



ARCHSTONE FOUNDATION

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

2001 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:

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.

2001 SECTION LEADERSHIP

Section Chairperson
Richard Fortinsky, Ph.D.

Program
Dana B. Mukamel, Ph.D.

Awards
Nancy A. Miller, Ph.D.

Archstone Foundation Award
Brenda Wamsley, M.S.W.

Secretary
Miriam Campbell, Ph.D., M.P.H.

Chairperson-Elect
Connie Evashwick, Sc.D.

Nominations
Gerald M. Eggert, Ph.D.

Development
Gerald M. Eggert, Ph.D.

Local Arrangements (Atlanta)
Allan Goldman, M.P.H.

Membership
Gary K. Mayfield, Ph.D., A.C.S.W.

Student Representative
Jennifer Weuve, M.P.H.

Continuing Education
Gary K. Mayfield, Ph.D.

Member of APHA Action Board
Sue Hughes, D.S.W.

Member of APHA Science Board
Kyriakos S. Markides, Ph.D.

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 2001 Archstone Foundation Award recipient:

Groceries to Go

Elder Services Network

Mt. Iron, Minnesota

Principal Investigator: Jeanne Ogilvie

2001 Archstone Foundation Award — Honorable Mentions:

Centralized Geriatric Nursing Assessment Service

DuPage County Health Department

Glen Ellyn, Illinois

The S.A.G.E. Project

The Area Agency on Aging 10B, Inc.

Uniontown, Ohio

Senior Wheels

United Services for Older Adults

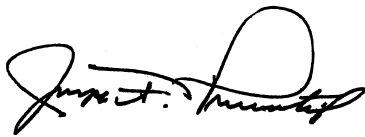
Greensboro, North Carolina

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.

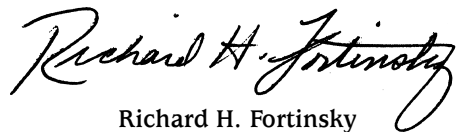
To Brenda Wamsley, M.S.W., Chair of the Archstone Foundation Award Selection Committee, and the other members of our selection advisory committee, we extend our deepest appreciation for their efforts in narrowing down the nominations and selecting the outstanding programs, which received this year's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

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

To the winners of the 2001 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 2001 ARCHSTONE FOUNDATION
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2001 SELECTION COMMITTEE

Brenda R. Wamsley, M.S.W., Chairperson
Archstone Foundation Award Chair,
Gerontological Health Section
Center for Aging and Healthcare
in West Virginia, Inc.
517 Market Street
Parkersburg, West Virginia 26101
(304) 422-2853
bwamsley@citynet.net

Gerald M. Eggert, Ph.D.
Chair, Development Committee,
Gerontological Health Section
Monroe County Long Term Care Program, Inc.
349 West Commercial Street, Suite 2250
East Rochester, New York 14445
(716) 248-8770
gmeggert@aol.com

Donna M. Cox, Ph.D.
Communications Editor,
Gerontological Health Section
Towson State University
Burdick Hall, Room 132
Towson, Maryland 21204
(410) 830-4214
dcox@towson.edu

Connie J. Evashwick, Sc.D.
Chair-Elect, Gerontological Health Section
Endowed Chair and Director
Center for Health Care Innovation
California State University, Long Beach
6300 State University Drive, Suite 270
Long Beach, California 90815
(562) 985-5881
cevashwk@csulb.edu

Allan Goldman, M.P.H.
Governing Councilor,
Gerontological Health Section
Director of Preventive Health Services
Department of Human Resources
Division of Aging Services
Two Peachtree Street, 36th Floor
Atlanta, Georgia 30303
(404) 657-5254
abgoldman@dhr.state.ga.us

Catherine M. Hawes, Ph.D.
Texas A & M University
School of Public Health
260 Centeq-1266 TAMU
College Station, TX 77843-1266
(612) 458-0081
hawes@medicine.tamu.edu

Nancy A. Miller, Ph.D.
Award Chair,
Gerontological Health Section
Policies & Sciences Graduate Program
University of Maryland, Baltimore County
1000 Hilltop Circle
Baltimore, Maryland 21250
(410) 455-3889
nanmille@umbc.edu



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THE 2001 ARCHSTONE FOUNDATION

