

# INNOVATIONS IN SENIOR SERVICES:

Highlights and Lessons Learned  
A Five-Year Review – 1998 - 2002

**Award for Excellence in Program Innovation  
Winners**

Selected by  
AMERICAN PUBLIC HEALTH ASSOCIATION  
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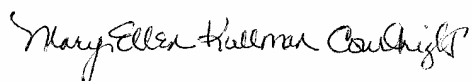
## FOREWORD

The Gerontological Health Section (GHS) of the American Public Health Association (APHA) and the Archstone Foundation are pleased to join together to recognize innovative programs for older adults. As the population ages, public health programs targeted at older adults gain increased significance. The Award for Excellence in Program Innovation celebrates the creativity of organizations that are pioneering approaches to help older adults remain healthy, functionally independent, and residing in the community. The purpose of this document is to showcase the 24 organizations that have won the award during its first five years, from 1998 to 2002, and to share the Lessons Learned as they apply to public health and aging initiatives.

We would like to thank the Archstone Foundation, especially President and CEO Joseph F. Prevratil and the Board, for their insight into the importance of public health and aging and their resulting generosity in supporting APHA, both endowing the Award and publishing a summary of the best programs annually, as well as this review document. The APHA Task Force on Aging, chaired by Dr. Faye Wong and Dr. Richard Fortinsky, with support from APHA Executive Director Dr. Georges Benjamin, have brought aging to the attention of the greater APHA membership, and we are grateful for their endorsement of this publication and aging as a priority issue.

We would like to thank the chairmen of the annual Selection Committee, Drs. Brenda Wamsley, Nancy Miller, and Allan Goldman, and all those GHS members who participated in the review process to evaluate more than 100 applications. Dr. Marcia Ory and Dr. Peggy Smith collaborated with us to conduct the five-year follow-up study that led to this publication. Our thanks to both of them and to the many award winners who took the time to talk with us about the history and current status of their programs. We also owe immense thanks to Ms. Patricia Fabian for unending patience in managing the formatting and design of this book.

APHA and the Archstone Foundation are both committed to advocacy for the nation's senior population. This document will make our task more understandable. Our compliments to the members of the GHS for having the vision and determination to enhance the future of public health for all older adults and to all of the nominees and awardees for being exemplary models.



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# INTRODUCTION

In 1998, the Gerontological Health Section (GHS) of the American Public Health Association (APHA) created an award to recognize innovative programs providing health and related social support services to older adults. The award was endowed by the Archstone Foundation as the Award for Excellence in Program Innovation. This book describes the 24 programs that have won the award or honorable mention between 1998 and 2002 and are thus deemed by peers to be exemplary in providing services to seniors.

The purpose of the award is to recognize best practice models with an emphasis on activities that effectively link academic theory with applied practice in the field of public health and aging. Criteria for selection include: creativity in project design; impact on population or service delivery system; measurable program outcomes and benefits; and potential for replication. The award recipients vary widely, from community-based services to educational initiatives.

The Award for Excellence in Program Innovation is widely announced in the public health and aging field. A committee of GHS members reviews the applicants. Committee chairs have been Brenda Wamsley, MSW (1998-2000), Nancy A. Miller, PhD (2001), and Allan Goldman, MPH (2002). By the end of 2002, over 100 organizations had applied for the award. Winners are recognized at the annual meeting of APHA. The 24 award-winning programs are listed in Table 1. Award application information is included at the end of this book.

This publication describes each program at the time of the initial award and gives an update on current status. Table 2 lists the sites with service characteristics, target audiences and number of people served. This report highlights features associated with program success and continuation over time.

The final section of the report summarizes Lessons Learned that contribute to immediate and sustained achievement, based on a follow-up study that was conducted in Fall 2002. In a time of scarce resources throughout the health care and social service systems, knowing the hallmarks of long-term success helps to focus human, physical, and dollar resources where they are most likely to make a permanent difference. Thus, the findings should be useful to grantors selecting recipients to test innovative programs and to organizations striving to initiate long term models to improve the lives of older adults.

<b>Table 1</b> <b>Award for Excellence in Program Innovation</b> <b>Winners and Honorable Mentions</b>		
<b>1998 WINNER</b>		
A Matter of Balance: An Intervention to Reduce Fear of Falling	Boston University - Roybal Center for Enhancement of Late-Life Function	Boston, Massachusetts
<b>1998 HONORABLE MENTION</b>		
Competence with Compassion: Abuse Prevention Training Program	CARIE – Center for Advocacy for Rights & Interests of the Elderly	Philadelphia, Pennsylvania
Mammography Optimum Referral Effort (MORE)	Connecticut Peer Review Organization	Middletown, Connecticut
Member-to-Member	Elderplan Community Services	Brooklyn, New York
The Alabama Stroke Project	Alabama Quality Assurance Foundation	Birmingham, Alabama
<b>1999 WINNER</b>		
Senior Wellness Project	Northshore Senior Center Senior Services of Seattle/King County	Seattle, Washington
<b>1999 HONORABLE MENTION</b>		
Strengthening Geriatrics Training for Primary Care Medical Residents	Medical College of Wisconsin Wisconsin Geriatric Education Center	Milwaukee, Wisconsin
Geriatric Evaluation Networks Encompassing Services (GENESIS)	County of Los Angeles Department of Mental Health, Older Adult Programs	Los Angeles, California
Partners for Healthy Aging	Medco Health Solutions, Inc.	Franklin Lakes, New Jersey
Aging Strength Training Task Force	Marin County Division of Aging	San Rafael, California
<b>2000 WINNER</b>		
Experience Corps	Center on Aging and Health Johns Hopkins Medical Institutions	Baltimore, Maryland
Assistive Equipment Demonstration Program	Gerontology Institute, University of Massachusetts, Boston	Boston, Massachusetts
<b>2000 HONORABLE MENTION</b>		
Aging and Memory Center	Montefiore Medical Center	Bronx, New York
Pathfinders	Gerontology Center University of Utah	Salt Lake City, Utah
Diabetes Care Monitoring System	Mountain-Pacific Quality Health Foundation	Helena, Montana
Medication Assistance Program	Mission St. Joseph's Hospital	Asheville, North Carolina
<b>2001 WINNER</b>		
Groceries to Go	Elder Services Network	Mountain Iron, Minnesota
<b>2001 HONORABLE MENTION</b>		
Centralized Geriatric Nursing Assessment Service	Community Health Services DuPage County Health Department	Wheaton, Illinois
The S.A.G.E. Project	The Area Agency on Aging	Uniontown, Ohio
Senior Wheels	Senior Resources of Guilford	Greensboro, North Carolina
<b>2002 WINNER</b>		
Kinship Support Network	Edgewood Center for Children and Families	San Francisco, California
<b>2002 HONORABLE MENTION</b>		
SeniorNavigator.com	SeniorNavigator.com	Richmond, Virginia
Take Charge of Your Health for Older Adults	DHR – Division of Aging Services	Atlanta, Georgia
Elder Rehab by Students Program	University of Arizona	Tucson, Arizona

