors:
Deborah Simpson, PhD
Edmund Duthie, Jr., MD

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Wisconsin Geriatric Education Center
414-288-3712

Overview: This programs strives to enhance physicians' understanding of geriatrics by structuring the education and training that medical residents receive at primary care sites. It provides a systematic set of instructional materials that faculty and medical residents can use at a variety of primary care training sites.

This project represents a multi-faceted and inter-disciplinary strategy to improving the geriatrics training of Wisconsin's adult primary care residents. Expert geriatricians were trained in Instructional Design and developed a series of ten geriatric educational modules which continue to be used to train primary care medical residents and other health care professionals. Additionally, the project created and pilot tested a Performance Based Assessment Station to assist medical residents in their management of patients with dementia. These training materials, representing systematic approaches to teaching and assessing skills in geriatric medicine, serve as a model for curriculum change in other areas.

Background: Training for physicians now requires that residents have experience in geriatrics in keeping with accreditation guidelines. Yet, few residency sites have geriatricians on staff, so non-geriatricians provide much of the medical residents' geriatric education. Although interested and motivated, these program faculty may lack the time and resources to produce quality educational materials in geriatrics. Expert geriatricians, while having breadth and depth in the content of geriatrics, may lack the time and skills to systematically produce educational modules for use by primary care physicians in teaching. To bring together the strengths of all involved and fill the gaps in appropriate educational materials, a consortium of geriatricians and educational consultants from six academic and health care institutions used a multi-step process to design and disseminate geriatric training modules to adult primary care residency sties.

Target Audience: Medical residents of the Medical College of Wisconsin and faculty at primary care residency training sites.

Program Components:

A consortium of geriatricians and educational consultants was convened to collaborate on the format and content of the residency training in geriatrics.

Ten topic areas were targeted for educational modules based on a comprehensive review of the literature and needs assessment. Using a Train the Trainer approach, expert geriatricians were recruited to design the training modules, including first attending an intensive workshop on the systematic process of instructional design. All modules included pre and post tests.

Workshops to disseminate the modules were held for resident faculty at the various primary care residency sites.

A companion *Performance Based Assessment (PBA) Situation* using a Standardized Patient was designed and implemented to assist faculty in teaching and assessing medical residents in their management of patients with dementia. This included a videotape of patient assessment and the resident's self-assessment of performance. The tape was subsequently evaluated by two experts in geriatrics, and feedback on performance given to the resident. Differences between the resident's and experts' evaluations of Functional Assessment was particularly noteworthy, with residents rating themselves higher than the experts.

Outcomes:

In 1997, 75% of the resident faculty and in 1998, 82% attended the dissemination workshops. To date, 300 medical residents have completed evaluations of the modules with high learner satisfaction. On a scale of 1 (strongly disagree) to 4 (strongly agree), the residents reported that they would recommend this presentation to colleagues and that the presentation provided practical information. Additional, each resident completed a retrospective pre/post assessment of competencies based on the module's educational objectives. For 27 of the 28 module objectives, the difference between the pre and post scores were significant at the .001 level or greater.

GENESIS OLDER ADULT SERVICES PROGRAM, *Building a Seamless System of Care*

Los Angeles County Department of Mental Health, Los Angeles, California

Overview: The Geriatric Evaluation Networks Encompassing Services, Information and Support (G.E.N.E.S.I.S.) is a program of the Los Angeles (LA) County Department of Mental Health established in conjunction with the Community and Senior Services Area Agency on Aging. The goal is to provide older adults services that support their dignity, maximize options, and enhance their independence, and in particular, to prevent unnecessary hospitalization for mental health crises. The program provides comprehensive, mobile, in-home community-based mental health and health services to adults 60 years and older.

Target Audience: Frail, homebound older adults in Los Angeles County suffering from mental health problems.

Program Components:

Several public departments of Los Angeles County and community agencies joined together to implement the project. The collaborative approach is cost-effective because it provides a multi-disciplinary perspective to evaluating and resolving client needs. By reducing fragmentation, dollars are saved, care outcomes are more effective, and client satisfaction is greater.