GROCERIES TO GO

*For more information
contact*

Groceries to Go

*Elder Services Network
8880 Main Street
P.O. Box 401
Mt. Iron, MN 55768*

*Principal Investigator:
Jeanne Ogilvie
(218) 735-8637 Telephone
(218) 735-8649 Fax
esn@Elder-Services.net
www.Elder-Services.net*

The Iron Range of Northern Minnesota is an area long known for brutal winters and slow economy. The Range is also an aging area, as the youth must leave to find work elsewhere. This leaves many seniors to live alone until they are no longer able to provide the necessities of life without assistance and then must go into nursing homes.

The Groceries to Go Program of Elder Services Network (ESN) was designed to meet some of those needs, thus allowing the seniors more time in their homes. This also reduces the burden on the county resources. The recent closing of the LTV Steel Mining operation was a severe blow to families on the Range. More families will no doubt relocate, leaving the seniors behind. Most seniors are quite independent and refuse to relocate, so the Groceries to Go Program will assist those who choose to stay.

Program Design

The Groceries to Go Program is a reliable grocery service for seniors who cannot accomplish this task for themselves. The program provides a weekly shopping and delivery service for persons who are over 60 years of age. Special efforts are made to reach individuals with the greatest need, minorities, frail, disabled, functionally impaired, limited hearing, visually impaired, rural and/or isolated persons. The program provides access to fresh fruit and vegetables and dairy products on a weekly basis. This program design allows the senior to make choices. They are able to take advantage of sales that were beyond them due to their lack of mobility. As there is no delivery charge,

most are able to stay within the fixed income many must live on. This program allows the senior to be an independent member of their community.

The program recruits and trains a volunteer base to deliver the service. Volunteers are given background checks and schooled in confidentiality. Volunteers are trained in good listening skills and they are encouraged to spend some time visiting with the program participants when delivering the groceries to help diminish feelings of isolation and loneliness. This also contributes to the participant's ability to live independently in his or her own home. Volunteers are able to deliver items that are beyond the strength of most elderly people (i.e., canned goods and laundry products).

The participant calls in the grocery orders to the ESN office on Monday morning between 9:00 a.m. and noon. On holidays other arrangements are made. The orders are written down and then faxed to participating grocery stores. Volunteers are also contacted on Monday and told what store to shop at. On Tuesday the volunteer will go to the store, and shop for the requested items. The store will give the volunteer an addressed envelope and the cash register receipt, which will be given to the participant. The senior then mails payment back to the store. No money is handled by the volunteer. The participating stores have reported the program is good for their businesses and their clerks often act as referral sources for the program. And, the participant chooses the store each week. The stores

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allow the seniors to use coupons and stamps for the advertised specials. They simply return them when they mail in their payment. ESN has provided a one day workshop on nutrition and food preparation.

Documentation and Benefits of the Program:

Since the start of the program, participants were asked to fill out a satisfaction survey. Of the 65 surveys mailed out, 42 were returned with very favorable comments. Overall, the senior participants were pleased and thankful for the program. \$440.00 in contributions were sent in by the seniors to help the program. To date 125 seniors have used the service.

Replication Potential:

The program was started in Virginia MN in 1999. In 2000 a branch was opened in Hibbing MN. In 2001 the program was expanded to Gilbert, Mt. Iron and Chisholm MN.

The ESN offices and three staff facilitate the programs. Volunteers assist in the office as well as in the stores. The program can be moved to most any community.

Dissemination Strategy:

The program has brochures, flyers and posters. These are put in public places such as hospitals, libraries, stores, laundries, senior housing and senior centers. The volunteer wanted sections of the newspapers are used to recruit volunteers. The program has been piggybacked in newsletters from other agencies and businesses. Newspapers are asked often to highlight the program.

The magazine *Your Life* (published in Duluth MN) has featured the program. Public Access TV is used. Colleges and churches are solicited.

Funding:

Funding for the office comes from grants, United Way of Hibbing, United Way of Northeast MN, Northland Foundation, St. Louis County, Iron Range Resources and Rehabilitation Board, and Senior's Agenda for Independent Living (SAIL)

The program allows seniors who have always been functioning members of society retain their personal dignity and feelings of self worth. By being able to provide for their basic needs without the intervention of family or social services, they feel independent and are still viable members of their communities. Because of this they remain healthy and happy longer.