<b>Table 2</b> <b>Awards for Excellence in Program Innovation Winners and Honorable Mentions</b> <b>Services Provided and Target Audience</b>				
<b>Program Name</b>	<b>Service</b>	<b>Target Audience</b>	<b># Years Provided</b>	<b># Served in 2001</b>
<b>A Matter of Balance: Intervention to Reduce Fear of Falling</b>	Group-based intervention designed to reduce fear of falling & increase activity levels	Community-based seniors (secondary target: Trainers)	9 years	Hundreds of seniors (plus 30 Trainers)
<b>Competence with Compassion: Abuse Prevention Training Program</b>	Training program to help participants meet the challenges of providing quality care to long term recipients	Long-term care staff	13 years	2,500
<b>Mammography Optimum Referral Effort (MORE)</b>	Physician office-based intervention designed to increase mammography use among women 65+	Women age 65+	7 years	Women throughout the state
<b>Member-to-Member</b>	Senior volunteers provide services to other seniors	Seniors	15 years	1,000
<b>The Alabama Stroke Project</b>	Collaborative project to improve the quality of care & compare the effectiveness of treatment methods	Stroke patients in Alabama hospitals  Health care professionals	6 years	NA*, as impact is indirect
<b>Senior Wellness Project</b>	Program to improve function/decrease disability risk	Seniors	10 years	2,000
<b>Strengthening Geriatrics Training for Primary Care Medical Residents</b>	Provides systematic set of instructional materials to enhance understanding of geriatrics for future physicians	Medical residents/faculty	7 years	NA*
<b>Geriatric Evaluation Networks Encompassing Services (GENESIS)</b>	Provides comprehensive mobile, in-home mental health services	Seniors with mental health problems, frail & homebound	8 years	2,000
<b>Partners for Healthy Aging</b>	Medication management, including education	Seniors within managed prescription plans	7 years	6,000,000
<b>Aging Strength Training Task Force</b>	Mobilize seniors to start lifting weights	Seniors Professionals working with seniors	7 years	NA*
<b>Experience Corps</b>	Designed to place senior volunteers in public elementary schools in roles selected to improve academic outcomes	Seniors  Elementary school students	7 years	2,500
<b>Assistive Equipment Demonstration Project</b>	Disseminate assistive equipment through case managers to	Seniors w/ADL deficits	3 years	NA*

	increase independence in care/ household management	Case Managers		
Aging and Memory Center	Provide specialized mental health care in primary care offices or at senior's homes	Seniors with mental health problems Case Managers	5 years	NA*
Pathfinders	Provide health and wellness information, and aid in the development of self-care skills	Recently widowed seniors	3 years	100 in 2000 (Demo ended in 2000)
Diabetes Care Monitoring System	Computer-based system used in physician's offices in remote areas to monitor diabetes care	Individuals with diabetes	6 years	50
Medication Assistance Program	Provides medications, education & disease management	Low income Medicare recipients	5 years	100
Groceries to Go	Provides weekly grocery shopping & delivery service	Seniors, especially frail & disabled	6 years	125 people; 1,820 orders
Centralized Geriatric Nursing Assessment Service	Improve the quality & efficiency of in-home nursing services	Seniors	3 years	50
The S.A.G.E. Project	Integrates many levels of care to provide a coordinated health care delivery system	Low income, frail seniors	7 years	600
Senior Wheels	Volunteer based program to provide medical transportation	Seniors	6 years	2,700
Kinship Support Network	Public/private partnership to assess and respond to needs of grandparent caregivers	Grandparent caregivers	10 years	250
SeniorNavigator.com	Website providing local health and aging information to seniors and their caregivers	Seniors, caregivers	2 years	7,000
Take Charge of Your Health for Older Adults	Program to improve nutrition, fitness, and physical activity through programs at Senior Centers.	Seniors	2 years	600
Elder Rehab by Students Program	Program to improve physical fitness, quality of life, and mood of patients with Alzheimer's type dementia	Persons with Alzheimer's and their caregivers	4 years	14

\*NA indicates data on number of seniors served in 2001 is not available. This occurred for a variety of reasons. For example, for some, the intervention reached seniors indirectly; in other instances, program specific data were not kept.

## **1998 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION WINNER**

### **A Matter of Balance: An Intervention to Reduce Fear of Falling Among Community-Dwelling Elders**

**Boston University Roybal Center for Enhancement of Late-Life Function and University of Illinois at Chicago**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**The program addresses older adults' fear of falling. Outcome data at one-year follow-up have documented program success: less fear of falling, greater falls management, and improved scores on physical, mobility, and social behavior scales. The program has been widely replicated nationwide and in other countries. The program has a strong marketing emphasis, training facilitators and disseminating program materials.**

#### **ORIGINAL PROGRAM DESCRIPTION**

A Matter of Balance is a structured group program serving community-dwelling seniors that is designed to reduce the fear of falling. Many older adults fear falling and may restrict activities, actually increasing the risk of falling, compromising social interaction, and increasing the risk of isolation, depression, and anxiety.

A multi-modal approach addresses physical, social and cognitive factors that affect fear of falling. Trained facilitators conduct classes designed for groups of 10 to 15 participants. The program emphasizes practical coping strategies to reduce the fear of falling. These include: promoting a view of falls and fear of falling as controllable; setting realistic goals for increasing activity; changing the environment to reduce the risk of falling; and promoting exercise to increase strength and balance. Behavioral contracts and goal setting are used to encourage desirable changes such as correcting home hazards, exercising regularly, and resuming desired activity.

Phase One of the project ran for five years from 1993-1998, with a grant from the National Institute on Aging. Phase One was devoted to developing and implementing the program, and collecting and analyzing data. The program was evaluated using a randomized controlled trial that enrolled 434 persons recruited from 40 senior housing sites in the metropolitan Boston area. Compared to control subjects, intervention subjects who completed sessions reported less fear of falling and greater fall management at one-year follow-up. Participants also reported increased physical and social activities and range of mobility. They reported that the program improved their quality of life and allowed them to be independent and maintain their strength, stamina and balance.

#### **CURRENT STATUS AND FUTURE PLANS**

The program received a second Phase Two grant from the National Institute on Aging to run from 1999-2004. The primary focus of the grant remains addressing the fear of falling, but Phase Two involves both research and dissemination activities. There is also added emphasis on the professional role of



occupational therapists (OTs). Medicare benefits will now pay for program services, if recommended by an OT.

The Phase One evaluation study identified elders who might derive more benefit from a different type of intervention—those who were more disabled, less active, and had lower self-efficacy. This need launched the design and evaluation of a modified fear of falling intervention, *Taking the Next Steps*, aimed at frail elders. This intervention is individually focused and provided in the homes of elders who have experienced a fall-related injury. Participants are older persons admitted to a hospital emergency department with a fall-related injury.

Dissemination efforts associated with A Matter of Balance have been far-reaching. The program is being replicated in Europe. Program materials have been translated into Spanish and Chinese in order to reach additional audiences.

The structure of the organization has changed over time. Boston Health Interventions (BHI) is a spin-off group formed to provide training and dissemination of the intervention. BHI has added a Continuing Education component to train facilitators and has conducted training for program facilitators in assisted living facilities, hospital rehabilitation departments, retirement communities, universities, senior housing sites, adult day health centers, home health agencies, and municipal health departments. Over 350 professionals have been trained.

## **OUTCOMES**

- Hundreds of older adults have been trained, with demonstrated improvement in physical performance and self-confidence.
- The program model has been disseminated to additional hospitals in Massachusetts, as well as in additional states.
- The Maine replication program has expanded statewide and has been recognized by an award from the American Society on Aging.

## **PRODUCTS**

- The program has produced and developed a program package suitable for community dissemination. Training manuals and packages have been sold to hospitals, home health care agencies and other agencies.
- The Roybal Center at Boston University maintains a website that features the Matter of Balance program.

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## **Competence with Compassion: An Abuse Prevention Training Program for Long-Term Care Staff**

**The Center for Advocacy for the Rights and Interests of the Elderly**

### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**Research identified problem areas where staff training was needed to prevent elder abuse, and a curriculum was designed to address identified needs. The training program is learner-centered and empowers participants to meet the challenges of providing quality care to long-term care recipients. Successful marketing of training and materials has led to widespread replication and made the program self-supporting.**

### **ORIGINAL PROGRAM DESCRIPTION**

The Center for Advocacy for the Rights and Interests of the Elderly (CARIE) is a Philadelphia-based non-profit organization founded in 1977 and dedicated to improving the quality of life for the frail elderly. Since 1989 CARIE has been working toward providing meaningful abuse prevention education for all long-term care staff. The training program is called *Competence with Compassion: An Abuse Prevention Training Program for Long-Term Care Staff*.

CARIE developed, tested and evaluated the training curriculum that addresses issues that can precipitate abuse behavior. The program also provides proactive, preventive solutions to difficult situations.

Participants actively engage in small group work, team activities and role-play exercises that encourage creative approaches to potentially difficult situations. The training program is learner-centered and empowers participants to meet the challenges of providing quality care to long-term care recipients.