A transdisciplinary team provides comprehensive assessment to clients in their homes, holds clinical case conferences, and conducts joint care planning and disposition. A master's level licensed clinical social worker and registered public health nurse conduct the initial assessment. Clinical support, consultation, and ongoing staff education are provided by a nurse practitioner, gerontologist, geriatric internist, and psychiatrist.

Formal interagency agreements are held with Adult Protective Services, mental health agencies, health providers, the Public Guardian, law enforcement agencies, care management programs, hospitals, religious organizations and other community-based services. Screening protocols are accepted by all agencies.

Services include mental health (assessment, crisis stabilization, short-term treatment and referral); health (screening, medication support, referrals); linkage, coordination and advocacy; and consultation by referral to other providers.

Outreach is done to senior housing, senior and community centers, and other community agencies.

Links to the client's primary care health care provider and made from the team back to the client's regular providers of health and mental health care.

Innovation Funding. Funds are provided through Medi-Cal (Medicaid), Medicare, private insurance, and blended funds through a unique partnership between the LA County Departments of Mental Health, Community and Senior Services, and Adult Protective Services.

A student unit trains and mentors undergraduate and graduate students in gerontology, social work, nursing, and medicine.

Performance outcome measures for older adults in the mental health system are developed and tested by GENESIS in collaboration with the State of California Department of Mental Health.

Outcomes: The two teams beginning the program in 1995 have been expanded to nine teams. GENESIS has resulted in decreased hospitalizations, increased consumer satisfaction and empowerment, and saved lives. Between 1995 and 1998, the program demonstrated an estimated gross savings of $2 million to the Department of Mental Health alone. Over 1000 clients served between 1995 and 1998, less than three percent of clients needed to be involuntarily hospitalized, maximizing client choice, independence, quality of life and reduce costs of higher levels of care. The multi-disciplinary, multi-agency approach has enabled the team to assist clients who for years had been served by individual agencies without positive results. The collaborative arrangements established are a model of public-public and public-private partnerships. The model screening protocols are being disseminated statewide.

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PARTNERS FOR HEALTHY AGING

Merck-Medco Managed Care, LLC, Montvale, New Jersey

For more information contact:

Partners for Healthy Aging

Merck-Medco Managed Care, LLC

100 Summit Avenue
Montvale, New Jersey
07645-1753

Overview: The Partners for Healthy Aging® Program was established by Merck-Medco Managed Care, LLC, the nation's leading pharmacy benefit management company, in 1995. It offers a comprehensive, systematic approach to coordinating pharmaceutical care for seniors. Partners for Healthy Aging® uses a computerized Seniors Drug Utilization Review Program (DUR), educational materials, and health management initiatives to reduce the use of potentially unsafe or ineffective prescriptions by older adults.

Target Population: Seniors enrolled in managed care plans that contract with Merck-Medco for pharmacy management, currently numbering 10 million.

Program Components:

The Partners for Healthy Aging® Program takes a multi-faceted approach to maximizing pharmaceutical care for seniors.

- *Drug Utilization Review (DUR)* focuses on eleven classes of drugs used to treat conditions common among seniors. This computerized system automatically evaluates all prescriptions submitted by managed care plan participants and red-flags any potential problems. Pharmacists from Merck-Medco Rx Services, Merck-Medco's mail service pharmacy, and from the company's network of 55,000 participating retail pharmacies are alerted when a prescription for a senior may be inappropriate due to drug selection or dose. The pharmacists then use the program's comprehensive on-line clinical information to counsel physicians regarding potentially harmful prescriptions that could cause adverse drug reactions and result in avoidable hospitalizations or doctor visits.

- The *Medication Guidebook for Older Adults* is published as an easy-to-use reference that addresses conditions common among seniors and focuses on possible side effects, drug interactions, and specific geriatric warnings for the medications most frequently prescribed for those conditions.

- Seniors also receive *drug information leaflets and pocket-size formulary guides*. These materials, combined with the Guidebook, provide pertinent information for individuals over age 65, warnings to alert patients and their physicians about medications that are generally not recommended for older adults, and information on drugs that may require age-specific dosage adjustments.

- The *Gatekeeper Program* attempts to identify patients in need and refer them to the appropriate local offices of the Area Agency on Aging. In 1998, this program identified more than 2,500 potential candidates for support services and worked to get them in touch with needed social services, such as homemakers, nurses, and transportation.