***Principal Investigator:
Jeanne Ogilvie***

THE GROCERIES TO GO PROGRAM IS A RELIABLE GROCERY SERVICE FOR SENIORS WHO CANNOT ACCOMPLISH THIS TASK FOR THEMSELVES. THE PROGRAM PROVIDES A WEEKLY SHOPPING AND DELIVERY SERVICE FOR PERSONS WHO ARE OVER 60 YEARS OF AGE.

VOLUNTEERS ARE TRAINED IN GOOD LISTENING SKILLS AND THEY ARE ENCOURAGED TO SPEND SOME TIME VISITING WITH THE PROGRAM PARTICIPANTS WHEN DELIVERING THE GROCERIES TO HELP DIMINISH FEELINGS OF ISOLATION AND LONELINESS.



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MENTION

CENTRALIZED GERIATRIC NURSING ASSESSMENT SERVICE

*For more information
contact:*

**DuPage County Health
Department
Centralized Geriatric
Nursing Assessment
Service**

800 Roosevelt Road,
Building A, Suite 208
Glen Ellyn, Illinois 60137

Contact:

*Sandra Alexander, MSW
(630) 682-7979 ext. 7022
(630) 469-8567 Fax
salexander@dupagehealth.org*

Historically, the elderly have not been the focus of public health agencies except to the extent that they are a part of the general population served by these agencies. However, in recent years that trend has been changing due to an increase in the numbers of people who are living longer.

This kind of growth presents a challenge to public health agencies on many levels, especially when they are providing in-home nursing services. Public health nursing services include health monitoring, health promotion, prevention services, health teaching, advocacy and linking the client to community resources. In the traditional public health nursing model, a referral is made and a nurse is sent out to the home to assess the client. Since most seniors have at least one chronic health problem and their health often follows a downward trend, most seniors were placed on the caseload for monitoring and were followed for several years or until the client's death. Additionally, changes in health care reimbursement have resulted in seniors being discharged from hospitals and home health agencies while still in need of medical care. Increasingly, these clients are referred to local public health agencies for follow-up.

Given these challenges, the Health Department became concerned about their ability to meet the demand for in-home nursing visits for seniors. With public health nursing resources declining, no funding for senior services available and the senior population rising, the Health Department realized that a new service model was needed

to improve the quality and efficiency of in-home nursing services.

To respond to this challenge a centralized geriatric nursing assessment service was developed. All clients who are 60 or over are referred to the Health Department's Gerontology Program and receive a telephone pre-screening by a nurse with training and experience in gerontology. If the client has risk factors that place their health at risk, the gerontology nurse makes an in-home visit to conduct a comprehensive nursing assessment. Clients with minor needs are followed up by the Gerontology nurse via telephone and then discharged when they are appropriately linked to community resources. Those with more complex needs who require additional in-home visits are referred to a public health nurse who can follow-up with that client for 3-6 months.

The DuPage County Health Department is at the forefront of public health agencies that are creatively addressing the dilemma of an increasing aging population amidst an environment of declining human and financial resources. By designing this centralized gerontology assessment service delivery model that emphasizes health promotion, the Health Department has resisted the tendency to view aging as a chronic and deteriorating process; but rather as a process that is amenable to early intervention to maximize health functioning, to promote self-sufficiency and to prevent further decline.



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MENTION

THE S.A.G.E. PROJECT

*For more information
contact:*

The S.A.G.E. Project
*The Area Agency
on Aging 10B, Inc.*
1550 Corporate Woods Pkwy.
Suite 100
Uniontown, OH 44685

Principal Investigator:
Phyllis M. Yoders RN, BSN
(330) 896-9172 Telephone
(330) 896-6644 Fax
pyoders@age.state.oh.us

The S.A.G.E. Project is a collaborative partnership between a large urban area agency on aging (AAA) and Summa Health System (SUMMA) including their Center for Senior Health (CSH) and SummaCare Health Plan. This long-term effort, established in October 1995, integrates acute medical care services, a multi-faceted geriatric clinical services program, Medicare-Risk managed care HMO, and the aging network of community-based long-term care services. This model has many levels of integration to provide a coordinated health care delivery system to reduce fragmentation of care and improve linkage to community resources. The client population consists primarily of low income, frail elderly in Northeastern Ohio with multiple chronic medical and social needs living in the community who are at risk of hospitalization, nursing home placement, or death due to declining functional and health status.