The curriculum consists of six modules requiring approximately 6.5 hours to complete and utilizes a broad range of instructional techniques. Feedback is encouraged throughout the training program. Another innovative feature of the program is the staff mix for each training class. Facilities are encouraged to include a combination of staff from all departments and all shifts in the organization. This helps to facilitate interdepartmental dialogue and improves communication.

The program is the first abuse prevention training program for long-term care staff to incorporate extensive evaluation. Evaluation has demonstrated the training's effectiveness in improving participants' ability to handle conflict, reducing conflict between staff and residents, reducing staff burnout, reducing resident aggression toward staff, and reducing the amount of self-reported abusive behavior by staff.

The original funding for the program was provided by the Retirement Research Foundation, Chicago, IL.

## **CURRENT STATUS AND FUTURE PLANS**

Training for long-term care staff in providing compassionate care and reducing abuse of elders is still the primary focus of the program. However, the program has been expanded to also serve adult day care centers, assisted living facilities, home care programs, and hospitals.

Additional funding was provided by the State of Pennsylvania Department of Education. The program is now supported by income from training and from the sale of program training resources. The program is self-supporting and also provides 35% of its revenue to support other programs. Curriculum materials, including training manuals and videotapes developed by the program, are available for sale.

Evaluation research was the key to developing and expanding. Outcome data were important to documenting success, and research has led to ongoing training refinements. Research also provided a marketing advantage, since this has been the only training package of its kind with statistically validated data.

## **OUTCOMES**

- The program trained 2,500 persons directly in 2001, and thousands more indirectly.
- The training program has been expanded to serve adult day care centers, assisted living facilities, home care programs, and hospitals.
- Training materials have been purchased by numerous agencies to implement training programs in their own agencies.
- Revenue produced from training and from curriculum materials have made the program self-supporting. The income generated also provides support to other CARIE programs.

## **PRODUCTS**

- Curriculum materials, including training manuals and videotapes are available for sale to other agencies through the parent organization website: [www.carie.org](http://www.carie.org).

### **FOR FURTHER INFORMATION CONTACT:**

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## **1998 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION**

### **The Mammography Optimum Referral Effort (MORE) Connecticut Peer Review Organization**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**The MORE project was implemented by a physician review board and identified physician opinion leaders to recruit other participating physicians. Medicare claims data were used to identify target areas, establish baseline data, and measure program success. The trusted physician-patient relationship proved effective in increasing the number of older women seeking biennial mammograms.**

#### **ORIGINAL PROGRAM DESCRIPTION**

This program was based on two well-documented facts: women age 65 and older are less likely than younger women to have a screening mammogram, and physician referral is the single most important factor in increasing mammographies among older women. The Mammography Optimum Referral Effort (MORE) used physician interventions to increase the number of older women who obtained mammograms in the targeted areas of Connecticut.

MORE, initiated by the Connecticut Peer Review Organization, used several strategies to increase the rate of older women's use of mammograms:

- enhancing patient-physician discussions about screening
- emphasizing patient education
- tracking physician referral rates and mammogram compliance.

Medicare claims were used to identify areas with the lowest rate of mammogram claims among older women. Three target areas in Connecticut were identified with the lowest mammography rates among older women, approximately 20%. Hospital leaders identified medical opinion leaders who recruited 37 physicians from target areas to participate in the MORE program.

An educational brochure was given to each woman 65 and over who was seen in a participating physician's office. The brochure helped facilitate physician-patient discussion about screenings, and a tear-off form attached to each brochure documented the mammography referral. Other intervention strategies included cancer screening flow charts, chart stickers, and post-intervention feedback of mammogram rates to physicians. Compliance was defined as the number of women receiving a physician referral who made a Medicare mammography claim during the study period.

Increases in biennial mammography rates of almost 20% were achieved with the MORE program. Women aged 65 to 74 who were patients of MORE participating physicians were 48% more likely to have a biennial mammogram than a comparison group of patients from non-participating physicians.

## **CURRENT STATUS AND FUTURE PLANS**

Increasing mammography use among older women continues to be the primary focus of the MORE project. The program has expanded from the original 37 participating physicians to 102. MORE is a distinct project within a Medicare-funded Quality Improvement Organization (QIO) contract, one of several interventions for a larger project.

The current project staff includes a physician clinician coordinator, a bio-statistician, a statistician and four additional full-time positions. The office is staffed at all times in order to answer questions. The coordinator has been proactive in seeking physician collaboration, conducting physician interviews, and providing feedback to participating physicians. The bio-statistician and statistician analyze Medicare claims data, physician referrals, and mammogram compliance in order to document need and improvement in rates. Materials used in the program, including the brochure, were relatively inexpensive, and the intervention strategy can potentially be replicated.

## **OUTCOMES**

- The MORE project has increased mammogram rates among older women in Connecticut. In 2001, 28,000 older Connecticut women received mammograms under Medicare, a significant increase over previous rates.
- Health promotion materials have been distributed to older women in physician offices.
- Multi-media publicity has encouraged the public to obtain mammograms.
- Medical society publications, as well as physician interviews, have informed physicians of successful project outcomes.
- Analysis of Medicare statistical data has established baseline rates against which future outcomes can be measured.
- Project strategies could easily be replicated in other locations.

## **PRODUCTS**

- An inexpensive pamphlet was developed to educate patients, to initiate physician/patient discussions, and to track physician referrals.

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## **1998 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION**

### **Member-to-Member Elderplan Community Services**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**Member-to-Member is an innovative time-dollar program that coordinates the use of member volunteers in providing support services to other elder members. A wide array of health and social services is available to participants through a Social HMO. Volunteer participants feel useful and needed in providing services to others and, in turn, receive reciprocal services from other members.**

#### **ORIGINAL PROGRAM DESCRIPTION**

Elderplan's Member-to-Member program empowers older adults to provide support services to each other. Elderplan is a Social HMO (S/HMO) in Brooklyn that uses its large network of members to assist in meeting the health care, social and emotional needs of other members. In what is known as a "time-dollar" model, for each hour that a member serves as a volunteer service provider, one credit is banked in Elderplan's computer. Volunteers can then spend those credits when they need help themselves. The program empowers members, many of whom are frail and/or in need of services, to contribute.

Individual and group services are available at no cost to members. Individual services include shopping and errands; escorts; transportation; respite care; minor home repairs; peer counseling; telephone reassurance; and visits at home, in the hospital and in nursing homes.

Group services, led by trained peer educators, include support groups for caregivers and widows/widowers; arthritis self-help courses; walking clubs; teleconference exercise and nutrition classes; and other educational and recreation courses. Comprehensive training, in-service education, and supervision of participants have contributed to the program's quality and success.

Pre- and post-surveys from participants in group courses indicated lifestyle changes, including increased exercising and attention to nutrition. Members reported high levels of satisfaction with the program and its services. Volunteers appreciated the opportunity to use their skills and receive training that enabled them to make a difference. They also developed a sense of community and expanded their own social networks.

The program was started in 1987 with a demonstration grant from the Robert Wood Johnson Foundation and additional support from Elderplan, the Social HMO. The program was innovative in testing the time-dollar model and was the first to offer peer counseling to older adults in the New York area.



## **CURRENT STATUS AND FUTURE PLANS**

The Member-to-Member program continues to be a supportive service of Elderplan and continues to coordinate volunteer services to elders. In recent years the program has expanded membership, both in numbers and in geographic areas, as the health plan has expanded. The program has also expanded services over time. Initially the program addressed only IADLs (Instrumental Activities of Daily Living), but later added the group services listed above, and then implemented computer classes.

The Member-to-Member program is now fully supported by Elderplan. Because of the recognized success of the program, the Robert Wood Johnson Foundation funded a second generation of “time-dollar” programs exclusively in managed care settings. The program has been replicated worldwide, and Elderplan serves as a consultant, both nationally and internationally, to other “time-dollar” programs. Elderplan has hosted many international delegations.

A two-year outcome study, funded by a private foundation, was recently completed. Some of the key findings from the study include:

- Over 40% of survey respondents doubted they would manage to stay living at home without the assistance of the Member-to-Member program.
- Participation in the Member-to-Member program may provide a “protective effect” for both providers and receivers of services against declining health status, increased health service utilization, and feelings of loneliness.
- Participation in the program leads to a significant decrease in voluntary disenrollment in the Social HMO, compared to non-participants.

