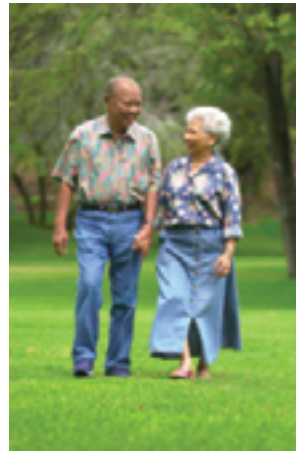




ARCHSTONE FOUNDATION

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



2002 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

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GERONTOLOGICAL HEALTH SECTION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

MISSION STATEMENT

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

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AWARDS PRESENTATION

MONDAY, NOVEMBER 11, 2002
PHILADELPHIA, PENNSYLVANIA

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 2002 Archstone Foundation Award recipient:

Kinship Support Network

Edgewood Center for Children and Families
San Francisco, California

2002 Archstone Foundation Award — Honorable Mentions:

Senior Navigator.com

Richmond, Virginia

Take Charge of Your Health for Older Adults

DHR-Division of Aging Services
Atlanta, Georgia

The University of Arizona Elder Rehab by Students Program

University of Arizona
Tucson, Arizona

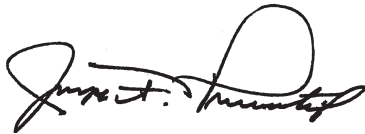
It is our hope that these model programs can be replicated in an effort to enhance services to the aging population throughout the U.S.

To Nancy A. Miller, PhD, Chair of the Archstone Foundation Award Selection Committee, and the other members of our selection advisory committee, we extend our deep appreciation for their efforts in narrowing down the nominations and selecting the outstanding programs to receive this year's award and honorable mentions.

Special thanks to Stephanie Jones for her hard work on this award.

To Karla De La Torre of Archstone Foundation, our appreciation for her work in preparing this program award booklet.

To the winners of the 2002 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



Connie J. Evashwick, ScD
Chair, Gerontological Health Section
American Public Health Association



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**THE 2002 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION**

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THE 2002 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

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KINSHIP SUPPORT NETWORK, EDGEWOOD

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The Kinship Support Network was the nation's first comprehensive, public-private partnership to support older persons who are raising their relatives' children as an alternative to foster care. Launched in 1993, this program model has been replicated across California and disseminated nationwide. The program has been documented to help elderly grandmother caregivers, predominantly African American, to improve health and mental health status during their participation.

Program Design

Nationwide, 3.5 million grandparents are raising their grandchildren—all told, these grandparents are raising more than 5% of all American youth. In San Francisco, relative caregivers are raising one in every six youth. The typical caregiver is a 60-year-old grandmother, raising children who have lost their parents due to abuse, neglect, substance abuse, or incarceration. Prior to 1993, when the Kinship Support Network was launched, there was no comprehensive public-private partnership to assess and respond to the needs of these generous but overburdened elders.

Grandparent caregivers have stepped forward to raise children at a time in life when many of us look forward to retirement. They know that the safe home of a loving relative is often the best place for an abused or neglected child to heal. However, poverty, poor health, and social isolation threaten aging caregivers' well-being and that of the children in their care. Edgewood's research has shown that **grandmother caregivers who enroll in the Kinship Support Network have poorer health and mental health than other women their age.** Reports from the US Census Bureau confirm that the burdens of poverty and poor health are shared by grandmother caregivers nationwide.

Edgewood created the Kinship Support Network as an innovative way to help these elderly caregivers. The program matches relative caregivers with peer mentors, support groups, and comprehensive whole-family services. Families are served within

the private agency, allowing them to bypass public welfare systems and maintain their dignity. When possible, they hire program graduates and other caregivers (often times seniors) as program staff. All together, elderly caregivers can sign up for **peer case management, grandparent support groups, respite care, emergency food or housing assistance, mental health counseling, or health care services.** They can also find parenting education, after school tutoring, and enriching activities for the children in their care. Services are now available in English, Spanish, Cantonese, Mandarin, Vietnamese, and Tagalog. Last year, they served about 250 elderly caregivers.

Documented Outcomes and Benefits of the Program

When the Kinship Support Network program was created, Edgewood simultaneously founded the Institute for the Study of Community-Based Services (Donald Cohon, PhD, Director). The Institute was charged with conducting formal research to document relative caregivers' needs and assess the program's outcomes—filling a national knowledge gap on this long-hidden population.

Since then, the Institute has conducted several longitudinal studies and has partnered with researchers at the University of California at Berkeley, which gathers statewide data on kin caregiving. This research has documented three significant, measurable outcomes:

- **Elderly grandmother caregivers in the program significantly improved their health and mental health,** as measured by pre-post tests using the SF-36 Health Survey (Ware 1993). In contrast, elderly female caregivers enrolled only in the public child welfare system showed stable or declining health and mental health during this same time period. (Cohon, D., Hines, L., Cooper, A. B., Packman, W. & Siggins, E. (2000). *Stuart Foundation Final Report July 28 2000*. San Francisco, Edgewood Center for Children and Families, Institute for the Study of Community-Based Services.)

AWARD FOR EXCELLENCE IN PROGRAM INNOVATION

CENTER FOR CHILDREN AND FAMILIES

- *Participating caregivers had reduced family needs in 30 out of 31 areas* after participating in the program, as measured by pre-post tests using the Family Needs Scale (adapted 9/1995 by D. Cohon from Dunst, Trivette & Deal 1988). (Ibid. 2001)
- *Children in the program improved their health, mental health, social competencies, and school competencies.* In addition, they have significantly fewer problems with anxiety/depression, withdrawal, sleeping, or interpersonal issues. These changes were measured by pre-post tests using the CHQ-PF50 (Landgraf, Abetz & Ware 1996) and Child Behavior Checklist/4-18 (CBCL) (Achenbach 1991). (Cohon, D., Brown, S., Wheeler, R. & Cooper, B. (2001). Office of Criminal Justice Planning *Final Report Abuse Reactive African American Kinship Youth Project November 2001*. San Francisco, Edgewood Center for Children and Families, Institute for the Study of Community-Based Services.)

The Kinship Support Network has continually linked these research findings to program practice and innovations. For example, *one of the Institute's earliest studies found that elderly grandmother caregivers in the program had poorer health and mental health than other women their age* by comparing SF-36 Health Survey scale scores with national norms. This finding led Edgewood to add a "Kinship Health Team" to the program model.

Replication Potential and Dissemination Plans

Edgewood has replicated the program in two other cities, East Palo Alto and South San Francisco. The program is also being replicated across California with funding from the state legislature; already, 13 California counties have stepped up to the plate to form local Kinship Support Networks with Edgewood's technical assistance. Finally, the Kinship Support Network has been recognized as a national model and has been shared in several other states. They sponsored the first National

Kinship Care Conference in 1997 along with AARP, Child Welfare League of America, and Generations United, and a regional follow-up conference in 2000.

Edgewood takes an active role in these replication activities and in disseminating research findings nationwide. They have produced a Kinship Operations Manual, Staff Training Manual, Advocacy Video, Research Fact Sheets, and brochures, which together can help any community plan and implement new services for elderly caregivers. Edgewood also provides group and one-on-one technical assistance to communities launching their own kinship programs.

Funding, Partnerships, and Collaboration

The Kinship Support Network is funded by a diverse blend of public contracts and private donations. They receive funds from their county Office on the Aging, mental health agency, child welfare department, and children's services department. They also seek foundation grants, donations, and volunteer support.

The Kinship Support Network partners formally and informally with many other community agencies to avoid service gaps and overlaps. These partners include the Foster Grandparents Program, Asian Perinatal Advocates, schools, community centers, churches, and the local community college. The county has also co-located social workers on-site at their kinship centers to facilitate collaboration and program referrals.

The Kinship Support Network is an innovative approach that has improved health and quality of life for hundreds of older people, and has raised the country's awareness of aging caregivers' essential role in our society. Indeed, this population of more than 3.5 million elders was virtually ignored by public and private agencies until the late 1990s—despite their selfless contributions to raising some of our country's most vulnerable youth. Thanks to the Kinship Support Network and other supporters, grandparent caregivers are no longer a forgotten part of our society.

GRANDPARENT
CAREGIVERS
HAVE STEPPED
FORWARD TO
RAISE CHILDREN
AT A TIME IN LIFE
WHEN MANY OF
US LOOK
FORWARD TO
RETIREMENT.



2002 ARCHSTONE FOUNDATION
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IN PROGRAM INNOVATION

HONORABLE
MENTION

SENIOR NAVIGATOR.COM

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SeniorNavigator.comSM is an innovative service model that combines the best practices of community-building and information technology to provide a free, confidential public service to Virginians. It is changing the way human resources are used and health and human service professionals work in Virginia. It is also bringing comfort, through knowledge and empowerment, to health care consumers. SeniorNavigator.com addresses two major health-related needs of seniors and caregivers: the need for health and aging information in general and the need for specific medical, long-term care, and community services in the locality of residence.