The social sector and the acute medical sector have historically operated for the most part independent of one another with little collaboration or integration. This "sector boundary" often results in less than optimal care and fails to appreciate that comprehensive and effective care requires attention to the biopsychosocial needs of individuals, particularly for those suffering from chronic disease and disability. The S.A.G.E. Project attempts to "bridge the boundaries" between these two sectors by making each of the agencies aware of the other's existence, working together toward a common goal that encompasses all aspects of the individual's care. This project furthers the mission and goals of all organizations involved by offering a forum and alliance to improve coordination of comprehensive health and human service delivery. By integrating and collaborating, the agencies involved are able to assist frail, elderly individuals and their families achieve a higher quality of life by improving their functional status, maintaining their independence in the community for as long as possible, and by avoiding or delaying institutionalization.

This partnership was designed to build upon the existing strengths of each organization. We each identified a lack of continuity in client care and developed new approaches to preventing fragmentation. The conceptual framework of The S.A.G.E. Project was designed to improve communication about patients across the continuum from the medical setting to the community setting. The **Interdisciplinary Community Aging Network (ICAN) Task Force**, the core of the initial intervention, provides the working environment to develop the resources and processes necessary for implementation. Membership in the Task Force includes representatives from every major segment of the health care delivery system.

The ICAN Task Force is unique in that it is a working task force, as opposed to other networking organizations in the community. The members of the ICAN Task Force are actively involved in the client's care and work together to develop a plan and insure its implementation.

The ICAN Task Force is also unique in that a physician (geriatrician) is an active member of the group. He is also an integral member of the geriatric assessment team that sees the client. He is able to communicate peer-to-peer with the client's primary physician and obtain support for the care plan.

Today, our healthcare agencies and institutions see that continuing on separate tracks is no longer in the interest of medicine, managed care, or community-based long-term care and certainly not in the interest of the clients we share. In the years ahead, with significant growth of the older population and with the pressures to contain expenditures, the development of new health care delivery models designed to respond to the complex needs of this population, such as **The S.A.G.E Project**, will become a necessity.



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SENIOR WHEELS

*For more information
contact:*

Senior Wheels

*United Services for Older
Adults*

*P.O. Box 21993
Greensboro, NC 27420*

*Director: John Morris
(336) 373-4816 Telephone
(336) 373-4922 Fax
uso@usoaquilford.org*

Many older adults find that the lack of transportation prevents them from access to daily needs such as medical care. **Senior Wheels** eliminates transportation as a barrier and allows an underserved segment of our community to improve their access to necessary health services.

United Services for Older Adults and the Shepherd Center of Greensboro, recognizing the need to enhance medical transportation options for our older citizens, partnered in 1997 to implement a volunteer-based medical transportation program, Senior Wheels. Both organizations had independently provided volunteer transportation assistance. However, the numbers of volunteers available to drive were limited and the agencies frequently could not adequately respond to all who requested transportation. Recognizing the gap that existed due to the limitations of our public system in our community for transportation, we sought to develop a response that would build the community's capacity to respond to the growing need for transportation to medical appointments. The resulting initiative, Senior Wheels, provided its first ride in May of 1997.

The goals of this program are:

- A. Increasing the number of seniors receiving primary and preventative medical care.
- B. Reducing the level of frustration experienced by the elderly in obtaining medical care.
- C. Maintaining the physical health of seniors, enabling them to continue to live independently.
- D. Assisting the medical community in offering quality patient care due to a reduction in the number of appointments the individuals cancel due to a lack of transportation.