## **OUTCOMES**

- In the year 2002, Member-to Member participants contributed over 15,000 hours of service to approximately 1,000 older adults.
- Currently, approximately 25 states have “time-dollar” programs. Other countries have also developed time dollar models, including England, Scotland, Japan, China and Israel.
- The program collaborated with the Arthritis Foundation and the Alzheimer’s Association to establish peer-led support groups.
- Elderplan, in conjunction with the AARP, provides supportive services to those who are newly widowed through the Member-to-Member program.

## **PRODUCTS**

- Elderplan has developed training materials to facilitate replication.

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## **1998 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION**

### **The Alabama Stroke Project Alabama Quality Assurance Foundation**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**Compelling data identified a need for improving the standards of care for stroke patients. Volunteer hospitals demonstrated improvements in quality of care. This contributed to a similar mandate for all hospitals statewide.**

#### **ORIGINAL PROJECT DESCRIPTION**

Stroke is the third leading cause of death in the United States, behind heart disease and cancer. Ten southeastern states, including Alabama, are known as the Stroke Belt because of their high rates of strokes. Alabama had 5,800 Medicare beneficiaries hospitalized with ischemic strokes in 1996.

The Alabama Stroke Project was a collaborative project designed to (1) improve the quality of care provided to stroke patients who are Medicare beneficiaries; and (2) compare the effectiveness of two different methods for providing baseline quality performance data to participating hospitals.

The project was a collaborative effort of the Alabama Quality Assurance Foundation, the Geriatric Education Center of the University of Alabama at Birmingham (UAB), and the UAB Office of Continuing Medical Education. Other collaborative partners included the Alabama Department of Public Health and the American Stroke Association, a division of the American Heart Association. The then Health Care Financing Administration (HCFA) and the UAB's Geriatric Education Center funded the project.

Physicians with expertise in the care of stroke patients identified five quality measures that addressed care procedures that could be improved. Eleven participating hospitals convened multi-disciplinary teams of health care professionals to evaluate baseline hospital-specific quality measures and develop and implement appropriate quality improvement plans.

Data were collected by trained medical record abstractors for the 1995 baseline period, and opportunities were identified for improving quality of care. Hospitals were randomly assigned to receive presentations of baseline quality measures either on-site or during an audio conference. The participating hospitals then developed and implemented their individual quality improvement plans.



Six months after implementing quality improvement plans, follow-up data compared to baseline data showed statistically significant improvement for several of the indicators.

- Appropriate anti-hypertensive therapy increased from 3% to 61%.
- Avoiding use of short-acting nifedipine went from 7% to 73%.
- Prevention for deep vein thrombosis (DVT) among at-risk patients went from 48% to 64%.

The project resulted in dramatic improvements in the appropriate use of blood pressure medicines and a significant increase in preventive interventions for DVT. Improvements were also better when hospitals received baseline data through on-site presentations than through audio conferences.

### **CURRENT STATUS AND FUTURE PLANS**

The results were so dramatic that the project was extended to all hospitals in the state as part of the Health Care Quality Improvement Program (HCQIP) mandated by the Centers for Medicare and Medicaid Services (CMS). Stroke is not currently one of the HCQIP priorities, but the positive impact of the stroke initiative has continued with a lasting changing in practice patterns.

### **OUTCOMES**

- Quality of care of stroke patients improved, with documented evidence on several parameters.
- The initial efforts with volunteer hospitals contributed to a mandate for all hospitals statewide.
- Knowledge learned in the initial pilot studies contributed to national efforts.

### **PRODUCTS**

- Professional journal articles, conference presentations, and Continuing Medical Education courses have documented the Alabama experience and promoted advances in the care of stroke patients.

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## **Senior Wellness Project**

**Northshore Senior Center, Senior Services of Seattle/King County**

### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**This multi-faceted health promotion program uses scientifically-based wellness activities to enhance the well-being of older adults. Web-based software provides national data collection from disseminated programs in multiple locations, strengthening national outcome data. The parent program assists new disseminations, trains new program staff and monitors web-based data collection.**

### **ORIGINAL PROGRAM DESCRIPTION**

The Senior Wellness Project is composed of disability-prevention and chronic disease self-management programs developed by the Northshore Senior Center in Bothell, Washington, an affiliate of Senior Services of Seattle/King County. The target population is older adults living in the community. Most services are provided at senior centers. The Senior Wellness Project seeks to implement and evaluate health promotion/disease management programs to provide evidence of outcomes to seniors and of cost-effectiveness to health providers.

Four distinct service components were initially developed and evaluated separately.

- Lifetime Fitness Program (LFP) is a comprehensive group exercise program aimed at disability and fall reduction for independent elders.
- The Health Enhancement Program (HEP) is an intervention to prevent functional limitations and reduce health care use. HEP is a participant-directed health promotion/disease management program for elders with chronic conditions. Participants receive a nursing assessment, health review, and support services from a registered nurse and a social worker.
- The Chronic Disease Self-Management Program (CDSMP) is a six-week course taught by lay leaders. Based on the work of Dr. Kate Lorig of Stanford University, the program builds skills in living with a chronic illness.
- The Health Mentor Program matches HEP clients to trained peer mentors that provide follow-up calls, companionship, and links to professional staff.

Researchers from the University of Washington and the Group Health Cooperative Center for Health Studies conducted evaluations that measured benefits to clients, as well as cost-effectiveness to health providers. Participants in the Lifetime Fitness Program showed improvements in physical function and reduced symptoms of depression. A randomized trial of the Health Enhancement Program showed a reduction in hospital days, a reduced use of psychoactive medications, greater physical activity, and improved functional status.

## **CURRENT STATUS AND FUTURE PLANS**

Of the four original components, three components continue to be used: the Health Enhancement Program, Health Mentor, and the Lifetime Fitness Program. Programs have been disseminated to 61 community-based sites in seven states. The Robert Wood Johnson Foundation provided a grant to implement the Senior Wellness Project in ethnically diverse low-income housing and another grant to assist in national dissemination and evaluation.

Funding for dissemination has been received from a variety of organizations, including the local Area Agencies on Aging, physician service networks, hospitals, the King County Health Department, the University of Washington Health Promotion Research Center (funded by the Centers for Disease Control), and local and national foundations. Senior centers provide office space, equipment, volunteers, and program supplies. Funding for registered nurses and social workers comes from several sources, including in-kind staff support from hospitals. Significantly, a national web-based data collection system enables data collection from multiple geographic sites, with ongoing evaluation. Web-based software enables the parent site to collect and compile demographic and outcome data from all sites.

## **OUTCOMES**

- The Lifetime Fitness Program operates in 52 sites in five states and has served over 1,200 participants annually in each of the past four years.
- In 2002, HMO members who used the Lifetime Fitness Program more than two times per week produced cost-savings to their HMO.
- The Health Enhancement Program operates in 25 sites in six states and has served over 600 participants annually in each of the past four years.

## **PRODUCTS**

- Articles in professional journals and conference presentations have led to widespread dissemination. Curriculum materials and training are provided by the parent site prior to implementation.
- A website and software have been developed that enable data collection from numerous dissemination sites.
- Videotapes produced with funding from the Robert Wood Johnson Foundation and the Centers for Disease Control highlight both the LFP and HEP programs.

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## **1999 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION**

### **Strengthening Geriatrics Training for Primary Care Medical Residents**

**Medical College of Wisconsin - Wisconsin Geriatric Education Center**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**Curriculum materials for geriatric training of medical residents were developed and disseminated in order to enhance physicians' understanding of geriatric concerns. An external mandate regarding accreditation, an absence of appropriate geriatric training materials, and the teaming of expert geriatricians with educational consultants led to program success in developing curriculum materials for geriatric training of medical residents in primary care sites.**

#### **ORIGINAL PROGRAM DESCRIPTION**

Medical training for physicians now requires that primary care residents have experience in geriatrics in order to meet accreditation guidelines. Yet few residency sites have geriatricians on staff, and appropriate geriatric training materials have been lacking. This program aimed to improve the geriatrics training of medical residents by developing geriatric curriculum materials and by structuring the education and training that medical residents receive at primary care sites.