SeniorNavigator.com has two major components—one “high tech” and the other “high touch.” The high tech component is a unique website that serves as an Internet guidebook for Virginia’s seniors, their families, and caregivers. The website provides information about particular conditions, as well as extensive details about local health and aging services. SeniorNavigator.com includes nearly 18,000 local service listings, over 400 health and long-term care-related articles, and 2,000 links to preselected websites. SeniorNavigator.com also offers an individualized Ask an Expert feature that brings the expertise of geriatricians, elder law attorneys, financial planners, occupational therapists, caregiving experts, care managers and others to people throughout Virginia.

The “high touch” component of the application complements the website and provides access to information for those without computers or Internet service. It involves training 10,000-12,000 volunteers and professionals throughout Virginia as Community SeniorNavigators. These “information ombudsmen” provide the human touch to help connect people to the information and services they need. SeniorNavigators are linked to official access sites in each community called “Senior Navigator Centers.”

SeniorNavigator.com was developed using an action planning methodology. Prior to developing the website or the volunteer network they recruited gerontologists from Virginia Commonwealth University, Virginia Polytechnic Institute and Union Theological Seminary to guide their design and implementation. These experts served to assist with critical reflection along the way to be

certain that the service met the needs identified through 15 regional steering committees around the state, urban, rural and suburban focus groups of seniors and caregivers, and interviews with over 100 health or human services professionals. In all, over 1,000 people in Virginia essentially co-developed this project and many more have joined along the way. Partners and sponsors contribute through technical assistance, identification of local services and programs, updating data, content (articles) contributions, funding, access to professionals and volunteers, assistance with promotion of the website, and opportunities to train Senior Navigators. They work collaboratively with all 25 area agencies on aging, many state departments, the information and referral system and others.

Access to this information, whether through the website or a SeniorNavigator volunteer, allows seniors and those who care for them to find the services they need to stay independent (and out of institutional care) longer, which reduces both social and economic costs. It also gives family members peace of mind, so that they can be more productive at work and home. The Senior Navigator training program has reached nearly 7,000 individuals to date and another almost 8,000 have been reached through other presentations and events.

SeniorNavigator.com has received inquiries from the Chicago area and the states of Alaska, California, Maryland, Montana, New Jersey, North Carolina, Oregon, and West Virginia regarding ways to replicate this website for seniors in their areas. In addition, other “population” segments have expressed interest in duplicating SeniorNavigator.com for children and for people with disabilities. The disability community in Virginia is already actively using SeniorNavigator.com. Because SeniorNavigator.com contains thousands of resources and articles related to disabilities, service providers and people with disabilities are finding it especially useful. Wherever SeniorNavigator.com is replicated, it will be imperative that the technological and the grassroots, community-building aspects of the initiative are incorporated. Most of the developmental phase of SeniorNavigator.com was spent in building relationships and listening to the people who this initiative was designed to serve—seniors, their families, and other caregivers.



2002 ARCHSTONE FOUNDATION
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IN PROGRAM INNOVATION

HONORABLE
MENTION

TAKE CHARGE OF YOUR HEALTH FOR OLDER ADULTS

“Take Charge of Your Health for Older Adults” is a community-based intervention program created to improve the nutritional status, fitness, and physical activity of Georgia’s older adults through health promotion programs at Senior Centers. The request for developing nutrition and physical activity programs for seniors and program evaluation came from the local community level from Senior Center managers and the Area Agencies on Aging. In 2000 and 2001, the Georgia Division of Aging Services partnered with private and state agencies across Georgia to develop and implement the **Take Charge of Your Health–Active Older Adult Speaker’s Kit and Placemat Leg Exercises**.

The audience addressed is older adults, and the program’s evaluation focused on those participating in Elderly Nutrition Programs where they received a congregate meal several times per week. As a group these older adults have low income and literacy skills. Services were delivered by Georgia Division of Aging Wellness Coordinators, Registered Dietitians, Cooperative Extension Agents, Senior Center Directors, and other professionals in the aging network who delivered the nutrition education programs and leg exercises at Senior Centers throughout Georgia. Strategies to reach the audience included lively and fun scripts with colorful overhead transparencies. Their collaborative partnership included, Ms. Sudha Reddy from the Georgia Division of Aging services, who had the initial vision of this project and Dr. Michelle Lombardo of Wellness, Inc., who collaborated with Ms. Reddy to create the nutrition education materials. Ms. Debra L. Kibbe from the ILSI–Center for Health Promotion in Atlanta, GA assisted with the development of the evaluation instruments. Dr. Mary Ann Johnson and her staff at the University of Georgia assisted with all aspects of the development of the evaluation instruments, training of educators and evaluators, data collection, data analysis and report writing. The key messages of the intervention materials are from Georgia’s Coalition for Physical Activity and Nutrition (G-PAN) which are: Take Down Fat, Take 5-A-Day, and Take Action.

The project’s education materials are available for sale, and the potential audience is quite large. There are 35 million adults aged 65 and older in the US, and 3.1 million older adults receive meals through community based congregate and home delivered meals programs (www.aoa.gov). The materials are available to anyone, and are particularly useful for community agencies with Elderly Nutrition Programs. To evaluate community programs, agencies may need to partner with specialists in evaluation from their local universities, public health districts, or Cooperative Extension Service. A budget for replicating the program would include per site of 25 older adults: funds for purchase of the materials (\$150), a nutrition and/or health educator (one hour/lesson + travel) for 12 lessons at each site (\$1,200), educational extenders and pamphlets to demonstrate concepts (\$500), and additional staff for those wishing to conduct an evaluation (variable) for a total of \$1,850/site/year.

The education materials were developed in 2000, and the training and intervention were conducted in 2001. The educators were primarily Georgia Division of Aging Services Wellness Coordinators, many of whom are Registered Dietitians. Each of the 12 Wellness Coordinators selected approximately two counties in their area in order to recruit 50 older adults from Senior Centers in each Planning Service Area for a total of 600 older adults. Up to 12 sessions were offered at each Senior Center. Over 50% of participants attended 10 or more nutrition education lessons, while 38% of participants attended 10 or more of the leg exercise sessions.

Both the pre-tests and post-tests were completed by 500 older adults: 84% women, 16% men, 64% Caucasians, and 35% African-Americans. Many participants also performed the leg exercises regularly at home. Measures of fitness, knowledge about nutrition, and food intake patterns were examined in detail in pre-tests before the intervention started and in post-tests conducted after the program was completed. These direct measures and questions showed many statistically significant improvements following the intervention ($p < 0.05$). Overall, it was demon-

strated that this community-based program improves nutrition, physical activity, and fitness in these older adults.

This project was funded by the Georgia Department of Human Resources, Older Americans Act, and USDA Food stamp Nutrition Education Program (contracts #427-93-26056). The nutrition education and exercise program materials have been distributed to all Senior Centers, Area Agencies on Aging and other Aging Network Partners in Georgia. Many other states in the country have purchased the “Take Charge of Your Health” project materials and are using the education materials in their programs.

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HONORABLE
MENTION

THE UNIVERSITY OF ARIZONA ELDER REHAB BY STUDENTS PROGRAM

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***Elder Rehab by Students
Program***

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The Elder Rehab by Students program is a physical fitness, cognitive, language, and “partnered volunteering” program for persons with mild to moderate Alzheimer’s Disease. The program operated from September 1997 to June 2001 as a research project at the University of Arizona. The purpose of the program was to improve the physical fitness, quality of life, and mood of persons with Alzheimer’s type dementia and their caregivers, and to slow the rate of cognitive decline.

Student rehab partners were responsible for providing one weekly session of fitness training, during which they administered 10-12 different memory and language stimulation activities. Participants’ responses to the various activities were recorded, so that progress could be monitored. A family member or student volunteer provided a second weekly fitness session without the cognitive interventions. The student partner also participated with his or her assigned participant in a weekly session of community/volunteer work, alternating with a cultural or recreational activity.

In June of 2001, the Elder Rehab program completed its fourth and final intervention year with 14 enrolled participants. During the four years, 23 individuals completed one year of participation; 13 completed two years; eight completed three years, and four completed all four years. All four of the four year completers were at the same stage of dementia as they were four years ago, three at the mild stage and one at the moderate stage. The longer participants stayed in the program, the less they declined from one year to the next. Significant fitness and mood benefits were achieved by participants as measured by standardized tests, and as is evident from numerous photographs and videos of patients and students engaging in their various activities. Caregivers benefited as well. For some, the program provided a twice-weekly respite

from caregiving. Others joined their care recipient and student in volunteer activities. Still others did their own physical fitness workout while the student was working with their care recipient. Students made significant gains in knowledge about Alzheimer’s Disease, as measured by standardized test results. They also gained valuable experience, rarely available to undergraduates, which gave them a competitive edge when applying for graduate school and jobs.

The program is disseminated worldwide through the Elder Rehab website, the National Center for Physical Activity and Disability website, through presentations at national and international conferences, caregiver and staff in-service training workshops, and through more than a dozen articles and videos. Replication could easily be accomplished through a college or university system and access to physical fitness facilities. Detailed instructions for administering the language, memory, and fitness activities are available from the principal investigator for the cost of duplicating and mailing. In October, 2001, University of Arizona Elder Rehab submitted a grant proposal to NIA for a clinical trial of its physical fitness and language interventions by a consortium of six universities: University of Illinois/Chicago, University of Central Florida/Orlando, Cal State Northridge, University of Southern California, University of Western Ontario, and the University of Arizona.