The strength of the Senior Wheels program has been in the partnerships formed with the faith community. Local congregations agree to "adopt" one day each month to provide volunteer drivers to the individuals requesting transportation. Each participating church appoints an individual to serve as the team captain. This individual coordinates the volunteers from their church. The agency staff person provides a list of ride requests to the team captain and then makes sure that the rider is aware that they will be picked up at their home at the appointed time. Drivers, using their own vehicles, pick up the riders and return them home at the appointments' conclusion. But the volunteer drivers provide much more than just transportation to and from medical appointments. The Senior Wheels program has been characterized not so much as a transportation system as a social support system of which transportation is a major element. Drivers often assist frail riders in getting prepared for their medical appointments (e.g., assisting them with putting on shoes and getting to the car), waiting for them during the appointment or returning at the agreed upon time. It is not unusual for the driver to stop at the pharmacy to allow the rider to obtain prescribed medications. Riders often become comfortable with their volunteer drivers and request them by name. In comparison, while Medicaid and Title III transportation programs meet the transportation needs for many people; they have difficulty providing the flexibility and the social support needed by many older adults who may be isolated and have multiple needs.

Senior Wheels provides transportation to individuals age 55 and older who are no longer able to drive themselves to medical appointments and lack anyone else to assist them in reaching their appointments. The program builds on the commitment of the faith community and promotes volunteerism.



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OTHER NOMINATIONS

5 STAR PERSONAL ACHIEVEMENT PROGRAM

5-Star Personal Achievement Program

Homewood at Williamsport
P.O. Box 250
Williamsport, Maryland
21795-0250

Contact Person:
John W. Warren
(301) 582-1626 Telephone
(301) 582-4896 Fax
jwwarren@hmwd.org

In January 2000, Homewood at Williamsport, a continuing care retirement community for 400 residents in Williamsport, Maryland, introduced the “5-Star Personal Achievement Program,” a wellness program borne out of the collaborative effort of the executive director, the director of nursing, the marketing director, and the chaplain.

It addresses five components of a healthy life: physical, spiritual, social, intellectual, and emotional well being. This new wellness program is another example of Homewood’s commitment to excellence for its residents. It is a fresh look at the needs of the residents, whose average age is 82. It is a positive and proactive approach to personal health and well being. The

program allows each resident the opportunity to define and prescribe the areas and types of activities that fulfill his or her own individual needs.

The 5-Star Program is a precedent-setting program for the aging population who want more out of life.

ACCESS DENTAL CARE

Access Dental Care
2275 Vanstory Street
Suite 102
Greensboro, NC 27403

Contact:
William Milner, DDS,
President
(336) 292-5029 Telephone
(336) 292-4206 Fax
bmilner@accessdentalcare.org

In North Carolina, frail and elderly residents of nursing homes and mentally retarded and developmentally disabled residents of group homes have had limited access to adequate dental care. Insufficient Medicaid reimbursement rates and on-site service requiring unfamiliar, lengthier appointments have served as barriers to care. Few dentists provide care to special needs patients, and general dentists are usually not equipped or trained to provide care to patients who are medically fragile and/or behaviorally difficult to treat.

Access Dental Care was established to provide comprehensive dental care on-site to residents of nursing homes, assisted living facilities and group homes. The Access Dental Care treatment team works only with special care patients and consists of a dentist, a dental hygienist, and a dental assistant. Four to five mornings each week,

the team takes mobile dental equipment to one of the twenty facilities it serves in a sixteen-foot truck. There, they move the equipment into the building and set up a two-chair dental office. The team provides comprehensive dental services—from cleanings to dentures—and provides them on a regularly scheduled basis with appropriate follow-up. Treatment decisions involve the full complement of caregivers, including the patient’s responsible party, daily caregivers, and physicians.

Access Dental Care’s statewide board of directors is involved in planning efforts in ten communities across the state to develop Access Dental Care programs in those communities.



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OTHER
NOMINATIONS

ADULT HEALTH AND DEVELOPMENT PROGRAM

Adult Health and Development Program

*University of Maryland
HHP Building
College Park, MD 20742*

*Contact:
Daniel Leviton
(301) 405-2528 Telephone
(301) 445-1546 Fax
d216@umail.umd.edu*

The Adult Health and Development Program (AHDP) at the University of Maryland at College Park began in 1972, and is the model for the National Network for Intergenerational Health (NNIH). AHDP was the first academic, multi-cultural, intergenerational, service-learning, and health promotion program in the country.