The target audience for this project was medical residents of the Medical College of Wisconsin and faculty at 35 geographically disbursed primary care residency training sites.

Expert geriatricians were trained in instructional design and developed a series of ten geriatric educational modules to train primary care medical residents and other health care professionals. Workshops to disseminate the modules were held for resident faculty at the various primary care residency sites. A training videotape was also developed depicting resident interaction with a typical dementia patient.

Funding was provided by the Helen Bader Foundation, the Wisconsin Area Health Education Centers, the Veterans' Administration Medical Center, the Wisconsin Geriatric Education Center (WGEC), and the Medical College of Wisconsin. Accreditation standards provided an external impetus to provide geriatrics training.

In 1997-98, 75-82% of the resident faculty at the 35 residency training programs attended the curriculum dissemination workshops. Attendees reported that the presentation provided practical information, and they would recommend this presentation to colleagues. By 1999, 300 medical residents had completed the

curriculum modules and also completed evaluations showing high learner satisfaction. Each resident also completed a retrospective pre/post assessment of competencies based on the modules' educational objectives. Self-assessments indicated increased knowledge of educational objectives.

#### **CURRENT STATUS AND FUTURE PLANS**

Geriatrics training is still a major focus of the Wisconsin Geriatric Education Center, which continues to distribute curriculum modules and training packets. In 2002, four additional modules focused on teaching methods were created and disseminated.

A follow-up project seeks to improve residents' capabilities in assessing complex geriatric patients. Through the use of a video, residents are exposed to virtual patients who "age." After reviewing the video, the resident completes assessment tools to evaluate the patient. The competencies encompassed in the assessment match the required competencies of the Accreditation Council of Graduate Medical Education.

#### **OUTCOMES**

- Over 300 medical residents completed the curriculum modules in the first two years, and additional residents have completed the modules since that time.
- A subsequent project targets the assessment of residents' skills with geriatric patients, and adjunct materials address lab results, gait demonstrations, discharge orders, and other geriatric issues.

#### **PRODUCTS**

- The original project developed curriculum modules addressing geriatrics training for medical residents and disseminated them to all primary care residency sites in Wisconsin.
- A training videotape was developed to assist faculty in teaching medical residents about understanding patients with dementia.
- Additional curriculum modules focused on teaching methods have been created since the original project, including an assessment module using a virtual patient.
- Curriculum materials are available from the Clearinghouse of the Society of Teachers of Family Medicine Bookshelf.
- A website provides information for potential users.

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**Geriatrics Evaluation Networks Encompassing Services,  
Information and Support (GENESIS)**

**Older Adult Programs Administration, County of Los Angeles Dept. of Mental  
Health**

**WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**Frail homebound adults age 60 and older receive comprehensive in-home mental health services from multidisciplinary teams that combine professionals from community mental health, social work, public health nursing, medicine and gerontology. Multi-agency collaboration promotes a seamless system of care reducing service fragmentation. By reducing inappropriate institutionalizations, the program has proven cost effective.**

**ORIGINAL PROGRAM DESCRIPTION**

In 1995, the County of Los Angeles Department of Mental Health established a partnership still in existence with the County of Los Angeles Department of Community and Senior Services/Area Agency on Aging to create the Geriatric Evaluation Networks Encompassing Services, Information and Support program (GENESIS). The program is designed to address the unique needs of frail homebound adults age 60 and older experiencing mental health problems or behavioral problems perceived as mental illness. The goal of GENESIS is to provide older adults with services that support their dignity, maximize options, enhance their independence, and in particular, prevent unnecessary hospitalization for mental health crises.

GENESIS provides comprehensive in-home mental health services that include mental health, public health nursing, social work, medicine and gerontology. Multi-disciplinary staff unite as a team to conduct:

- Mental health services that include assessment, crisis stabilization and short-term treatment;
- Health screening and medication support to identify and mediate mental health problems;
- Care coordination and linkage utilizing a trans-disciplinary approach that incorporates other care providers, including caregivers, primary care physicians, care managers, and others;
- Education, training and consultation on mental health and related health issues to professionals and caregivers;
- Outreach to senior housing, senior and community centers, and other community agencies.

In order to address the complex service networks and strengthen service coordination, GENESIS established multi-interagency agreements thereby reducing service fragmentation, promoting a seamless system of care and preventing inappropriate institutionalization. A formal interagency agreement is held between the two primary departments of the county, Mental Health and Senior Services (of which Adult Protective Services is a unit), as well as



collaborative partnerships with mental health agencies, health providers, law enforcement agencies, hospitals, and other community-based organizations. Funds are provided through Medicare, Medi-Cal, private insurance and blended county funds. The collaborative approach is cost-effective. By reducing fragmentation, care is more effective, client satisfaction is greater, and healthcare dollars are saved.

### **CURRENT STATUS AND FUTURE PLANS**

GENESIS has become recognized throughout the county as a provider of older adult services. In 2002, a three-year GENESIS program review report indicated that over half of consumers served (60%) were age 75 and older, lived alone (69%) and had no prior history of mental illness (60%). Program goals have evolved and established the basis for expanding mental health services throughout the county. The needs of older adults have been incorporated in a countywide strategic plan that include expanding clinical services in each service area, training for professionals, and creating new collaborations.

Program development has included establishing best practice guidelines for field screening and developing the Geriatric Field Screening Protocol for First Responders. This was developed as a spin-off project in partnership with the Glendale Police Department, and certified as a Peace Officer Standards and Training (POST) course, called the Elder Abuse Intervention and Education for the First Responder. One year after implementation, a survey sample revealed improvement of more than 50% in both inpatient evaluation and in communication with public and community agencies.

### **OUTCOMES**

- During fiscal year 2002-2003 services were provided to 1,983 consumers (unduplicated).
- Over 500 staff in the Departments of Mental Health and Community and Social Service have been trained in using the field screening protocol.
- Over 500 police officers and emergency personnel have been trained to use a field protocol for first responders.

### **PRODUCTS**

- A Geriatric Field Screening Protocol was developed for use in multi-disciplinary screening of older adults.
- A Geriatric Field Screening Protocol was developed for first responders.
- An educational module for professionals was developed entitled, "*Parameters for Clinical Assessment*," and posted on the parent agency website: [www.dmh.co.la.ca.us](http://www.dmh.co.la.ca.us).

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## 1999 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION

### Partners for Healthy Aging

Medco Health Solutions, Inc.

(Formerly Merck-Medco Managed Care, LLC)

#### WHAT IS SPECIAL ABOUT THIS PROGRAM?

**The program offers a comprehensive, multi-component approach to coordinating pharmaceutical care for older adults. An on-line computerized drug utilization review, training of pharmacists, and other educational materials identify potentially inappropriate prescriptions for geriatric patients. Pharmacists counsel physicians in order to avoid possible adverse drug reactions in older patients.**

#### ORIGINAL PROGRAM DESCRIPTION

Medco Health's Partners for Healthy Aging®, established in 1995, uses a computerized Drug Utilization Review (DUR) program, educational materials, and health management initiatives to reduce potentially unsafe or ineffective prescriptions for older adults. The target population is adults age 65 and older who receive their pharmacy benefit services from Medco Health Solutions. The initial populations was more than 10 million seniors.

The Partners for Healthy Aging® program takes a multi-faceted approach to maximizing pharmaceutical care for older adults. Program components included:

- A Drug Utilization Review (DUR) focused on eleven classes of drugs used to treat conditions common among older adults. A computer system automatically evaluates all prescriptions submitted by managed care plan participants and identifies potential problems, alerting pharmacists when a prescription for a senior might be an inappropriate drug selection or dosage.
- *The Medication Guidebook for Older Adults* is an easy-to-use reference about conditions common among older adults. It focuses on possible side effects, drug interactions, and specific geriatric warnings for the medications most frequently prescribed for those conditions. The original *Guidebook* publication in 1998 included condition-specific information on more than 140 conditions.
- Seniors also received drug information leaflets and pocket-size formulary guides. These materials, combined with the *Guidebook*, provided pertinent information for older adults and warnings to alert patients and their physicians about medications generally not recommended for older adults, as well as information on drugs that may require age-specific dosage adjustments.