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OTHER
NOMINATIONS

VLADECK CARES PROGRAM:

**A NATURALLY OCCURRING RETIREMENT COMMUNITY MODEL
WITHIN A LOW-INCOME, MINORITY URBAN NEIGHBORHOOD**

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Henry Street Settlement's Vladeck Cares/NORC (a naturally occurring retirement community) is New York City's first supportive services program that was organized to serve poor, mostly minority, and literacy-disadvantaged seniors who live in a public housing complex. It offers its services within a culturally responsive framework using a culturally competent service delivery model. It also provides a continuum of health care and social services through its successful integration into the Settlement's Senior Services Division, opening to Vladeck's elderly a seamless system of services and opportunity. Vladeck Cares' four major service areas include: 1) *Outreach and education*, 2) *Individual supportive services*, 3) *Group and social activities*, and 4) *Intern and volunteer assistance*. The majority of Vladeck seniors are poor; 80 percent are Hispanic, African-American, or Asian. Three-quarters are female and one-quarter is male. About 40 percent are disabled to some extent, and about 70 percent live alone. Their age groups are: 36 percent: 60 to 70 years old, 36 percent: 70 to 80 years of age, and 28 percent: over 80 years old.

Significant cultural and social barriers have prevented Vladeck seniors from accessing the traditional health care system.

To respond to these barriers, Vladeck Cares uses a culture- and language-based nutrition, health education, and wellness service delivery model within the context of a community in providing integrated senior care. Their social workers aim to serve as caregivers, who are perceived as trusted family members or friends who understand and validate the seniors' cultural identity and nurture a sense of hope to overcome their physical and mental illnesses. Small group activities prioritize culturally and linguistically appropriate, small group activities that reinforce well-being, while staff development training teaches workers cultural sensitivity and ways to use culturally appropriate responses.

2001 data indicates that long-term benefits of the program include: 1) 41 nursing home placements prevented, 2) hospitalization of 36 seniors prevented, 3) diseases diagnosis of 275 seniors (107 hypertension, 34 osteoarthritis, 95 diabetes, 23 heart diseases, 19 psychiatric cases, 12 chronic obstructive pulmonary diseases), which have prevented potential stroke, cerebral-vascular accidents, and coma as well as hospitalization of these seniors for the escalation of the diagnosed diseases.

CHF EDUCATION INITIATIVE

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In November 2000, MidState Medical Center received a grant to study the causes of frequent admissions to the hospital and determine whether diagnoses that caused these frequent admissions could be better managed in the community. Results of the study revealed that congestive heart failure (CHF) was and continues to be a frequent diagnosis. Because of the decreased average length of stay and the acuity of inpatient illness, there are increased barriers to effective patient education during the hospital stay. This lack of education could have a potentially negative impact on the individual's quality of life.

The initial study substantiated the need to create a community-based nurse case coordinator whose role it is to work with patients who have frequent admissions as well as those who are at high risk for admission. The creation of this initiative led the

coordinator to develop a multidisciplinary group comprised of healthcare team members, community health and social service agencies, and physician providers. This has led to the establishment of an innovative mechanism to identify the patient prior to discharge, initiate education at the bedside, establish a relationship that will continue once the patient goes home, and provide timely communication with the physician.

The CHF Education Initiative was implemented in February 2001. Now that the initial phase has been completed, the program is moving into the next phase, which entails establishing indicators to track quality measures related to ejection fraction, medication therapies, and admission rates. The goal is to have 500 patients enrolled in the program by the end of 2002.



2002 ARCHSTONE FOUNDATION AWARD FOR EXCELLENCE IN PROGRAM INNOVATION

OTHER NOMINATIONS

COMMUNITY BRIDGES

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Findings from a statewide survey, conducted through the Wisconsin Lifelong Planning Initiative, revealed that seniors with developmental disabilities wanted to reconnect with family, expand their relationships and circle of friends, and exert more control over their lives. Through a grant in 1992 from the county health and human services department, Elder Care of Dane County developed the Community Bridges program to creatively and effectively address these issues. Community Bridges piloted the program with eight developmentally disabled elderly, whose life experiences had primarily been devaluation and exclusion. Based on the successful pilot, Elder Care of Dane County expanded the program and included isolated seniors in addition to elderly with developmental disabilities.

Community Bridges was founded based on the principles of citizen advocacy, circles of support, and community building. The primary goal is to encourage and help cultivate natural social supports for each participant—fostering meaningful and often long-lasting relationships with others in the

community. By bringing together businesses, public agencies and non-profit organizations, they develop and expand opportunities and advance advocacy for developmentally disabled elderly and isolated seniors in our community. The program empowers each participant to initiate and nurture meaningful connections. The person-centered approach is tailored to participants' needs and desires, while resources and opportunities are unique to their communities.

The basis for the program—community building has been incorporated into several programs within the community due to its success. Community Bridges puts community-building and citizen advocacy theories into practice through: person-centered planning; finding valued roles for people to participate in their communities, and seeking unpaid companions for friendship and support. The program is unique in that it breaks down isolation while saving money and time for service systems. It can be easily incorporated into a variety of existing service programs.

CONDELL HEALTH NETWORK

*For more information
contact:*

**Condell Day Center for
Intergenerational Care**
Condell Health Network
801 S. Milwaukee Avenue
Libertyville, IL 60048-3199

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Condell Health Care
Foundation
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Nearly ten years ago, the Condell Day Center for Intergenerational Care (IDC) put Erickson's academic theories of the benefits of intergenerational interaction into practice. Condell Medical Center invested \$5.5 million in funding to design and erect what was thought to be the first freestanding building in the U.S. designed specifically for interactive day care for older adults and young children. From a disparate set of circumstances and needs and the creative collaboration of Condell's hospital administration and family practice physicians, the IDC emerged to open on June 1, 1992. Facilitating daily planned interaction, the IDC program is designed to promote relationships across the age spectrum of its 40 adults and 135 children.

Cross-generational activities are designed around a simple question: "What would you be doing with your grandparent today?" All age groups work together on coloring books, letter bingo, making valentines, dancing, learning each other's songs and exchanging cross-generational

oral history. Each group learns from the other. As the seniors enjoy this daily interaction, they are also providing the children with a curriculum unlike any provided in school systems. Condell's Volunteer Department joins in leading the seniors in lively explorations of current events, reading the newspaper, serving lunch, playing board/memory/word games, reminiscing, hand massages, gardening, playing music, leading book groups, and storytelling.

Continuing innovations include implementing a Physical and Psychosocial Rehabilitation Initiative for older adults who may have suffered a setback and intend to return home to live independently. The IDC is also home to various community outreach activities: Caregivers Support Group—an informational gathering for those taking care of seniors, and "Lifetimes"—a new program to help the 55+ age group access the forms of help they need, crossing the continuum of health, wellness, illness, and cure.



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OTHER
NOMINATIONS

INFORMATION IS GOLDEN

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Information is Golden
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While research shows adults over 50 remaining sexually active, there has been a lack of education directed specifically for this population. Aging individuals are often overlooked when it comes to sexual awareness including HIV/AIDS. However, no one in today's society is immune from HIV/AIDS. Whether seniors themselves are at risk, have a child or family member at risk, or live with or near someone diagnosed with HIV/AIDS, every age group, culture and gender must be made aware of this disease and how it is spread.

To better address the gap in services, the American Red Cross launched the **Information Is Golden** program on World AIDS Day 1999. This extension of their already successful HIV/AIDS outreach program addresses the needs and concerns of the senior population. ARCGC gathered representatives from HIV/AIDS service agencies and senior serving organizations to develop and implement Information is

Golden. This partnership provides prevention education to seniors in a focused way in order to evaluate and address this audience's specific needs. Supported by the Retirement Research Foundation, the program continues to conduct outreach while developing a curriculum for use throughout the country.

There is a great need for more HIV/AIDS prevention information among seniors and nationally as newly diagnosed cases over the age of 50 continue to climb past 12 per cent of the total. Postings about Information is Golden on the NAHOF website have generated dozens of inquiries from agencies nationally that are seeking the types of tools ARCGC is currently developing. Few programs address seniors and HIV/AIDS, and Information is Golden has a tremendous opportunity to design a standard program that can be replicated to better serve seniors across the country.