The NNIH is the proliferation of AHDPs to 25 other colleges and universities. Unique to the AHDP/NNIH is the individual match-up of diverse university and high school students, and people from the community (called “staffers”) to work as “friendly coaches” with a diverse group of institutionalized and non-institutionalized older adults (called “members”). Here

staffers apply gerontological health theory and research.

NNIH members ascribe to the goal of using physical and social activities, health education, and the one-to-one match-up of diverse staffers and members to reduce ageism and other negative stereotypes that predict hostility and aggression. Thus the NNIH is one means of tightening the social fabric while improving individual and community health.

AMERICAN RED CROSS LIFELINE PROGRAM

American Red Cross Lifeline Program

*American Red Cross
Orange County Chapter
601 North Golden Circle Dr.
Santa Ana, CA 92711*

*Contact:
Suzanne Boothe
Lifeline Specialist
(714) 481-5352 Telephone
(714) 480-5015 Fax*

Established in 1995, the **Lifeline Program of American Red Cross, Orange County Chapter**, provides 24-hour personal response services to at-risk seniors to enhance their independence and quality of life. The American Red Cross provides this valuable service in partnership with Lifeline Systems, the nation’s leading provider of Personal Response Services. Recognizing the need for enhancement of the standard Lifeline program based on community need, the Orange County Chapter is unique in that it offers two additional components: scholarship program/financial assistance for economically disadvantaged seniors, and monthly “check-in” calls made by volunteers to subscribers, which provide reassurance and peace of mind to both the seniors and their families. The Chapter

works with health care professionals including social workers, case managers, physical therapists and physicians in the community who are able to identify seniors in need of this program.

Through the Lifeline Program, the Orange County Chapter continually strives to service and reach out to those with the greatest need who have been unfortunate to suffer both medically and physically. The most important innovation of this program is the successful implementation of a service that provides an impetus for seniors to maintain and enhance their independence and overall quality of life.



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OTHER
NOMINATIONS

THE BORGENICHT PROGRAM FOR AGING STUDIES AND EXERCISE SCIENCE

The Borgenicht Program for Aging Studies and Exercise Science

*The College of William
and Mary
P.O. Box 8795
109 Adair Hall
Williamsburg, VA
23187-8795*

*Contact:
Ken Kambis, Ph.D.
(757) 221-2766 Telephone
(757) 221-2761 Fax
Kwkamb@wm.edu*

The Borgenicht Program was established in 1996 as the result of an endowment funded by a generous gift from Jack and Fran Borgenicht of Long Valley, New Jersey. The Borgenicht Program for Aging Studies and Exercise Science is focused on supporting faculty/student research investigating issues in aging and exercise science. The program has funded laboratory bench science as well as field research. By supporting numerous invited talks, it has also become an information resource for the academic and lay community alike.

In its short existence, The Borgenicht Program has funded research that has resulted in refereed paper publications, published refereed abstracts, and presentations at scientific meetings. Most importantly, the research projects funded to date by this innovative program have supported research experiences for many undergraduate students at The College of William and Mary. Hopefully, these experiences will encourage many of these bright young scientists to pursue careers in aging research.

DEMENTIA SUPPORT SERVICES

Dementia Support Services

*Family Alliance, Inc.
2028 N. Seminary Avenue
Woodstock, IL 60098*

*Contact:
Lynda A. Markut
(815) 338-3590 Telephone
(815) 337-4406 Fax
Family@Stans.com*

Family Alliance developed **Dementia Support Services (DSS)** to assist seniors experiencing memory problems and caregivers attempting to meet the seniors' needs. RN's certified in psychiatric, geriatric, and gerontological treatment visit the client at home, provide assessment, answer questions about dementia, provide linkage to community resources, and develop a plan that considers the needs of family members as well as the senior. Comprehensive support services and follow-up eliminate the gap in care intervention between diagnosis and long-term placement.

The primary goals of DSS are to promote optimum functioning of seniors, give impaired seniors the opportunity to reach full potential within range of ability, allow seniors to remain at home and active longer, and avoid crisis.

Introducing support services early in the process of caregiving gives the caregiver a broader base of support and assistance in managing the senior's illness, reduces stress for senior and caregiver, and helps to protect caregiver health.