- The Gatekeeper program identifies patients in need and refers them to local offices of the Area Agency on Aging. In 1998, this program identified and referred more than 2,500 potential candidates.
- Medco Health's Department of Medical Affairs and an external advisory board regularly review all initiatives and protocols.

The program is internally funded by Medco Health Solutions and is regarded as a core component central to the organization's mission of providing quality pharmaceutical products. In the year reported for the award application (1998), the Partners for Healthy Aging Program achieved a 24% change rate in the use of medications generally recognized as inappropriate for patients over age 65. This rate of change is twelve times greater than normally occurs without such a program.

### **CURRENT STATUS AND FUTURE PLANS**

The Partners for Healthy Aging® program continues as the cornerstone of Medco Health Solutions' programs for older adults and delivers a wide range of services to millions of older members. All of the components are still operating; some have expanded; others have been modified. The Senior Drug Utilization Review content has been expanded to identify more drug interactions. The *Guidebook* has been expanded from the original 100 pages to 800 pages and is now sold commercially. Additionally, Medco Health Solutions' Home Delivery pharmacists receive training on specific medication concerns of older adults that help them identify potential problems more quickly and resolve concerns with the physician. Finally, Medco Health Solutions' customer service representatives receive detailed training addressing the needs of older customers.

### **OUTCOMES**

- Six million medication alerts for older adults were identified in the year 2001, and 500,000 prescriptions were changed.
- In 2002, 9,000 patients were identified as potential candidates for the Gatekeeper program and related support services.

### **PRODUCTS**

- *The Essential Medication Guidebook to Healthy Aging*, which is available for commercial sale, has information on specific medical conditions common to older adults.

#### **FOR FURTHER INFORMATION CONTACT:**

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**Aging Strength Training Task Force  
A Model in Community Organizing for Primary Prevention  
Marin County Division of Aging**

**What Is Special About This Program?**

**The program was initiated as a grass-roots initiative that created community awareness and developed an infrastructure to offer strength training for seniors at multiple sites. The original Task Force has been replaced by a newly-formed professional organization that continues to promote the community objectives and to train professionals in offering strength training for older adults.**

**ORIGINAL PROGRAM DESCRIPTION**

The mission of the Marin County Strength Training Task Force was to incorporate recent scientific evidence on the value of weight-bearing exercises for older adults into a community health promotion campaign. The Task Force sought to mobilize the older community in Marin County to start strength training, specifically, by lifting weights.

The Task Force developed program components in four areas:

- Community outreach was conducted through a multi-media approach and demonstrations of strength training exercises at local senior centers.
- A model strength training program was implemented at local nursing homes.
- Strength training classes were implemented at senior housing complexes.
- Professional exercise teachers and nursing home directors were trained and certified as senior fitness instructors.

The target population was older adults living in Marin County, including those living in low-income housing complexes and nursing homes, as well as those living independently in the community. A second target population included professionals who work with older adults.

Although there were initially no such strength training programs for older adults in the county, 12 core sites began offering the program. The Task Force also arranged professional training to exercise instructors and to nursing home administrators. During the first three years, 22 professionals were certified by the Senior Fitness Association. An exercise physiologist performed pre- and post-test measurements on older adults to provide reinforcement and encouragement. However, no formal evaluation was conducted.

The program was cost-effective, spending only \$15,000 over the three years of program operation. During the first year, the Task Force and program were strictly grass-roots, with no formal funding. During the second and third years, modest funds were obtained from the Older Americans Act Preventive Health Care initiative.

### **CURRENT STATUS AND FUTURE PLANS**

While the Task Force no longer exists, an infrastructure has been created that continues to address program objectives. A new professional organization, The Marin Association of Senior Strength Trainers (MASST), has replaced the original Task Force, as initially planned. The strength training programs continue to be offered at 12-15 core sites. Participants in formal classes may pay \$3-4 per class to pay program expenses.

The California Department of Health Services provided a small replication grant to 33 Area Agencies on Aging. Through this grant, an exercise physiologist has provided technical assistance to two other counties seeking to implement similar programs. The same model is now being used in Marin County to implement fall prevention programs.

### **OUTCOMES**

- An infrastructure was created to offer strength training exercise classes for older adults through a variety of sites. About 12-15 core sites offer the program regularly.
- 22 professionals have been trained and certified by the Marin Association of Senior Strength Trainers (MASST) and continue to offer strength training for older adults.

### **PRODUCTS**

- A video was produced to motivate individuals and organizations to start strength training classes.
- The Task Force distributes Strength Training Bulletins with recommended exercises. About 500-1,000 flyers encouraging strength training exercises are distributed yearly.
- The California Department of Health Services recognized the value of the program and published a replication manual to guide other Area Agencies on Aging and senior service providers who may wish to implement a similar health promotion campaign.

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## **2000 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION WINNER**

### **Experience Corps**

**Center on Aging and Health - Johns Hopkins Medical Institutions**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**The Experience Corps has made effective use of older volunteers as positive role models to emphasize the value of education to children in inner-city schools. Volunteers are older adults who have not traditionally volunteered and who have limited education, as well as health problems. Rigorous evaluation demonstrates improved health for adults and improved academic performance for children.**

#### **ORIGINAL PROGRAM DESCRIPTION**

The Experience Corps is a service model designed to create new and productive roles for older adults while meeting unmet needs of public inner-city elementary schools. It is simultaneously designed to be a health promotion program for older adults. The program places older volunteers in public elementary schools in roles designed to improve academic performance of students.

The model is based on research evidence showing that structured and productive activities and remaining physically active improve well-being and protect against major chronic diseases of aging and depression. The program was designed to meet the personal needs of older adults to “give back” and to be socially engaged, but also to promote health by increasing social, cognitive and physical activity, thereby increasing health benefits. Participating in structured, productive social activities, such as volunteering, decreases the risk of disability and mortality and improves psychological health.

The original target population was older adults living in the Baltimore, MD area. Volunteers were one-third male, over two-thirds African-American, and many had less than a high school education. Volunteers averaged more than two chronic health conditions, and the majority had not volunteered in the previous year. Volunteers were assigned to schools identified as having high-risk student populations. Each school developed the role of volunteers based on its individual needs. However, the role content and training were developed by the program, addressing skill development and the abilities of a broad range of older adults. Meaningful roles involved volunteers in literacy and math support, library programs, violence prevention, enrichment activities, and public health programs.

The original demonstration project was funded in 1996 by the Corporation for National Service in five, and later nine, cities in the United States. In the fall of 1999, the Experience Corps was implemented in six Baltimore schools, jointly sponsored by the Johns Hopkins Center on Aging and Health and the Greater Homewood Community Corporation, a community organization. Funding came from various sources: the State of Maryland, the State Department of Education,

the Baltimore City School Board, the Baltimore City Commission on Aging and Retirement Education, and the Corporation for National Service.

Early data suggested improvements in social, psychological, cognitive and physical function for the older volunteers, and deep satisfaction with “making a difference.” Teachers described improvements in literacy by at-risk elementary age children.

#### **CURRENT STATUS AND FUTURE PLANS**

Older adult volunteering in elementary schools continues to be the primary focus, with 100 volunteers giving 15 hours per week at five school sites. The program has a full-time project director and an on-site volunteer coordinator at each school. The school has combined several grant funding sources, including the Department of Education, Johns Hopkins University, the Greater Homewood Community Corporation, and others, but continues to seek funding from outside sources. The Civic Ventures consortium has been instrumental in obtaining funding from AmeriCorps for replication, and the program has expanded in recent years to 18 cities. Receiving the Award for Excellence in Innovation was reported to be helpful in gaining recognition and obtaining funds.

#### **OUTCOMES**

- The Baltimore program remains the second largest Experience Corps in the nation, serving 2,500 children in grades K-3 and involving over 100 older adults.
- Positive role models of older adults emphasize the importance of education to inner-city children.
- Older adults who were not previously involved in volunteer activities are involved in social activities.
- Volunteers report deep satisfaction with the program and teachers report improved literacy in children.
- Older adult volunteers show positive health status as a result of their involvement.