GOODWILL'S NEIGHBORS
HELPING NEIGHBORS PROGRAM

For more information contact:

**Goodwill's Neighbors
Helping Neighbors
Program**

Social Research Institute
Graduate School of
Social Work
The University of Utah
395 S 1500 E Rm 111
Salt Lake City, UT
84112-0260
(801) 581-4857 Telephone
(801) 585-6865 Fax

The mission of the Neighbors Helping Neighbors Program (NHN) is to improve the health, safety, and quality of life of community-dwelling seniors through the promotion and maintenance of independent living. NHN strives to enable elderly individuals to reside in the community for as long as possible. In order to accomplish the program's mission and goals, NHN uses a community-building approach to mobilize various entities within the community to participate in meeting the needs of neighboring seniors. These various community entities or informal support networks include residents, businesses, stores, churches, clubs, and organizations such as schools, medical centers, and corporations. Recognizing that formal aging service systems are often overwhelmed by the demand for services and lack of sufficient resources, NHN attempts to bridge this gap by accessing resources from the informal support network. Building partnerships and positive working relation-

ships with informal support networks can lead to valuable sources of information regarding those who may be in need as well as rich in resources of time, money, supplies, services, skills, and people power to meet those needs.

NHN is dedicated to serving those who are aged 65 and older who may be at risk of institutionalization due to the lack of social supports and limited financial resources. NHN provides a variety of services that focus not only on reducing the isolation and limited socialization experienced by many homebound elderly people, but also focus on maintaining or increasing their level of self-care, independence, and home maintenance. Services include information, referral, and link aging to existing aging services and community resources, advocacy, companionship, and reassurance via friendly home visiting and, the coordination of community service projects.



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**OTHER
NOMINATIONS**

HEALTH PROMOTION INITIATIVE

For more information contact:

The New Jersey Geriatric Education Center

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School of Osteopathic Medicine Center for Aging
One Medical Center Drive
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Stratford, NJ 08084*

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umdnj.edu*

The Health Promotion Initiative was developed in response to a Center for Disease Control (CDC) recommendation that state health departments and state agencies on aging work collaboratively to promote wellness among older adults. The Health Promotion Initiative was implemented in 1998 under the leadership of the New Jersey Geriatric Education Center (NJGEC). The statewide training initiative is being implemented over a period of five years and targeted to reach over half of the 21 counties in the state. Three training modules were developed in response to the identified needs: 1) Drug Use and Misuse in the Elderly; 2) Mental Health and Aging; and 3) Falls Assessment and Prevention. The NJGEC delivers the two-day training program in the local community and adapts the program to address local needs. The training is targeted to multidisciplinary staff from health departments, Offices on Aging, mental health agencies and community-based organizations involved in the delivery of services for older adults. Training includes the most current information available on the subject presented

by a team of leading health professionals.

Since 1998, the Health Promotion Initiative has conducted 15 two-day trainings for over 400 participants. Participants have included home health nurses, social workers, mental health screeners, alcohol and drug counselors, local health officers, public health nurses, senior center coordinators, adult protective service workers, housing managers, day care program providers, and police officers. Agency coalition leaders have consistently reported that the training provided by the NJGEC increases awareness about community resources and provides workers with a greater understanding of and sensitivity toward the elderly. The Health Promotion Initiative has received national recognition for its efforts to bring together aging and health professionals to enhance services for older adults. The program was selected as a "Promising Program" and will be included in the Aging States report, which will be disseminated nationally by the Administration on Aging and the Centers for Disease Control.

INTEGRATED CASE MANAGEMENT/MONEY MANAGEMENT PROGRAM AT ST. BARNABAS

For more information contact:

St. Barnabas Senior Services

*Integrated Case Management/Money Management Program at St. Barnabas
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Los Angeles, CA 90057*

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Managing one's financial resources is key to maintaining independence and dignity. The senior citizens served by St. Barnabas Senior Services and its collaborating partners live on Social Security income of \$700-\$800 per month. The senior citizens often have few or no remaining family ties and a limited social network in this highly urbanized, sometimes risky neighborhood. Failure to manage their resources can quickly lead to homelessness or institutionalization in this environment—an outcome that is costly to society and undesirable for these senior citizens in their 70s and 80s who have spent lifetimes working hard to take care of themselves.

The Money Management Program began as collaboration between St. Barnabas Senior Services, Southern California Presbyterian Homes and the University of Southern California and funded by The Archstone Foundation. Over the past five years, the program has become standard at St. Barnabas

Senior Services, as a service offered to all clients served by the agency. St. Barnabas Senior Services remains the leading proponent of this demonstrated successful program. St. Barnabas Senior Services provides comprehensive case management services, of which the Money Management Program is a component. Social services are often provided in tandem with Money Management Services. St. Barnabas case managers serve about 2,000 low-income clients a year from diverse cultural backgrounds. Currently 1,250 clients are enrolled in the Integrated Case Management/Money Management Program. More than 95% of their case management/money management client relationships have been documented as successful. Success is defined as the client's having the maximum income available to him/her and possessing the ability to pay for housing and other needs that allow him/her to live independently.



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OTHER NOMINATIONS

DUQUESNE UNIVERSITY SCHOOL OF NURSING NURSE MANAGED WELLNESS CENTERS

*For more information
contact:*

**Duquesne University
School of Nursing
Nurse-Managed
Wellness Centers**
College Hall, 6th Floor
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Pittsburgh, PA 15282

Director:
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In 1994, Duquesne University School of Nursing faculty established an inter-disciplinary nurse-managed wellness center (NMWC) in a high-rise urban apartment building that houses primarily older African-Americans (K. Leroy Irvis Towers). Subsequent funding from a Housing and Urban Development (HUD) Community Outreach Partnership Grant led to a second NMWC that services predominately Caucasian elders (St. Justin Plaza).

Residents of both sites typify the phenomenon of "aging-in-place" where older adults are residing longer than expected, with some assistance available to facilitate their independent living. Because seniors are able to stay in their apartments longer than expected, more health problems are surfacing. The NMWCs hope to remedy them.

The NMWCs have enabled residents to live independently and longer, and to utilize health care facilities more appropriately. Significant

medication dosage errors and drug side effects have been discovered and corrected. Health screening has resulted in referrals for follow-up evaluation of blood pressure and abnormal physical findings. Health teaching has resulted in a decreased need for office visits and an increase in knowledge of self-care and consumer rights. Residents also report a high degree of satisfaction with the NMWCs and a positive effect on quality of life.

In 1996, the NMWCs received international recognition by being awarded the Archon Award by Sigma Theta Tau International Nursing Honor Society. The NMWCs serve as a model for best practice in servicing well community-dwelling older adults in two diverse urban community settings. The program has documented results that have effectively linked academic theory with applied practice in the field of public health and aging.

RURAL GERIATRIC CARE MANAGEMENT PROGRAM MODEL IN THREE RURAL COMMUNITIES

*For more information
contact:*

**Medical University of
South Carolina**
College of Health
Professions
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The Rural Geriatric Minority Care Management Program is an innovative, comprehensive, community-capacity building service delivery model of care coordination and management for older minority African Americans enrolled in two safety net health care organizations (two satellite sites of a federally qualified community health center and two sites of a rural health clinic) in three counties in South Carolina. The program's aim is being accomplished by utilizing a new type of paraprofessional, a trained geriatric coordinator (GC), who functions as an advocate to assist patients in accessing and using health and social services.

Since clinicians, especially in rural underserved areas, have little time and staff resources available to assist with non-medical tasks (i.e. transportation, obtaining durable medical equipment, or help when applying for enrollment in entitlement programs), many of their older patients go without these much needed services. Unmet needs often impact on the older adult's ability to receive and benefit from medical care and social services

minimizing their quality of life. An inability to access the health and social service systems by many rural older African Americans deem third-party arrangements and monitoring of referrals necessary for assuring successful outcomes.

Program outcomes demonstrate that geriatric coordinators are a viable and cost-effective method to increase the quality of life for older adults in meeting their varied needs. According to a health center director, "sustainability is assured due to the sheer impact the program has garnered in the improvement of patients' lives and the networking and collaboration it has strengthened with many agencies throughout the community." The program has enriched the lives of many older patients by giving them a sense of well being through a focus on wellness and linkages with needed services, thereby generating purpose and conviction where there once was little to none. The program's principles and approaches have been applied to other outreach programs in an effort to show commitment to improving the lives of the residents in the served communities.



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OTHER NOMINATIONS

SHALOM PARK

For more information
contact:

Shalom Park
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Director, Donor and
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Throughout the healthcare industry, nursing homes and hospitals are faced with severe staffing shortages. The need for Certified Nursing Assistants (CNAs), those who provide the substantial majority of direct hands-on personal care to residents, is particularly acute. Shalom Park has designed and implemented a model training program to recruit potential CNAs, ensure the success of trainees, improve the quality of the training, and more fully and accurately prepare potential CNAs for the role and responsibilities they are pursuing.

The program is designed to be most congruent with adult learning practices, consistent with relevant training and evaluation requirements, and attractive to potential CNAs. Shalom Park recognizes that the work of a CNA is largely technical and not professional or academic in nature. The program, therefore, is most consistent with both the type of work and individual profile typical of CNAs. This program has

enabled Shalom Park to recruit and train staff who continue to work at Shalom Park as nursing assistants. Since completing the course, most of the trainees have become regular Shalom Park employees. Residents are pleased with the continuity of care, routinely seeing caregivers who know them personally and understand their particular care needs. Other staff members are able to work manageable hours, the use of outside agency staff has been significantly reduced, and theft rates have dramatically decreased.