- All initiatives are built on a well-established clinical foundation. Merck-Medco's Department of Medical Affairs regularly reviews and updates all initiatives and protocols. An independent *Medical Advisory Board* of leading experts in geriatric medicine and pharmacy practice reviews and approves all initiatives.

Outcomes: A study reported in the *Journal of the American Medical Association* (October 14, 1998) found that the Partners for Healthy Aging® Program achieved a 24 percent change rate in the use of medications generally recognized as inappropriate for patients over 65—a rate of change twelve times greater than normally occurs without such a program.

A MODEL IN COMMUNITY ORGANIZING FOR PRIMARY PREVENTION

Marin Commission on Aging Strength Training Task Force, San Rafael, California

Marin County Commission on Aging Strength Training Task Force

Marin County Commission on Aging
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Chair: Ruth Youngquist
Staff: Liz Rottger, MPH

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Overview: The mission of the Marin County Strength Training Task Force was to translate recent scientific data on the value of weight bearing exercises for seniors into a community health promotion campaign with concrete activities by community agencies and individual seniors. In brief, the Task Force sought to mobilize the older community in Marin County to start lifting weights.

Target Audience: Older adults through-out Marin County, including those residing in nursing homes and low-income senior housing; and professionals who work with seniors.

Program Components:

The Strength Training Task Force invited seniors, physical therapists, exercise teachers, and experts in the field of personal fitness training to assist in defining its activities as well as in determining which exercises older persons should perform. It developed activities in four areas:

- *Community Outreach* through media and presentations to senior groups. The Task Force developed and distributed three motivational Strength Training Bulletins with recommended exercises. Local newspapers published articles on the benefits of strength training. Task Force members demonstrated strength-training exercises and discussed their importance at local senior organizations. The Task Force produced a short video to motivate both individuals and organizations to start strength training classes. The program was featured on a local cable television program.

- *Model Strength Training Program* in a local nursing home. The Task Force assisted in implementing a strength training program for the residents of a local nursing home in Marin. The program was then replicated in other nursing homes in Marin.

- *Strength Training Classes as Senior Housing Complexes,* with a peer teaching component. An experienced strength trainer started classes in four low-income housing facilities. Weights were purchased or donated. These classes met with extraordinary success. In order to ensure the continuation of the classes after grant funding ended, two enthusiastic residents from each facility were selected as peer teachers and given extra encouragement and training in order to lead the classes themselves. Pre and post measures of the residents showed participants how they had directly benefited from strength training.

Marin Housing Authority is considering expanding the pilot program to all its complexes in Marin.

- *Trained personnel.* From the outset, the long-range plan of the Task Force was to maintain strength training programs for seniors in Marin by training current exercise teachers and nursing home activity directors who would be certified by the Senior Fitness Association (SFA). This effort was very successful. In the first year, two people were certified by SFA; in 1998, eight people were certified. In 1999, another twelve people have been certified. This process has established a core group of professionals who are very interested in increasing their knowledge of the field and committed to providing more opportunities for strength training classes for older people.

Outcomes: The Strength Training Task Force was very cost effective. Total funds spent in the three years to support its activities were less than $15,000. The Task Force had planned to establish a program with sufficient infrastructure that it would continue when the Task Force ended. This was accomplished. Whereas in 1996 there was not a single senior strength training class in Marin County, current classes for seniors are offered by the YMCA, the Jewish Community Center, senior centers, and local branches of the Departments of Parks and Recreation. The Marin Housing Authority is considering expanding the pilot program to its complexes throughout the county. The California Department of Health Services recognized the value of the program and published a replication manual to guide other Area Agencies on Aging and senior service providers who may wish to implement a similar health promotion campaign.

CAREGIVING CLASSES

Suncoast Gerontology Center, College of Medicine, Tampa, Florida

The production and dissemination of the caregiver tapes is being funded by the Shimberg Foundation.

Caregiving Classes
Suncoast Gerontology Center
College of Medicine
University Of South Florida
Tampa, Florida

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Overview: Suncoast Gerontology Center of the University of South Florida in Tampa, Florida, has developed Caregiver Classes to help caregivers take practical steps to manage stress, avoid patient care problems, and improve the quality of their lives.