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OTHER
NOMINATIONS

THE DOCTORS SHENSON QUALITY OF LIFE PROGRAM

The Doctors Shenson Quality of Life Program

*Jewish Home
302 Silver Avenue
San Francisco, CA 94112*

*Contact:
Mary Steinhauer
(415) 334-2500 Telephone
(415) 334-4375 Fax
Msteinhauer@JHSF.org*

In 1997 the Jewish Home began a program to serve a group of mostly Russian speaking residents considered to be at greatest risk of transfer from their current nursing unit to more restrictive living areas.

Named for its funders, **The Doctors Shenson Quality of Life Program** integrated the adult day care model with the home's approach to long-term care. Twenty-three Russian and English speaking residents, along with community participants, were assigned to one of two simultaneous English and Russian-speaking groups, offering four hours of intensive, on-going programming and greater opportunities for socialization and recreation.

The program succeeded in maintaining the residents on their nursing units and provided a sense of community that decreased the depression and isolation many nursing home residents experience.

Now 77 residents participate in this program.

ELDER READY COMMUNITIES

Elder Ready Communities

*Florida Department of
Elder Affairs
4040 Esplanade Way
Tallahassee, FL
32399-7000*

*Contact:
Gema C. Hernández, D.P.A.
(850) 414-2000 Telephone
(850) 414-2004 Fax
Hernandezg@elderaffairs.org
Spainhowerj@elderaffairs.org*

To prepare Florida for its aging population and to assure opportunities to age in place with security, purpose and dignity, Secretary Gema G. Hernández, Florida Department of Elder Affairs, created the **Elder Ready Communities initiative: A Community for Life**.

Utilizing her agency as a catalyst for change, she engaged city and county governments in identifying and removing mobility barriers that are often manmade and restrict elders' independence.

Facilitating this process, Secretary Hernández designed three Elder Ready Communities Report Cards containing evaluation guidelines of zoning laws, pedestrian access, leisure activities and

other infrastructure. Each report card contains over 25 items needing re-evaluation from the perspective of elders and less-able adults. Each of the three report cards helps communities become elder ready for a specific group: well elders, frail elders, and elders in rural areas.

In a short time, 25 communities have resolved to become Elder Ready, and 24 are preparing resolutions.



2001 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

OTHER
NOMINATIONS

FAMILY RESOURCE AND ADULT DAY SERVICES CENTER OF BROOKLYN, INC.

Family Resource and Adult Day Services Center of Brooklyn, Inc.

*Park Slope Geriatric
Day Center*

*199 14th Street
Brooklyn, NY 11215*

*Contact:
Marianne Nicolos
(718) 499-7701 Telephone
(718) 768-2119 Fax
psgdc1@aol.com*

Integrating a holistic vision of programming with a state-of-the-art facility, **Family Resource and Adult Day Services Center** serves people and families affected by Alzheimer's and other forms of dementia.

The facility was designed to enhance both the independence and safety of participants in day programs. With goals of reducing stress and agitation, an indoor wandering path allows members to move about freely any time; small alcoves offer space for isolation; walls are decorated in soft colors; and doors disguised with beautiful, hand-painted flowers inhibit entry to kitchens and closets. Professional staff direct day program activities and help with

personal care in the "members only" spa and hair salon.

In this beautiful and carefully planned environment, caregivers feel less stress about accepting respite care and also find support groups, educational workshops and a Resource Library stocked with videos, pamphlets, books and referral listings. In the two years since it opened, Family Resource and Adult Day Services has demonstrated that environment and quality programming go hand-in-hand.

THE GERONTOLOGY PROGRAM

The Gerontology Program

*4700 College Oak Drive
Sacramento, CA 95841*

*Contact:
Barbara Gillogly, Ph.D.
(916) 484-8512 Telephone
(916) 484-8519 Fax
gillogb@arc.losrios.cc.ca.us*

The **Gerontology Program at American River College (ARC)** began in 1975 when Dr. Charles Borowiak and a group of students spent six weeks during the summer living and studying at the Veterans' Home in Yountville, California. From that beginning, individual courses were added as the need and the opportunity arose. Initially, the program had a health care focus, until demographics provided an additional component to be levied with. After Dr. Borowiak retired in 1992, the program was taken over by Dr. Barbara Gillogly.