This program trains competent caregivers who use the practical skills, which they have acquired to meet caregiving needs in the community. Individuals completing the course are equipped with entry-level knowledge and skills for employment as CNAs, expanding and strengthening the work force, and preparing them for future growth in the nursing profession.

SENIOR CENTERCISE

For more information
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Hospital
Wellness Department**
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Pickens, SC 29671

Christy Harned
Wellness Coordinator
(864) 878-4791 Telephone

Many senior adults in Pickens County, South Carolina lack opportunities and access to regular exercise programs. The goal of **SENIOR CENTERCISE** is to enhance quality of life for senior adults through regular exercise and to empower them through opportunities of age appropriate health education. By delivering an exercise and health education program at the Senior Centers, those who are limited by transportation and/or socioeconomic resources have the freedom to participate in a life enhancing program that had only been available to seniors with greater discretionary incomes. **SENIOR CENTERCISE** is open to all senior residents of Pickens County who attend any of the four county Senior Centers. There is no cost to the participants. Pickens County Senior Centers are non-profit nutritional sites open to seniors of all racial, gender and socioeconomic backgrounds within the county, to meet, socialize, enjoy games and crafts and eat lunch. Exercise classes are tailored to seniors and their individual capabilities and transportation is provided by each center for those in need of this service.

The major objectives of **SENIOR CENTERCISE** are: to provide regular exercise, enhance lifestyle independence through information sharing and education, and to monitor participants' physical health. The program began with 59 participants in 1999, and at present, there are over 100 regular participants. Community partners include wellness professionals from Cannon Memorial Hospital, Clemson Extension Services, Clemson University Health Science Interns, SC Department of Health and Environmental Control, and Partners Healthwise Initiative. Each of these organizations has volunteered to make presentations or visits to the Centers to help promote wellness among the participants. Topics include diabetes awareness, breast, prostate and colon cancer awareness, cardiac awareness, managing stress, and nutrition seminars. As a result of **SENIOR CENTERCISE**, strength and flexibility have been gained in the regular participants and endurance and energy have increased. Participants testify that the quality of their lives has definitely improved.



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OTHER
NOMINATIONS

QUALITY IMPROVEMENT PROGRAM FOR MISSOURI

For more information
contact:

**Quality Improvement
Program for Missouri
University of Missouri-
Columbia**

S422 MU Sinclair School
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Columbia, MO 65211

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The Quality Improvement Program for Missouri's Long-Term Care Facilities (QIPMO), a cooperative venture between the Missouri Department of Health and Senior Services and the University of Missouri (MU) Sinclair School of Nursing, is an innovative project providing on-site quality improvement assistance to nursing facilities. Members of QIPMO's gerontological nursing team visit facilities that request their help and provide detailed, site-specific recommendations at no cost to the facilities. QIPMO nurses help nursing facility staff learn to interpret the federal quality indicator (QI) reports based on the facility's Minimum Data Set for Resident Assessment (MDS) as well as the Missouri "Show-Me QI Reports," which were developed to show the QIs over five quarters, thus allowing for longitudinal comparisons. During these visits, QIPMO nurses help nursing facility staff learn how to prepare and interpret state and federal paperwork, address clinical issues affecting patient care in individual facilities, and provide in-service training to suit each facility's needs.

The QIPMO team superbly demonstrates that it is possible to improve the quality of life

of men and women in long-term residential care settings. QIPMO helps facilities identify problem areas and make recommendations for their improvement, and is also committed to helping facilities identify what they do best. Most facilities do many things well, but few are recognized for their best practices. To support these best practices, QIPMO nurses facilitate support group meetings around the state so that facility administrators and key staff members can meet and share their insights with their counterparts at other facilities.

QIPMO has proven successful. Every year since its inception in 1999, more and more facilities have learned about its services and have asked for visits that have often resulted in the formation of ongoing relationships between QIPMO nurses and a number of the state's nursing facilities. During 2000 and 2001, more than 569 site visits in more than 268 different facilities have been conducted. Response from facilities has been resoundingly positive, with additional visits requested repeatedly.

SENIOR PHARMASSIST

For more information
contact:

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Since 1994, **Senior PHARMAssist** has helped more than 3,000 individuals with two public health issues: 1) financial access to medications for seniors with limited incomes and 2) polypharmacy—the use of multiple, sometimes unnecessary medications. The mission of Senior PHARMAssist is to educate Durham County senior adults about preventive health measures, consult with seniors and healthcare providers about safe and effective medication use, and provide financial assistance for necessary medications to seniors with limited incomes.

Senior PHARMAssist combines access to medications with counseling and education to better ensure that the medications participants receive are more helpful than harmful. Although medication counseling is available to all Durham County seniors, eligibility for Senior PHARMAssist's financial assistance is determined by income. There are three categories of participants: funded, unfunded, and Medicaid. "Funded" participants are those

seniors who are 65 or older, live in Durham County, have incomes at or below 150% of the federal poverty level (\$1,108/single or \$1,493/couple) with no prescription insurance, and savings not exceeding \$8,000 (single) or \$12,000 (couple). "Unfunded" participants are those individuals who are not 65 or older, do not live in Durham, or have incomes or savings above the limits and medication reviews and "Medicaid" participants are those seniors with full Medicaid benefits who are identified as "at risk" for medication-related problems.

Participant data are collected on an ongoing basis at six-month intervals. The primary focus of the participant evaluation is to assess health services utilization, functional assessment, medication adherence, and satisfaction. Program data demonstrates that 31% fewer "funded" participants used emergency rooms, and 29% fewer participants stayed overnight in hospitals after being enrolled in the program for one year.



2002 ARCHSTONE FOUNDATION AWARD FOR EXCELLENCE IN PROGRAM INNOVATION

OTHER NOMINATIONS

THE PALLIATIVE CARE AND BEREAVEMENT PROGRAM

*For more information
contact:*

***The Palliative Care and
Bereavement Program***
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Foundation*
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There are many growing problems in our nation today regarding access to quality health care for all individuals, whether they are in the beginning, middle or ending phases of their lives. The Palliative Care and Bereavement Program was designed to assist individuals facing the ending phase of their lives, specifically addressing the death and dying process and the many decisions and issues that must be dealt with during this process.

Palliative Care is designed to meet the special needs of anyone suffering from a serious illness or life-threatening condition. The Palliative Care Program's primary goal or purpose is to achieve the best possible quality of life through relief of suffering, control of symptoms and restoration of functional capacity while remaining sensitive to personal, cultural, and religious values, beliefs, and practices. The program manages the patient's physical, psychological, social, spiritual, and existential needs. The staff focuses on a patient centered approach in regards to pain and symptom control, family

involvement, as well as bereavement support to the extended family after the patient has passed on. Additional services provided include education and materials regarding Advance Directives, Home Care Services, Caregiving Services, and Hospice Care.

The Palliative Care and Bereavement Program helps patients and their families understand and accept their disease and its progression, guides them through the end-of-life process, and allows the patient to make their own choices and decisions. In doing so, the patient can experience more peace and comfort, knowing that their family will not be burdened with difficult decisions, as well as the family can rest assured that their loved one's final wishes are being followed. This program helps maintain respect and dignity as well as enhance quality of life. With all these aspects in place, the community can face the process of life from beginning to end with a sense of serenity, knowing that there are such programs available when you are in the midst of losing a loved one.

SENIOR SERVICES

*For more information
contact:*

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The population in Pittsburgh's Allegheny County is ranked as the second oldest in the nation (percent of residents 65 +). This area embraces 32 communities with a population of 500,000, of which approximately 100,000 are over 65. Senior Services was created in 1995 after extensive research confirmed the need to coordinate the area's numerous programs and services, fill service gaps, and work collaboratively with the resources already available. Jefferson Regional Medical Center took the lead in the development of Senior Services, providing a single point of contact that would guide older adults and their caregivers through the maze of fragmented services. Of the more than 600 service providers assisting clients, they represent approximately 1800 services which include community agencies, faith based organizations, local/community groups, alternative housing, long-term care options, a caretakers' registry, support groups, and many others.

Senior Services offers community-based referrals, free on-site programs such as medical insurance counseling, tax preparation, financial consulting, and advance directives planning. The program also provides an array of low cost senior health and wellness classes. Examples of additional areas of service include: assistance with subsidized housing, adult day care, support groups, transportation, financial and legal assistance. Since 1995, over 19,000 seniors have received ongoing coordinated services. More than 94,600 calls have been made to seniors and/or their caregivers providing over 107,220 network service referrals. Senior Service workers have worked diligently to provide free assistance to seniors in need of someone to objectively assess their situation and become their advocate. The program is essential because it assists seniors in overcoming the many barriers in obtaining the resources necessary to maintain a health quality of living.