Target Population: Caregivers are the primary audience. The majority are caring for patients with Alzheimer's disease. Professionals, paraprofessionals providing services to seniors, and graduate students with an interest in aging also participate. Most come from counties throughout the West Central region of Florida.

Program Components: Three distinct services are provided. *Informational Services* comprises education classes on basic caregiver topics. In 1998, six one and one-half hour sessions were offered each quarter. The primary goal is to provide instruction on practical approaches for managing the medical, social, and legal aspects of Alzheimer's disease.

Through *Consultation Services,* Center staff members provide one-on-one guidance to caregivers. These professionals help caregivers clarify issues, identify options, and receive referrals for specific services.

Share and Care Services are socialization opportunities designed to encourage attendees to provide moral, social, and practical support to one another.

Through a grant from the Shimberg Foundation, the educational programs are being developed into a *six-part audiocassette program* that will be distributed to caregivers on a national basis. An accompanying *information booklet* containing "frequently asked questions" and class handout materials will be published.

Outcomes: Since inception in 1996 through 1998, 210 family and professional caregivers participated. Participants report improved ability to manage stress, better planning for the future, greater understanding of ways to provide care, more knowledge about community resources.

END OF LIFE INITIATIVE

On Lok Senior Health Services, San Francisco, California

End of Life Initiative

On Lok
Senior Health Services
San Francisco, California

For more information contact:
Kate O'Malley at
(415) 292-8883

Overview: On Lok Senior Health Services' End of Life Initiative, launched in July 1997, began a one-year internal training and practice improvement program to ensure that all participants who died of chronic illness received comfort care at least 28 days prior to death.

Target Population: On-Lok participants suffering from chronic illness who became terminal.

Project Components: Practice improvements and staff training were enacted. The key elements of the care plan included pain and symptom management and emotional and spiritual support for participants and families. Major challenges included identifying the terminal phase of chronic illness early, especially for those suffering from dementia; establishing family and team members' acceptance of imminent death; recognizing and adapting to cultural aspects of providing end-of-life and comfort care.

Outcomes: The duration of comfort care plans increased, on average, from 13.6 days to 54.9 days. The five care teams became more adept at early identification of the terminal phase of chronic illness: the percentage of participants receiving comfort care increased from 59% to 78%. Sixty-eight percent (68%) died at home or in a transitional care setting, with just 13% in an acute hospital and 16% in a nursing home.

We learned from our participants and their family members how to give appropriate support at the end of lives to cognitively impaired older people of Asian or Latino backgrounds. Specific changes to care include:

- Cultural considerations are now part of all comfort care plans.
- Existing pain assessment tools have been adapted to include non-verbal aspects.
- All participants receive an early assessment of their spiritual needs.

In summary, as a result of the initiative, participants dying from end-stage dementia routinely receive comfort care, and most die comfortably in a non-institutional setting.

INCREASING THE USE OF ADULT IMMUNIZATIONS

Qualidigm, Middletown, Connecticut

For additional information please call:

Deepak Mathur, MPH
Project Coordinator
Qualidigm at
(304) 422-2853

Overview: This initiative is an adult immunization campaign designed to increase the use of pneumococcal vaccine (PVV) by Medicare beneficiaries age 65 and older in Litchfield County, Connecticut by linking PVV with flu shots.

Target Population: The campaign targeted 23,000 non-HMO Medicare beneficiaries within the 60 zip code areas of Litchfield County.

Program Components: Qualidigm provided funding for the project. SPARC, a Disease Prevention Survey conducted by the Centers for Disease Control, developed a county-wide infrastructure. Eleven mass immunizers in Litchfield County participated in the project. Three steering committees included local health departments, medical care providers, public health organizations, consumers, the county chapter of the American Association of Retired Persons, representatives from local churches, and Qualidigm. The steering committees developed protocols for immunization, publicity messages from well-known health care leaders and elders, and a letter to all beneficiaries signed by the county health commissioner and a well-known physician. Two local radio stations and a local cable channel helped publicize the immunizations. Information and educational materials were also mailed to all physicians.