#### **PRODUCTS**

- The program model for the Experience Corps has been expanded to 18 cities. The template is available through Civic Ventures.

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**Assistive Equipment Demonstration Project**  
**The Gerontology Institute - University of Massachusetts, Boston**

**What Is Special About This Program?**

**An educational program for case managers led to expanded provision of low-cost assistive devices to frail older adults receiving home care services.**

**Assistive equipment can be highly beneficial to those with functional disabilities, but such equipment is typically under-utilized. The program increased independence skills of frail participants and became an integral part of case managers' training and responsibilities.**

**ORIGINAL PROGRAM DESCRIPTION**

The Gerontology Institute at the University of Massachusetts, Boston (UMB) and the Executive Office of Elder Affairs (EOEA) collaborated on a three-year demonstration project to distribute assistive equipment to older home care clients. Low-cost assistive equipment was distributed through case managers to older clients of a publicly-funded home care program. The aim of the project was to increase the independence of older adults in personal care and household management. Assistive equipment can be highly beneficial to those with functional disabilities, but such equipment is typically under-utilized. In the past, assistive equipment had not been a well-utilized service of home care programs within Massachusetts, partially because case managers were not knowledgeable about assistive equipment.

Frail older adults receiving home care because of difficulties with self-care activities were the target population. Nearly 200 clients received assistive equipment through the demonstration project. These seniors were typically female, white, and single, with a median age of 81. Over half the participants had at least two ADL (Activities of Daily Living) deficits and nearly all had at least four IADL (Instrumental Activities of Daily Living) deficits. Typically, participants were receiving three or four home care services. Nearly all of these frail persons used homemaker services. Other commonly used services included home-delivered meals, home health aides, transportation services, skilled nursing, and personal care attendants.

The program trained case managers in client assessment and in procedures for ordering low-cost assistive devices. Case managers screened home care clients, recommended equipment, and followed-up equipment delivery to determine client satisfaction and any additional needs. Assistive devices were purchased with existing state home care funds, at an average cost \$76 per client, and interventions were carried out with existing case management resources. The project involved collaboration with a rehabilitation hospital that provided case manager training. Thirty-seven case managers received training and distributed equipment to an average of five clients.



The Robert Wood Johnson Foundation provided research funding through its Home Care Research Initiative. The Gerontology Institute at UMB designed the demonstration and research evaluation, and the Center for Survey Research at UMB conducted interviews with project participants. Most clients (88%) expressed satisfaction with their equipment and, according to case managers, 71% were using their equipment regularly after two weeks. Case managers also reported increased awareness of the range and benefits of assistance equipment and were more likely to consider assistive equipment as a service option in the future.

#### **CURRENT STATUS AND FUTURE PLANS**

The assistive device service component has been expanded throughout the state and institutionalized into 27 state government home care agencies. A training manual is used in the orientation of case managers and now includes information on identifying need and procuring assistive devices for frail older adults. A statewide meeting was also held to educate case managers and to publicize training materials. Currently, approximately 40 case managers are trained to provide this service throughout the state, and web-sites provide information and instructions about this service component. Presentations at professional conferences disseminate information about the potential efficacy of assistive devices for frail older adults.

#### **OUTCOMES**

- Training about assistive device use has been incorporated as a regular part of the orientation for new case managers working for the State of Massachusetts home care program.
- The Information Manual has been distributed to home care programs that collectively serve over 30,000 frail older adults throughout the state.

#### **PRODUCTS**

- An Information Manual to assist care managers in identifying and ordering assistive equipment for frail older clients was developed based on findings of the demonstration project. The manual can be obtained on the Gerontology Institute website:  
**[http://www.geront.umb.edu/proj\\_index.htm](http://www.geront.umb.edu/proj_index.htm).**

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**Aging and Memory Center**  
**Montefiore Medical Center**

**WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**This program seeks to improve mental health services for frail older adults by stationing psychiatric trainees in primary care offices for purposes of screening and treating mental health problems. Psychiatric screening is provided to homebound older adults in their own homes when necessary. Community agencies, including senior centers and health fairs, assist in screening and providing referrals.**

**ORIGINAL PROGRAM DESCRIPTION**

The goal of the Aging and Memory Center was to improve mental health services for frail older adults residing in a naturally occurring retirement community. Psychiatric services were provided to frail adults by geriatric trainees in primary care offices. When necessary, psychiatric screening was provided to homebound seniors in their own homes.

Screening programs, lunch time talks at senior centers, case finding training, and health fairs were used to detect depression and memory impairment and to assist older adults to make a living will or appoint a health care proxy. This virtual geriatric mental health center had three full-time staff plus fellows in geriatric medicine and psychiatry who were not confined by the conventional boundaries of care. The program was, and continues to be, community-based and interdisciplinary.

Data from a National Institute of Aging study documented the need, showing that the Jewish population had double the rate of depression of other ethnic populations. The United Jewish Appeal (UJA) spearheaded the initial project. The UJA had earlier provided services to Holocaust victims, and staff saw the need for mental health services in the community. UJA provided the initial external grant of \$200,000 for the first year that provided a social worker and geriatric psychiatrist. UJA support continued at \$50,000 per year, and the Weinstein Foundation provided additional funding.

Because Co-Op City houses over 11,000 residents aged 65 or older, it qualifies as a Naturally Occurring Retirement Community (NORC), and thus is eligible for New York State NORC Project support to provide social services. Matching funds must be provided from the private housing entity. The Co-op NORC Project is partially funded by the New York State Office for Aging and the Co-op City Riverbay Housing Corporation. The project was administered by the Coordinating Council of Co-op City Senior Citizens. Montefiore Medical Center made space available at two sites at no cost to the program, as an outreach strategy to attract Medicare patients.



Clinical statistics were available for initial periods of operation at two sites: 59 weeks at one site and 25 weeks at the second site. A total of 161 new patients were evaluated at the two sites, 13 of them in their own homes. There were 465 follow-up visits including 19 house-calls. A significant number of referrals came from community agencies. Almost two-thirds of patients were age 75 or older, and a substantial number of persons served came from underserved and disadvantaged minority groups. The majority of diagnoses were for dementia and depression.

#### **CURRENT STATUS AND FUTURE PLANS**

The program continues, with the primary goal to provide clinical education of psychiatric residents of the Albert Einstein College of Medicine. Psychiatric residents rotate through the program one day a week for one month. The staff has expanded to include two physicians (a geriatric psychiatric fellow and a geriatric medical fellow) and a geriatric nurse. The program also has a full-time office manager and a social worker. Montefiore Medical Center continues as the parent organization.

The Aging and Memory Center charges Medicare and Medicaid for patient services. NORC provides funding for the social worker, and Montefiore Medical Center provides for three-fourths of the nurse's time in the community. Philanthropic support from private foundations augments these revenue sources. Collaborative agreements exist between the social worker, the physicians, and the Senior Coordinating Council.

Clinical data regarding patient services are reported to the United Jewish Appeal at the end of each year. The nurse also collects qualitative case study data.

#### **OUTCOMES**

- The Aging and Memory Center continues to provide psychiatric screening and services to frail older adults in a Naturally Occurring Retirement Community.
- During the first year of operation, 161 new psychiatric patients were screened, with the most common diagnoses being dementia and depression.
- Residents in psychiatry and medicine receive training in screening and serving frail adults.
- The Montefiore Medical Center provides community office space for psychiatric services at two community sites as an outreach strategy to reach more Medicare patients.

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## **2000 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION**

### **Pathfinders**

**Gerontology Center, University of Utah**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**The Pathfinders program provided self-care and health promotion classes in a supportive environment to recently bereaved widows and widowers. Self-management strategies were encouraged through the concept of contracting. Participants specified short- and long-term goals, action plans, and rewards upon completion. The local Area on Aging adapted the Pathfinders model to conduct a similar program for caregivers.**

#### **ORIGINAL PROGRAM DESCRIPTION**

The Pathfinders program was a self-care and health education program for older widows and widowers. The primary purpose was to provide participants with important health and wellness information in a supportive environment where they could learn self-care skills, gain understanding of and coping with grief, and learn how to access other community resources. Research on spousal bereavement in later life provides the foundation for program components. Life transitions like bereavement require the acquisition of new information and/or skills for effective adaptation.