In 1992, the ARC Gerontology Program began to offer a degree/certificate in gerontology and three vocational courses for nurses. In 1994 the scope was broadened to reflect the growing need for workers to receive quality training in the aging arena. It was at that time that the program was

restructured, this then engaged other disciplines on campus, and offered the student body an opportunity to specifically focus on the study of aging. As a result, students are now afforded the opportunity to select a focal area in which to complete nine units outside of Gerontology, and then conclude with six units of fieldwork in their specific area of expertise. This enhanced the student's ability to enter their field of choice, or a four-year institution with practical knowledge and hands on experience.

The ARC Gerontology Program is a model for state and community colleges that can be replicated. The program has been shared with many campuses interested in starting a similar program.



**2001 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION**

**OTHER
NOMINATIONS**

**THE HORIZON FOUNDATION—
AGING IN PLACE INITIATIVE**

Aging In Place Initiative

*The Horizon Foundation
 10805 Hickory Ridge Road
 Suite 215
 Columbia, MD 21044*

*Contact:
 Richard M. Krieg, Ph.D.
 (410) 715-0311*

The Horizon Foundation’s “Aging in Place Initiative” expands existing services of its primary partner, the Howard County Office on Aging, and adds new ones to assist older adults who wish to remain in their homes to do so for as long it is practical, and as long as they wish to do so. Additional goals include: improving the health and wellness of older adults living in the community, providing clients with increased access to services, and integrating project components into a seamless service delivery model.

Elements of the Aging in Place Initiative include:

- Affordable in-home care;
- Home modification and repair;
- Fall prevention activities;
- Flexible mental health services for elders; and
- Specialized planning and evaluation.

The Aging in Place Initiative brings additional resources to older adults living in Howard County through the cooperation of a public sector agency and multiple partners operating in the not-for-profit sector, including: Developmental Services Group, Inc, Family and Children’s Services; and Our House Youth Home.

**SENIOR HEALTH SERVICES OF THE WESTERN PENNSYLVANIA
HOSPITAL CONTINUUM OF CARE INITIATIVE**

Senior Health Services of the Western Pennsylvania Hospital Continuum of Care Initiative

*The Western Pennsylvania Hospital
 c/o The Western Pennsylvania Hospital Foundation
 4818 Liberty Avenue
 Pittsburgh, PA 15224*

*Contact:
 Cynthia Napier Rosenberg, M.D.
 (412) 362-1480 Telephone
 (412) 362-2052 Fax
 crosenbe@wpahs.org*

The Senior Health Services of the Western Pennsylvania Hospital—Continuum of Care Initiative (SHS-CoC), which began in 1998, is intended to increase communication among providers and facilitate appropriate use of psychological resources within the continuum of care for seniors.

The initiative uses social service case managers with expertise in geriatrics to act as liaisons between senior patients, their primary care physicians and the hospital, long term care providers, home health agencies and other community resources to ensure that patients receive the right level of service at the right time.

The SHS-CoC initiative addresses the frustrating and potentially dangerous gaps in information and service that often occur when the various providers of senior health and social services do not communicate with each other or with their clients’ primary care physician.

The SHS-CoC initiative would be easy to replicate in other institutions willing and able to commit staff to it and could be customized to the needs of a particular institution’s patients and physicians. There are plans to present this model at upcoming conferences concerning senior health care both regionally and nationally.



THE 2002 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 **2002 Archstone Foundation Award for Excellence in Program Innovation** effective November 1, 2001. 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. Only one program may be nominated per agency or organization.

The winner is expected to attend the 130th Annual meeting of the American Public Health Association in Philadelphia, PA, November 9-13, 2002, 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, 2002.

Nomination materials for the 2002 Archstone Foundation Award for Excellence in Program Innovation can be obtained from:

Nancy A. Miller, Ph.D.

2002 Archstone Foundation Award Chair
Policies and Sciences Graduate Program
University of Maryland, Baltimore County
1000 Hilltop Circle

Baltimore, Maryland 21250

Phone: (410) 455-3889

E-mail: nanmille@umbc.edu



2001 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

NOTES



ARCHSTONE FOUNDATION

401 EAST OCEAN BOULEVARD
SUITE 1000
LONG BEACH, CALIFORNIA 90802
562-590-8655
562-495-0317 FAX
WWW.ARCHSTONE.ORG