Outcomes: In Litchfield County, the number of vaccinations increased from 1,122 in 1996 to 3,016 in 1997, an increase of 169%. The participating mass immunizers immunized 3.9% of persons age 65 and older in Litchfield County and 6.9% of unvaccinated persons age 65 and older in Litchfield Counties. The percentage of beneficiaries who have ever received the pneumococcal vaccine increased from 43.4% as measured immediately before the flu season, to 50.3% as measured through claims data immediately after the flu season. This represented an increase of 15.9% in a four month period. Linking PVV with flu immunization proved to be an effective technique to increase immunization among those age 65 and older. The intense publicity increased use of the vaccination among private physicians as well as by mass immunizers.

THE MAIN STREET QUALITY OF LIFE PROGRAM

LAS/Aging Research and Education Center, Mars, Pennsylvania

The Main Street Quality of Life Program

LAS/Aging Research and Education Center
Mars, Pennsylvania

Principal Investigator:
Paul David Nussbaum, Ph.D.

For additional information:
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kbutler@ageon.com

Overview: Main Street Quality of Life Program is a lifelong learning initiative implemented at the LAS/Passavant Retirement Campus as a community, grassroot program. It provides and promotes a stimulating, safe, and integrated environment that fosters educational, physical/medical, recreational/social, and spiritual/emotional components necessary to thrive and achieve success with aging. The program is based on evidence that lifelong learning and social activity are effective in preventing neurodegenerative disorders, such as Alzheimer's disease.

Target Population: Older adults, including those residing at the LAS/Passavant Retirement Campus, and those in the neighboring communities. Participants come from homes in the community, group independent living, assisted living, and nursing home settings.

Program Components: Main Street Quality of Life is located on a continuum of care campus for seniors. Nearly two-third of the programs are led by residents. Over 100 activities and programs are offered each term (fall, spring, summer), with topics organized around four themes, called The Four Domains of Main Street. Examples of classes include computer classes, strength training, world history, music. Types of programs vary, including special events, lectures, study groups, activity groups, and individual opportunities. The diversity strives to meet the interests of a diverse population.

Outcomes: The Main Street Quality of Life program recognizes the wisdom and experience of older adults and provides an opportunity for expression and sharing. The total number of individuals from program initiation in Fall 1995 through summer 1998 measured 2,321. Attendees increased 43% from the first to the second year of operation. Average annual attendance is currently about 1200 people, 600 from the continuing care complex and 600 from the community. Satisfaction with programming is high, with an average rating of 3.7 out of 4 (excellent) for all three program years.

A MODEL INTERVENTION FOR ELDER ABUSE AND DEMENTIA

The Benjamin Rose Institute, Cleveland Heights, Ohio

A Model Intervention for Elder Abuse and Dementia
The Benjamin Rose Institute
Cleveland Heights, Ohio

For additional information: Contact
Georgia J. Anetzberger, Ph.D.
Principal Investigator
(216) 791-8000

Overview: This is a collaborative effort of five partnering agencies to establish a multifaceted project in greater Cleveland, OH, to improve the detection and handling of elder abuse involving people with dementia. The goal was to increase case identification, improve care planning and treatment, and promote prevention in older persons with dementia who were suspected of being or were at risk of elder abuse by cross-training professionals from the fields of elder abuse and dementia. The project was funded by the Cleveland Foundation. Collaborators included the Cleveland Area Chapter of the Alzheimer's Association, Adult Protective Services, the Benjamin Rose Institute, Northeastern Ohio Universities College of Medicine, and Western Reserve Consortium for the Prevention and Treatment of Elder Abuse.

Target Population: Professionals who work with older people who have dementia and are at risk of elder abuse

Program Components: An educational program was developed to cross-train staff from the Alzheimer's Association (AA) and Adult Protective Services (APS). Specific products included a 156 page educational curriculum with modules on elder abuse and dementia; training sessions for staff and volunteers; a screening tool to identify abusive situations; a screening tool to identify dementia; protocols for referral and intervention among the three service providing partners (AA, APS, Benjamin Rose Institute); a ten-page handbook for caregivers to self-assess risk of elder abuse and to identify community resources; rigorous evaluation of the overall project and its components. Three advisory committees with representatives from the partnering agencies guided the project.

Outcomes: Participants of the training sessions demonstrated an increased understanding of the issues related to dementia and to elder abuse, as well as improved willingness to collaborate with the staff of other agencies when serving clients. Referrals among the partnering organizations have increased and become more appropriate.