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OTHER
NOMINATIONS

R.E.A.L. FITNESS (RENEWING ENERGY, ACTIVITY AND LIFE) ADULT FUNCTIONAL FITNESS PROGRAM

For more information
contact:

**R.E.A.L. Fitness Adult
Functional Fitness
Program**

BodyWISE Center for
Health and Fitness
University of New England
College of Osteopathic
Medicine

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Biddeford, ME 04005

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mgugliucci@une.edu

R.E.A.L. Fitness is a unique functional fitness program designed by the University of New England BodyWISE Center for Health and Fitness professional staff in 1998. Functional fitness is a concept that the body should be trained and developed to make the performance of everyday activities easier, smoother, safer and more efficient. Priority is given to exercises that enhance everyday movements and improve an individual's ability to "function independently." It is generally assumed in our society that all who age suffer from a decline in physiologic function. The University of New England BodyWISE Center for Health and Fitness embodies a different philosophy. By focusing on the unique physical and emotional needs of each person and applying sound adaptive and creative exercise strategies, physiologic function can be maintained and often times improved as we age.

R.E.A.L. Fitness is a group exercise program for older adults, including those with arthritis, diabetes, cardiovascular disease, low functional fitness, obesity, and chronic

obstructive pulmonary disease. The program focuses on established parameters of cardiovascular fitness, muscular strength, balance, coordination, and range of motion. Social interaction within the group is encouraged. The goal is to help older adults gain or maintain personal quality of life goals through stimulating the body, mind, and spirit with exercise and interaction. The benefits of *R.E.A.L. Fitness* include: increased flexibility and range of motion, improved feeling of overall well-being, improved muscular strength, increased duration of walking-time and distance, increased balance and proprioception, increased dexterity, and increased self confidence.

R.E.A.L. Fitness is true to its name . . . Renewing Energy, Activity, and Life through fitness, and offers older adults and care providers an easily implemented, inexpensive means to higher quality of life, increased safety, and reduced health care costs. The program has translated scientifically-grounded exercise into a simple program with profound benefits to its participants and little to no cost to its sponsors.

IMPROVING PAIN MANAGEMENT IN LONG-TERM CARE FACILITIES

For more information
contact:

**Medical College of
Wisconsin
Palliative Care Program
Division of Neoplastic
Diseases and Related
Disorders**

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This project was begun in 1995 with the goal of improving management of pain for residents in long-term care (LTC) facilities. It is well documented that a large percentage of LTC residents suffer pain, and that although good pain management practices are available, many barriers exist that impede effective care. These include lack of basic pain management education for health professionals, low expectations of pain relief by the public, fear of addiction and side effects from drugs used to treat pain, lack of assessment standards and quality monitoring programs, and fear of LTC regulatory oversight. To address this issue, the Palliative Care Program staff at the Medical College of Wisconsin developed a project to assist LTC facilities *institutionalize* improved pain management practices.

Over 100 LTC facilities in Wisconsin have participated in this project since 1996, with demonstrable improvements in facility assessment processes, educational programming, standards development, and quality

outcomes. Since 1998, this project has been replicated outside of Wisconsin as part of a national project, replicated in Montana, Delaware, Virginia, Connecticut, Michigan, New Mexico and North Carolina. Data from these states has confirmed that 1) the project can be successfully replicated outside Wisconsin and, 2) that similar results can be obtained; the national project has demonstrated measurable improvement in pain ratings by individual patients.

Undertreated pain is a significant public health problem, especially among the elderly and cognitively impaired LTC residents. There is no simple solution to the problem of undertreated pain; twenty years of traditional educational interventions failed to improve pain management practice. This project used a novel approach, grounded in academic theory and has proven to be successful in a large cohort of Wisconsin LTC facilities (25% of all Wisconsin facilities have participated), both in terms of improved institutional standards, but also patient care.



PARTNERS IN DEMENTIA CARE

For more information contact:

Partners in Dementia Care

VA Healthcare Network
Upstate NY and Upstate
Chapters of AA/RD
Bath VA Medical Center
76 Veterans Avenue
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“Partners in Dementia Care” was born out of participation in the national demonstration project, “Chronic Care Networks for Alzheimer’s Disease.” It is a unique active collaboration between a governmental entity, the Veterans Healthcare Network in Upstate New York, and not for profit community organizations such as local state chapters of the Alzheimer’s Association. These organizations have partnered to create an innovative dual track of support and intervention for patients with dementia and their caregivers during clinical primary care encounters. The purpose of the project is to promote early screening and identification, assessment, and diagnosis of dementia and development of support to care for and manage these patients from early onset to end of life. Early detection and engagement of caregivers in management and treatment of dementia increase likelihood of continuity of care beyond the clinical encounters throughout the course of the disease.

From October 1999 through January 2002, a total of 1,338 health care and support staff have been trained. The training has lead to an increased awareness of dementia and its prevalence, and an awareness of the

availability and importance of support resources for caregiver and patients outside of the primary care clinical encounter. This is evidenced by increased provider referrals to dementia care managers, memory disorder clinics and to Alzheimer’s Chapters.

Similar partnerships are being developed nationally, with different types of organizational partners replicating collaboration in a variety of settings in real life health care operations. Benefits to families and patients with dementia through this program are that they have access to a seamless continuum of services. This comes without increased cost or increased demands. Partnership offers value by increasing the quality and range of services to be offered. Effective management and care planning through this partnership has the potential to forestall premature and expensive, institutionalization, preserve health or caregivers who continually support the patient with dementia, and improve the quality of life for patients and their families as well as increasing the willingness of providers to actively engage and work with these patients across settings and phases of progression of the disease.

HOME CAREGIVER TRAINING AND SERVICES PROGRAM

For more information contact:

Home Caregiver Training and Services Program

Schmieding Center for
Senior Health and
Education of Northeast
Arkansas
2422 N. Thompson, Suite B
Springdale, AR 72764

Beth C. Vaughan-Wrobel,
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With the aging baby boomers, declining birth rates, longer life spans, and rising levels of chronic and debilitating diseases, Americans will experience a “caregiver crisis” over the next 30 years. Elder caregiving can be broadly defined as the provision of paid or unpaid assistance with the physical, psychosocial, emotional, and behavioral needs of another person. The Schmieding Center “Home Caregiver Training and Services Program” provides a resource to families who are experiencing the “caregiver crisis” today and addresses concerns for caring for the aging population in the future.

This unique program includes the following components: caregiver training, the Schmieding Caregiver Registry, continuing education for caregivers, community programs on caregiving, referral and consultation services related to caregiving, and the Aging Resource Center. The training

program provides initial and continuing education for individuals seeking knowledge and skills in home caregiving. Three levels of training are available: Elder Pal (25 hrs), Personal Care Assistant (25 additional hrs), and Home Care Assistant (50 additional hrs). Each level of training includes didactic and laboratory experiences. The Schmieding Center also provides referral information on housing options, Medicare/Medicaid, and other resources available in the area.

Since the start of the program in August 1999, 150 persons have graduated as Elder Pals, 77 as Personal Care Assistants, and 17 as Home Care Assistants. Two graduates have passed the state certified nursing assistant exam, one has completed LPN training, and one is currently enrolled in LPN school.



2002 ARCHSTONE FOUNDATION AWARD FOR EXCELLENCE IN PROGRAM INNOVATION

OTHER NOMINATIONS

ALEGRIA GROUP

*For more information
contact:*

Alegria Group
The Support Center, Inc.
1010 Grandin Avenue
Rockville, MD 20851

Frances M. Goldstein
(301) 738-2250 Telephone
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supportcenter@aol.com

The Support Center, Inc. is a non-profit, service intensive, medical adult day service center located in Rockville, Maryland. For more than 27 years the Center has proudly served the Montgomery County community. Their mission is to provide day services to frail and/or disabled adults, thereby enabling them to continue to reside in the community. The structured environment, medical supervision and therapeutic activities provided at the Center help raise the self-esteem of the participants and encourages them to function independently. In 1994, the administration at the Center became aware that there was a large underserved population of multi-impaired, Spanish speaking elderly who would benefit from this type of program. From this awareness, the Alegria Group was conceived.

Presently, the Alegria Group has 33 participants. The coordinator of the group organizes activities that are creative, as well

as therapeutic. Weekly multi-disciplinary staff meetings are held to discuss the needs of the participants, and family members or caregivers are invited to attend these meetings. In addition, a bi-monthly caregivers' support group is offered as a community service.

The program emphasizes familiar memories of the Hispanic culture and is conducted in Spanish. Positive impacts have resulted from participants hearing their own language, music, and reminders of their culture. Participants were found to be more alert, and began to take more interest in their environment. Activities held for the Alegria Group include: celebrations of native countries' national holidays, field trips to senior centers, trips to Hispanic embassies, and community parties for National Hispanic Month. In addition, the Group has Hispanic instructors from Arts for the Aging Program conducting classes in painting, ceramics, and sculpture

OPTIMAL ELDERERS PROGRAM

*For more information
contact:*

Creighton University
**School of Occupational
Therapy**
2500 California Plz
Omaha, NE 68178

Helene Lohman
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The Optimal Elders Program in Omaha, Nebraska involves a partnership between professional occupational therapy university students and elders in assistive and independent living facilities. There are two aspects to the program: (1) inter-generational book discussion groups and (2) service learning partnerships with students and elders. The intergenerational book study groups involve regular meetings with elders and students to discuss books. The objectives of these discussion groups are to enhance intergenerational understanding through discussion, and increase awareness of aging trends. The second aspect of the program was inspired by the Well Elderly Program, a program based on wellness and quality of life for elders. The objectives of this program are to understand the meaning of activities for elders and encourage involvement in these activities, to improve safety in the elders' apartments, and to integrate coursework with service learning experiences.