THE NORTH CAROLINA EDEN ALTERNATIVE *(Initiative: A Paradigm for Quality of Life Improvement)*

North Carolina Department of Health and Human Services, Raleigh, North Carolina

The North Carolina Eden Alternative

(Initiative: A Paradigm for Quality of Life Improvement)

North Carolina Department of Health and Human Services
Division of Facility Services
Raleigh, North Carolina

Nadine Hamilton

For more information call Nadine Hamilton at (919) 733-7461.

Overview: The North Carolina Eden Alternative™ Initiatives incorporates philosophies of using pets, plans, and children to provide a human habitat model for life in long-term care settings. The goal is to improve the quality of life for residents.

Target Population: Those involved in long-term care, including representatives of nursing homes, assisted living facilities, hospitals, mental health agencies, government agencies, academia, and the lay public.

Project Components: The North Carolina Eden Alternative™ Coalition was started in Fall 1996. Its members comprised a group of volunteers representing long-term care providers, the government, advocates, and other related organizations. Its function was as a consumer driven educational body. The Coalition sponsored a two-day education conference in September 1997, which had over 100 participants. The Coalition also developed a grant program to encourage Medicaid-Certified nursing homes to implement Eden Alternative™ philosophies. Civil monetary penalties for regulation violations collected through the enforcement process and approved by the Health Care Financing Administration provided the funding for grants to facilities to implement programs consistent with the Eden Alternative™ philosophy. In January 1998, 13 grants of $15,000 were awarded to nursing homes throughout the state.

Outcomes: Data have been collected to measure the outcomes at grant facilities, including resident and staff issues. Evaluation of early data has shown no compromise in resident safety. In 1998, North Carolina received the 1998 Best Practice Award for quality improvement from the Association of Health Facility Survey Agencies. Replication has begun: other states have formed coalitions and grant programs mirroring North Carolina's.

THE PROVIDENCE INSTITUTE

Providence Mount St. Vincent, Seattle, Washington

For more information please contact:
Patricia Szabo
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pszabo@providence.org

Overview: The Providence Institute (PI) seeks to educate professionals working in long-term care about the value of self-directed living and resident-directed care through education and experiential learning. The PI is a collaboration of Providence Mount St. Vincent, a multi-level nursing facility and senior housing complex located in Seattle, WA; and the Providence Mount St. Vincent Foundation, a non-profit corporation established to promote quality care for the elderly.

Target Population: Administrators and other professionals in long-term care who desire to learn about and experience resident-directed care.

Program Components The PI offers a unique glimpse of the inter-workings of a multi-level long-term care facility that has successfully moved to a social model of service delivery. In 1996, Providence Mount St. Vincent implemented "resident-directed care." This approach to care that empowers residents to govern their own daily routines and choose the services they wish to receive.

The PI was developed to respond to inquiries by professionals about how to develop resident-directed care. On-site education held at Providence Mount St. Vincent is customized to meet the needs of each individual participant. Learners from other long-term care facilities have the opportunity to talk directly to the administrator, architect, and front-line program managers, including managers of the nursing center, assisted living, adult day health, intergenerational childcare, adult family home, subacute-transitional care center, and outpatient rehabilitation. Learning opportunities include on-site observation, discussion, and problem-solving strategies through consultation and observation. An advisory committee includes representatives of staff, Foundation board members, community members, and peers.

Outcomes: Since inception, the Providence Institute has provided 40 tours, 15 speaking engagements, answered countless phone calls, and testified as an example of a best practice model at two U.S. Senate special subcommittee hearings. Representatives of facilities from throughout the nation have visited or otherwise contacted the PI and used the information gained to begin changes at their own facilities.

SENIOR CASE MANAGEMENT PROGRAM

County of Ventura Area Agency on Aging, Ventura, California

For more information please contact:
Holly A. Evans
(805) 641-4420

Overview: The Ventura County Senior Care Management Program combines medical, nursing, and social models of case management. This program addresses the needs of the frail, at risk elderly through a holistic, comprehensive model of care. The Senior Case Management program works closely with the Aging Network to access all resources available to its clients, with the goal of keeping seniors functioning safely and independently within their own homes.

Target Population: Frail, at risk seniors in Ventura County, California

Program Components: The case management staff assist seniors to attain maximum independence in a home environment by using appropriate and available social, medical, and volunteer resources. Senior Care Management provides home visit evaluations by a public health nurse. The client is assessed for nutritional deficits, safety in the home, medication use, access to medical care, and financial need. A bilingual staff assist in client assessment to identify cultural issues that are integral to designing a plan of care. A community service worker partners with the public health nurse. A plan of care is compiled and discussed with the client and family. The program then works to place available resources with the permission of the senior and their family members. The community service worker escorts the clients as needed on visits to the physician, community agencies, and other service providers, then reports to the public health nurse.

Outcomes: The Senior Case Management Program has been instrumental in working with the Ventura County Area Agency on Aging, the Inter-Agency Council, the Elder Abuse Council, geriatric assessment teams, and other senior service providers to identify and meet the needs of the frail seniors in Ventura County who are under served and in greatest social and economic need.

SENIOR HELPING HANDS

St. Cloud Hospital, St. Cloud, Minnesota

Senior Helping Hands
St. Cloud Hospital
St. Cloud, Minnesota

For more information please contact:
Nancy Fandel

(320) 251-2700 ext. 4991

Overview: Senior Helping Hands (SHH) is an outreach program designed to serve older adults who may be experiencing chemical and/or mental health problems.

Target Population: Recovering seniors are recruited as volunteers to act as role models and mentors for other seniors suffering from substance abuse and/or mental health problems. The geographic area served is Central Minnesota.

Project Components: Designed as a community outreach program, SHH extends the chemical dependency and mental health services of the Behavioral Care Center of St. Cloud Hospital. A coordinator and an outreach case manager recruit, train, and monitor the volunteers. The sponsorship of the hospital facilitates access to experienced staff, including psychiatrists, psychologists, and a wide array of chemical dependency programs. The professional staff provide ongoing educational workshops to medical, social, and aging network staff, as well as to the volunteers and caregivers. Four major forums were presented in 1998, with 80 + people attending, in addition to an average of five presentations per month to community organizations.

Outcomes: The SHH program graduates show a recovery rate of 80% over a two-year time period. The volunteer core has grown steadily, to 70 at the time of the application. Five community agencies provide funding for the program, including the United Way, two regional Councils on Aging, Minnesota Department of Human Services, and the St. Cloud Hospital. In 1998 alone, the services model has been replicated in 14 counties in Central Minnesota. Over 500 people attended educational sessions, and volunteers and staff traveled over 12,000 miles to assist older adults and their families.

SENIORS SUPPORT PROGRAM

Baycrest Centre for Geriatric Care, Toronto, Ontario, Canada

For more information contact:
Margaret MacAdam at
mmacadam@baycrest.org
(416) 785-2480 or
(416) 785-2500

Overview: Baycrest Centre for Geriatric Care is a multi-level health care system whose mission is to enrich the quality of life of older adults by providing a comprehensive continuum of care. The Seniors Support Program was implemented in 1997 to bridge a gap in services to seniors and their families waiting admission to the Jewish Home for the Aged, the Continuing Care Program in Baycrest Hospital, and apartments in the Baycrest Terrace, a supportive housing complex.

Target Population: Older adults and their families waiting for admission to a unit of Baycrest and seniors living in the community who reside within the local area code.

Program Components: The Seniors Support Program uses a multidisciplinary team of professionals and volunteers to support older adults and families. The program strives to provide a cost-effective range of information, education, support, counseling, and advocacy services that reduce caregiver burden and ease caregiver stress. After an initial assessment, the client is contacted weekly by volunteers, who provide social support over the phone on an as-needed basis, as well as reassurance, behavioral management, and linkage to community services. Volunteer interaction is augmented by professionals when indicated. Services provided by professionals may include assessment; counseling; health promotion; behavioral management; crisis intervention; referrals based on the ethnic, cognitive and emotional needs of clients; and support groups for child caregivers. At the time of application, 20 volunteers, collectively speaking seven languages, were each providing telephone service for two to three hours per week to a total of 211 clients.