Some of the documented benefits of this program include developing relational links and increasing reciprocal learning between generations. The program promotes "healthy aging and independence" and "quality of life within institutional settings." The overall focus of the Optimal Elders Program is keeping elders healthy and independent in their living situations by encouraging involvement in meaningful activities, such as the book discussion groups, and promoting safety. The fact that many of the elders reinitiated self identified meaningful activities, desired continual contact with the students, and expressed their enjoyment in participating in the intergenerational book discussion groups, illustrates the overwhelming success of the program.



2002 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

OTHER
NOMINATIONS

MAIN LINE HEALTH COMMUNITY HEALTH SERVICES FOR SENIORS

*For more information
contact:*

**Main Line Health
Community Health
Services for Seniors**
130 South Bryn Mawr Ave.
Bryn Mawr, PA 19010

James Plumb, MD
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plumbj@mlhs.org

As the healthcare environment changes, health care providers are faced with the need to educate patients, prevent unnecessary hospitalizations, enhance continuity of care, and improve the quality of life in the communities they serve. With these challenges as a guide, Main Line Health's (MLH) Community Health Services for Seniors-Continuum for Independent Living Program and Ask A Nurse Program-target high risk elderly people in the community.

There are 186,500 people living in Main Line Health's service area who are 65 years and older. Health problems, combined with functional limitations, often lead to an increased dependency on family and other caregivers, a gradual decline in the older person's quality of life, and a threatened ability to live at home. One in four older adults in the MLH region lives alone, and

more than 13,000 older adults, 60% of whom live alone, have incomes below the poverty level. These low-income older adults, especially those living alone, are more likely to be prematurely institutionalized because they lack the social and financial resources to continue living independently.

Both Continuum for Independent Living (CILP) and Ask A Nurse Programs focus on early detection and prevention, health screening and promotion, and coordination of care. CILP is a blended community health and social service model and is designed primarily for the frail elderly who require comprehensive in home assistance in order to avoid premature institutionalization, while Ask A Nurse is a community health model specifically addressing the health needs of the elderly.

ONE/VPH STROKE PROJECT

*For more information
contact:*

**ONE/VPH Stroke Project
Organization for the
Needs of the Elderly (ONE)
in Partnership with
Valley Presbyterian
Hospital**
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Van Nuys, CA 91406

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onejoy@pacbell.net

Stroke Prevention and Management in Our Community ("The Stroke Project"), a collaboration between Valley Presbyterian Hospital (VPH) and Organization for the Needs of the Elderly (ONE) was created in the fall of 2000 with a grant from Unihealth Foundation. The Stroke Project meets a critical need for comprehensive stroke prevention and management services in the central and west San Fernando Valley. It is a first of its kind project that partners a hospital with a community social service agency in a unique continuum of care modality.

Annually, over 175 persons present themselves for care at VPH due to a stroke. Stroke is the largest single cause of neurological crippling in our nation. Without continuous support and assistance in managing the outcomes of stroke, victims are at a high risk for a recurrence and/or premature institutionalization. The deterioration in health and well-being that results in premature institutionalization is avoidable given proper care management.

The Stroke Project's services have been shown to significantly reduce stroke risk, decrease the number and frequency of re-strokes, and increase the degree to which stroke victims are able to function in their environments. Combining immediate and ongoing case management with public education about stroke prevention, the Stroke Project has dramatically surpassed expectations of success. The word has reached the community about the Stroke Project and demand for its services grows daily. In addition to VPH, other area hospitals, senior centers, multi-purpose centers, home health agencies, physical therapists, and others addressing the needs of stroke victims now refer clients to the Stroke Project for continuity of care. Nothing like the Stroke Project exists anywhere else in the nation. An evaluation and dissemination component will facilitate the use of the program as a regional and nationwide model.



2002 ARCHSTONE FOUNDATION AWARD FOR EXCELLENCE IN PROGRAM INNOVATION

OTHER NOMINATIONS

PET AND ELDER TEAM SUPPORT (PETS) PROJECT

*For more information
contact:*

PETS Project
Jewish Association for
Services to the Aged
132 West 31st Street
New York, NY 10001

Joan Kincaid
(212) 273-5217 Telephone
(212) 695-9070 Fax
jlowry-kincaid@jasa.org

The Jewish Association for Services to the Aged (JASA), a social service agency dedicated to enhancing the lives of elderly New Yorkers, created the Pet and Elder Team Support (PETS) project in 1997, to address the needs of elderly pet owners whose capacity to care for their pets has been compromised by frailty, illness, and/or inadequate income. The establishment of the program recognizes the critical role of pets in the lives of older people, particularly those who are homebound. Increasing age and declining health often create obstacles to providing proper care for pets. Seniors afflicted with arthritis lose the ability to walk their dogs or groom long-haired cats; fixed incomes often cannot be stretched to cover routine veterinary bills, and pet owners with complex health problems may refuse hospitalization because they have no one to care for their animals in their absence.

The program matches volunteers with elderly pet owners to provide assistance tailored to the needs of each client. Volunteers help with dog walking, litter box cleaning, emergency feeding, shopping for pet food and supplies, transportation, training, and pet sitting. Since the challenges of pet care for the frail elderly are universal, this program has enormous potential for replication. The important ingredients are: a recognition of the value of pets in the lives of seniors, a social worker with the skills to capitalize on the bond between older people and their pets, and the establishment of strong collaborative relationships with social service and pet care provider to help identify individuals in need of help and to bring together a network of resources to respond to the needs of elderly pet owners and their pets.

PREVENTING FALLS PROGRAM

*For more information
contact:*

**Preventing Falls
Program**
The New Jersey Society
for Public Health
Education (NJ SOPHE)
1 Chestnut Place
Lebanon, NJ 08833

Sue Lachenmayr
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lach@blast.net

The Preventing Falls Program is a highly cost-effective, unique collaboration among private and public agencies and a professional organization to improve the quality of life for older adults through a health promotion program to reduce the risk of falls. Falls among older adults are rising in epidemic fashion, resulting in long term disability and death. In fact, frail seniors are three times more likely to fall than vigorous seniors and nearly ninety percent of all hip fractures are the result of a fall. The New Jersey Society of Public Health Education (NJ SOPHE) utilized its diverse membership of health educators to provide one-hour programs on falls prevention in diverse settings throughout the state.

Health educators attended train-the-trainer courses and agreed to provide at least three one-hour Preventing Falls Programs in their communities. The two hour train-the-trainer sessions covered a broad range of topics including: goals and objectives for

the program, a definition of falling, the physical, emotional, and financial impact of falls, osteoporosis risk, prevention, diagnosis, and treatment, how to identify risks for falls and how to prevent them, house assessment for fall risk, and many others.

The Preventing Falls Program developed for older adults included basic information on the same topics in a one-hour program. Using social and individual behavioral change theory principles, participants identified potential environmental hazards and their personal risk of falling through an osteoporosis risk assessment and an in-home safety assessment tool. Throughout the program, participants were encouraged to take action to reduce their personal risk by getting an eye exam, talking with their health care provider about their medications, and asking their provider about a bone density screening.



2002 ARCHSTONE FOUNDATION AWARD FOR EXCELLENCE IN PROGRAM INNOVATION

OTHER NOMINATIONS

SENIORS AT HOME

*For more information
contact:*

Seniors at Home
Jewish Family and
Children's Services
2150 Post Street
San Francisco, CA 94115

Bonnie Tenenbaum
(415) 449-1200 Telephone
(415) 922-5938 Fax
admin@jfccs.org

For many frail elderly, non-medical problems put them at risk for hospitalization, inappropriate use of the healthcare systems, or institutionalization. The challenge is to connect them with affordable supportive services that can keep them safe and comfortable in the environment of their choosing for as long as possible. To accomplish this, the Seniors At Home (SAH) program of Jewish Family and Children's Services has developed a social work-based care management model uniting geriatric social workers, physicians and their front office staff, other senior care professionals, and the senior and his or her family in integrating medical care with needed social resources.

To expand the scope of care to address the non-medical needs of patients that might adversely affect health outcomes, the SHA program recruits office staff members from participating physician offices to be trained as geriatric resource persons able to identify at risk seniors and refer them for case management. Referrals can also come

from discharge planners, nurses, family members, the elderly, or community members/organizations. Within 48 hours of the referral, a geriatric social worker conducts a complete in-home assessment. The case manager then works with the elder, his/her support systems, and the physician, as needed, in developing plans to create a comfortable and safe environment so that the elder can successfully manage at home.

Seniors at Home is forging a path uniting social work-based case managers with physicians' offices in order to arrange for timely, appropriate supportive services that can address non-medical challenges facing frail elderly before these put them at risk of hospitalization or premature institutionalization. SAH has worked closely with HMOs and physician's organizations to demonstrate the advantages of such early intervention and negotiate funding streams that make it accessible to increasing numbers of frail elders.