Outcomes: The program was so successful the first year that it was expanded beyond those awaiting a place at Baycrest to include residents of the local area. Pilot funding from the Ministry of Health was converted to ongoing funding from Baycrest as part of operating expenditures. Two formal evaluations are being conducted by the local university. Initial findings are that stress of caregivers has been reduced by the contact with the Seniors Support Program.

SERVICE LEARNING IN ELDER CARE PROJECTS

Foundation for Long Term Care, Albany, New York

For more information please contact:
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Overview: The Service Learning in Elder Care addresses the unmet needs for providing care to seniors in the community and simultaneously enhances the quality of academic learning about eldercare issues and policies by integrating meaningful community service with college student course work. Students work as volunteers in community agencies serving seniors, with the experience carefully structured so that the students learn about the need, importance, and policy implications of the service being provided.

Target Population: Universities seeking to provide multi-dimensional educational and college students desiring experience in community settings; community agencies serving seniors who want to expand their capacity by using students as volunteer providers.

Program Components: The Long-Term Care Foundation (LTCF) has developed models for community experiences for college students that augment didactic learning with practical hands-on interaction with community members. The LTCF has produced manuals for faculty, students, and staff and a video to help agency staff prepare to mentor service-learning students at the work site. At least twelve disciplines have participated.

Outcomes: The service learning model has been adopted by 27 campuses in New York State and at three campuses in other states. At least twelve disciplines have participated over the years, and a diverse array of students have taken the program. Evaluations has been conducted by Cornell University. They have shown that students, agency staff, and seniors all report high satisfaction with the service-learning experience. Students' attitudes toward seniors showed a significant change as a result of the experience. In addition to objective data, anecdotal and subjective reactions have indicated that the service learning model results in positive relationships among community agencies and between students and seniors.

THE WERTLIEB EDUCATIONAL INSTITUTE FOR LONG TERM CARE MANAGEMENT

George Washington Medical Center, Washington, D.C.

Overview: The Wertlieb Educational Institute for Long-Term Care Management is a new initiative developed by the George Washington University School of Public Health and Health Services to offer management training in long-term care to graduate and undergraduate students.

Target Population: Graduate students attending the George Washington University School of Public Health and Health Services and practicing professionals desiring continuing education.

Program Components: The Institute enhances the graduate program in Long-Term Care Administration through a variety of educational offerings, including a certificate program in long-term care administration, colloquiums, guest lecturers, and an internet-based distance learning program. It also provides continuing education for current health care professionals. A Summer Institute started in 1998, which offers six sessions per course, with several courses offered each summer. A national summit on long-term care quality is being developed for early 2000. Scholarships are offered for students interested in the Masters in Health Services Administration (MHSA) focusing on long-term care.

The Institute draws upon expert faculty and researchers from a variety of relevant units within the University, including the Center to Improve Care of the Dying, Center for the Study and Advancement of Disability Policy, Center for Health Services Research and Policy, Center for International Health. In addition, the Institute has established strong linkages as well with Washington, D.C.-based national and international organizations dealing with long-term care policies.

Outcomes: The Institute has succeeded in bringing an impressive set of experts together to collaborate on the education of students and professionals. The multi-faceted approach to education is designed to increase the visibility, academic recognition, and practitioner knowledge of long-term care.

CALL FOR NOMINATIONS

The Gerontological Health Section of the American Public Health Association is accepting nominations for its 2000 Archstone Foundation Award for Excellence in Program Innovation. This award has been established to identify best practice models in the field of aging and health. Emphasis will be given to those innovative 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. Newcomers are encouraged; recipients of other awards are not disqualified. An independent panel will review all nominations.

The criteria for award selection will include:

- creativity in project design,
- measurable program outcomes and benefits,
- potential for replication,
- dissemination plans.

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. You may attach news 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 annual meeting of the American Public Health Association and make a paper presentation about their program in a special Gerontological Health Section Award session. There will be one winner and up to nine honorable mentions.

Prize: $500 cash award and award certificate.

Nomination material for the 2000 Archstone Foundation Award for Excellence in Program Innovation can be obtained from:

Brenda R. Wamsley, M.S.W.
Archstone Foundation Awards Chair, GHS/APHA
Center for Aging and Healthcare in West Virginia
517 Market Street
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Nominations are due May 1, 2000.