TAKE THE AFTERNOON OFF A CAREGIVER RESPITE PROGRAM

*For more information
contact:*

**Take the Afternoon Off
(Caregiver Respite
Program)**
Visiting Nurse Association
and Hospice of Southern
California
150 West First Street
Suite 270
Claremont, CA 91711

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mfox@vnasocal.org

The 2000 Census indicates that there are 35 million Americans over 65 years of age. The fastest growing group among these seniors is those 85 and older. As medical advances help seniors live longer, the number with chronic and debilitating illnesses also grows. One of our society's greatest assets is the fifteen million middle-aged children and older spouses who provide care to these ill or disabled family members.

Take the Afternoon Off has been in operation since July 2000 and is a comprehensive program designed to relieve the stress experienced by seniors and others who provide full time care for an ill or disabled family member. Although these family members perform an important service to society and their relatives, they do so at considerable risk to themselves. A five-year study reported that caregivers who

experience stress are 63% more likely to die than a similar population that does not provide care. Recognizing the need for a comprehensive program to provide respite for caregivers in the community, VNA and Hospice created this program.

Take the Afternoon Off accepts full time caregivers who do not have paid help in the home. Most of the recipients of program services are spouses of the ill and disabled; some are sons or daughters who care for elderly parents, and a few are parents or grandparents who care for children who are ill. There is no time limit on how long caregivers may remain in the program and caregivers are not asked to pay for services. Currently there are forty-one caregivers receiving Take the Afternoon Off services. The program is funded entirely by grants, United Way funding and individual donations.



2002 ARCHSTONE FOUNDATION AWARD FOR EXCELLENCE IN PROGRAM INNOVATION

OTHER NOMINATIONS

YOU DECIDE: SENIOR DRIVING AWARENESS PROGRAM

*For more information
contact:*

**Area Agency on Aging 1-B
You Decide: Senior
Driving Awareness
Program**

*Tina Abbate Marzolf
(248) 262-9217 Telephone
www.aaa1b.org*

One of the most prominent issues facing older adults today is safe mobility. Statistics indicate that as people age, the need for safe mobility does not decrease. Safe mobility or the lack thereof, affects every other aspect of life, and is critical to maintaining dignity and independence. The mission of the Area Agency on Aging 1-B (AAA 1-B) is to maintain the independence and dignity of older adults and persons with disabilities in a community based setting. In response to this critical need, the AAA 1-B established the You Decide: Senior Driving Awareness Program (SDAP) in 1997.

The program meets monthly in five geographically diverse venues in Southeast Michigan, features an expert speaker on a

variety of issues related to safe mobility, offers peer support and problem solving group discussions, provides one-on-one mobility counseling to older adults and their families, and provides referrals to mobility related services, along with additional services. More than 1200 people have participated in the program since its start. A March 2001 focus group evaluation showed that: 52% of participants have changed their driving habits as a result of information learned through the program, and 100% believe the program should be replicated in other communities in Michigan, allowing more individuals access to vital mobility information.

PROJECT S.U.C.C.E.S.S.

*For more information
contact:*

**Project S.U.C.C.E.S.S.
Kirtland Community College
10775 N. St. Helen Rd.
Rosecammon, MI 48653**

*Shannon Hasty and
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or
hastys@kirtland.edu*

Many gerontology projects center on improving traditional healthcare priorities in assisted living institutions and nursing homes. Nursing home clients are seen as sad, lonely people who spend their days in gowns or pajamas. Many receive excellent healthcare, compassionate patient care, recreational activities, and adequate dietary support. Still, the patient is confined in the institution with little in the way of extras. The Cosmetology Department at Kirtland Community College has instituted Project S.U.C.C.E.S.S. This service learning initiative in partnership with area nursing homes transports residents to the state licensed facility at the college. Student teams create individual nail, hair and skin care programs for the residents.

Forty students worked with twenty residents during the 2001-2002 academic year. Students gain valuable experience and awareness from these unique clients, while the residents receive personalized nail, hair

and skin care that is unavailable in the home. Essentially, this project addresses basic quality of life issues that plague institutionalized people.

Project S.U.C.C.E.S.S. has had a positive effect on the students and the clients. Positive feedback has been received from the residents' families and friends. They enjoy seeing their loved ones being pampered. They also love that this program gives the residents a chance to be mobile and they feel the services really add to the residents' self esteem. The college students get important training in dealing with the aged, and this valuable experience increases gerontological awareness, improves inter-generational communication, and fosters an increased level of student engagement with a currently underserved population.



2002 ARCHSTONE FOUNDATION AWARD FOR EXCELLENCE IN PROGRAM INNOVATION

OTHER NOMINATIONS

PROJECT SHEMA

*For more information
contact:*

Project SHEMA
Madlyn and Leonard
Abramson Center for
Jewish Life
1425 Horsham Road
North Wales, PA 19454

Frank Podietz
President and CEO
(215) 371-1802 Telephone
(215) 371-3032 Fax

Project SHEMA is an acronym for Sharing and Enriching through Multi-generational Activities. Project SHEMA's mission is to facilitate multi-generational activities for the residents they serve with community, families, children, congregations, schools, and other groups. Their programming goals are to: 1) secure Jewish continuity as Jewish elderly instill in Jewish youth an appreciation and interest in Jewish heritage and culture, 2) to facilitate hope in the future of the residents as Jewish youth share their enthusiasm for Judaism, 3) to educate all ages about the mitzvot associated with honoring the elderly, 4) to transmit the experiences of one generation to another, and 5) to enable the community to be involved with the elderly in a passionate, technological, and friendly environment.

Since 1999 Project SHEMA has evolved from informal activities conducted by and for youth into a structured program with multiple components. At the core of Project SHEMA is education and collaboration. Through orientation, family education programs and other services, Project SHEMA educates and prepares children and families for appropriately working with the elderly. Orientations encompass understanding

dementia and Alzheimer's disease, discussing and practicing good communication and empathy skills, exploring biblical imperatives to "honor the aged" and other interactive activities to prepare these volunteers for intimate interaction. Volunteer, recreation, and/or social work staff is always available to lead, discuss and answer questions regarding visits.

Over the past three years Project SHEMA has collaborated with over 40 organizations both locally and regionally. These organizations include private religious schools, youth groups, public schools, day schools, college associations, social action groups, and other Jewish and non-Jewish organizations. The concept and content of this multi-generational program can be adapted to a variety of settings which offer healthcare and care for the aged. The program components are based upon organized activities that are creative, educational, and spiritual in nature and promote interaction among the generations. The changing demographic profile in the United States suggests that the 65+ segment of the population will be growing as the baby boomers age. Therefore, there will be increased need and value for programs such as Project SHEMA.

THE HUBBARD PROGRAM

*For more information
contact:*

The Hubbard Program
University of North
Carolina at Chapel Hill
School of Medicine
Program on Aging
CB#7550
141 MacNider Bldg.
Chapel Hill, NC
27599-7550

Director:
Cherie Rosemond
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The Hubbard Program provides an ongoing interdisciplinary team training program, focused on geriatric assessment, for advanced level medicine, social work, nurse practitioner, physical therapy, or occupational therapy, and pharmacy learners. Trainees gain knowledge and skills in collaborative interdisciplinary practice applied to the care of geriatric patients in the context of family, home, and community. In addition, the team's work contributes to patient care by providing comprehensive, home based assessments of individual patients who have been referred to the team and recommendations to referring caregivers.

The Hubbard team meets one afternoon each week of the semester to perform interdisciplinary geriatric assessment. Patients selected for Hubbard team evaluation are medically and socially complex and are often in crises or transition. Patients are referred from the UNC Geriatric Evaluation

Clinic, the UNC Family Medicine Clinic, the Orange County Department on Aging, home health care providers, and community-based practitioners. The designated trainee team leader reviews the chart and presents information and concerns guiding the referral of the patient to be seen that day. Each discipline interviews and evaluates the patient in the presence of all team members so trainees can begin to understand the contributions each discipline makes to the care of older patients. The patient's family members also are encouraged to participate in the evaluation process, affording the trainees exposure to the importance of family systems. In January 2002, the Hubbard Program began a partnership with a new, student coordinated, home visiting service for older adults. This program, which provides monthly home visits to frail elders, receives patient referrals from the Hubbard Program. Currently, 18 teams of interdisciplinary students visit Hubbard patients once monthly in their homes.



THE 2003 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 **2003 Archstone Foundation Award for Excellence in Program Innovation** effective November 15, 2002. 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 single-space typed 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 131st Annual Meeting of the American Public

Health Association in San Francisco, CA, November 15-19, 2003, and make a presentation in a special Gerontological Health Section Award Session. Honorable Mention may be awarded to other finalists.

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, 2003.

Nominations for the 2003 Archstone Foundation Award for Excellence in Program Innovation should be sent to:

Allan Goldman, MPH

DHR -Division of Aging Services
Two Peachtree Street N.W., 9th Floor
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THE 2003 ARCHSTONE FOUNDATION
AWARD FOR EXCELLENCE
IN PROGRAM INNOVATION

NOTES



ARCHSTONE FOUNDATION

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