The program consisted of 11 weekly classes (offered twice a year) led by professionals with expertise in specific self-care or health education areas. Presenters came from a variety of sources including University of Utah faculty, the local Area Agency on Aging, university extension services, and professionals in private practice in human services and business.

Self-management strategies were encouraged through contracting. Participants completed short and long-term goals, specified a plan of action and described how they would reward themselves once goals were attained. The program was designed for those who were recently widowed (within the past 18 months), but was open to any widow or widower age 50 and older. Funding for the demonstration project was provided by the Ben B. and Iris M. Margolis Foundation for a three-year period.

Evaluation of the project consisted of baseline measures and three follow-up assessments two months apart. Participants reported improvements in: reading and understanding food labels, managing one's household, filing insurance and tax forms, performing physical activities, identifying and accessing community resources, time management, coping with stress, meeting leisure needs, and timely arrangement of important medical exams and immunizations.

**CURRENT STATUS AND FUTURE PLANS:**

The project is currently in a dormant state since funding from the Margolis Foundation ended in 2000. However, project leaders continue to seek additional funding for continuation. The local Area Agency on Aging used the Pathfinders model to conduct a similar project for caregivers. A local mortuary may sponsor an aftercare program in conjunction with the Area Agency on Aging. The program has received inquiries from around the world regarding possible replication.

**OUTCOMES**

- Pathfinders served 84 recently widowed persons during the three-year demonstration project.
- The local Area Agency on Aging has used the Pathfinders model to implement a similar project for caregivers.
- Program staff have received inquiries from around the world regarding replication.

**PRODUCTS**

- The Pathfinders model has been described in presentations at professional meetings and in two professional publications.

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## **2000 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION**

### **Diabetes Care Monitoring System (Originally Chronic Disease Monitoring Team) Mountain-Pacific Quality Health Foundation and Montana Department of Public Health and Human Services**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**The Chronic Disease Monitoring System is a software system that enables physicians to track case management of patients with chronic diseases such as diabetes. It is web-based, easily accessible to physicians in remote areas, and modifiable for new developments and other chronic conditions. The software is also flexible, permitting physicians to include other indicators or to modify the protocol for individual patients.**

#### **ORIGINAL PROGRAM DESCRIPTION**

Diabetes is a major health problem for many older adults; more than 40% of diabetes patients are age 60 or above. The original goal of the Chronic Disease Monitoring Team was to provide the highest possible level of evidence-based care to persons with diabetes. The Chronic Disease Monitoring System (CDMS) is a computer-based system, still in operation, that provides participating clinicians with a simple, standardized tool to monitor care for individual patients with diabetes.

The system provides action-oriented reports that identify patients in need of preventive services, as well as important clinical follow-up services. The system allows physicians to efficiently and continuously monitor evidence-based indicators of diabetes care on individual patients by monitoring blood pressure, blood sugar and lipid levels, urine protein status, eye care, foot care, and adult immunization status. It also tracks important treatment steps for some indicators of diabetes care.

A peer review organization and a state health department developed the criteria for the Chronic Disease Monitoring Team. Funding was provided by the then Health Care Financing Administration (HCFA) and by the Centers for Disease Control and Prevention. The CDMS system was initiated in October 1997, and by February 2000, the CDMS team had installed the monitoring software in 36 physicians' offices in four western states. The electronic monitoring system is easily accessible and can be readily implemented in individual physicians' offices in remote, rural areas and in small towns. The project produces a quarterly newsletter for participating sites. Each issue includes a "Successful Quality Improvement" column that documents evidence of improved care, such as reduced rate of complications at participating offices.

#### **CURRENT STATUS AND FUTURE PLANS**

The Chronic Disease Management System (CDMS) has expanded in several ways: the number of sites, the structure of the organization, and in the diseases addressed. The Diabetes Care Monitoring System (DCMS) has been expanded to 80 sites in Wyoming, Montana, and the Pacific Islands.

The program is now internet-based, facilitating ease of access to remote locations and frequent modifications for new medical developments. The improved software also permits greater flexibility. Physicians continue to provide input to modify the program, and it is updated regularly. Physicians in additional states have adopted software based on the Montana model. The Diabetes Coalition of Montana is encouraging more physicians to use the Diabetes Care Monitoring System.

The CDMS software has been discussed at national professional meetings. Peer Review teams in five other states have sought information in order to replicate the model. Several locations have developed systems of their own, based on the Montana model, and each site determines the types of patients to be monitored.

The software can also be used to track data, provide comparisons, identify outliers, and suggest needed improvements in patient care. Feedback data are provided to physicians quarterly, encouraging better patient care. Software is being developed to address other chronic diseases, and plans are underway to develop software for monitoring cancer patients.

Funding for software development has been provided through the Center for Medicare and Medicaid Services (CMS). Internal funds for hardware have been provided through the Montana-Pacific Quality Health Foundation as part of the Foundation's quality assurance program.

#### **OUTCOMES**

- Care for diabetic patients has improved markedly.
- The flexibility of the software permits physicians to adapt the program to include other indicators, or to modify the protocol for individual patients.
- Software for other chronic illnesses, including cancer, is being developed.
- Other locations have adopted similar programs, based on the Montana model.

#### **PRODUCTS**

- Software developed to monitor indicators and treatment of diabetes patients has been installed in over 80 sites.
- The software is available through the internet, allowing expansion to remote areas and small towns. The flexibility of the internet also permits continual modification based on physician input and new developments.
- A quarterly newsletter provides information to physicians and publicizes successes in avoiding patient complications.

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**Medication Assistance Program  
Mission Saint Joseph's Hospital**

**WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**The Medication Assistance Program provides medication review and health screening and education to low-income Medicare patients. The program also seeks and receives free medications for low-income patients from pharmaceutical companies. The availability and use of medications has reduced health risks and hospital readmissions, resulting in better quality of life for enrolled older adults, and cost-avoidance for the hospital.**

**ORIGINAL PROGRAM DESCRIPTION**

The Medication Assistance Program (MAP) was established by Mission Saint Joseph's Hospital in 1997. The purpose of the program is to provide medications, education, and disease management for low-income Medicare recipients. Hospital discharge planners facilitate the proper referral of patients identified during hospital admissions. Patients enrolled in the program receive services at no cost to them. The program continues to operate, and at the present time, is staffed by two pharmacists and a program coordinator.

The target population for the MAP program is Medicare beneficiaries at or below 130% of the federal poverty level with no other prescription coverage or Medicaid. In 1999, 87 patients were enrolled in the Medication Assistance Program. The program has been solely supported by Mission Saint Joseph's Hospital through its community benefit program. However, the program requests free medications from drug manufacturers through the companies' indigent patient programs. In 1999, MAP achieved a 95% retrieval rate on applications submitted through drug manufacturers' programs. The dollar value of medications obtained for patients that year was \$353,590.

Program services involve three components:

- Financial Review and Referrals: The program coordinator conducts financial interviews and refers patients to appropriate assistance agencies, including other financial resources.
- Medication Assistance and Education: The pharmacist conducts a comprehensive medication review, patient education and medication management, and obtains the needed medications through the drug manufacturers' indigent care programs. Education focuses on in-home monitoring of diseases, use of medications, and lifestyle modifications such as diet and exercise.
- Preventive Health Screening: Preventive health screenings are encouraged for breast, colon, and prostate cancer, as well as vaccine shots for flu, tetanus, pneumonia, and other conditions.



The program addresses not only the financial needs of the patient, but encourages the older person to become an active participant in their health care through education about medications and diseases.

### **CURRENT STATUS AND FUTURE PLANS**

Assisting low-income Medicare patients in obtaining free medications continues to be the primary focus of the MAP program. The program has expanded in numbers at the local site, organizationally to free clinics, and geographically to additional regions. Approximately 120-130 patients are served per year at the hospital or free clinics. In addition, another 300-400 patients receive interim assistance. The program has received over \$800,000 in free medications for low-income patients through pharmaceutical indigent patient programs. The availability of medications has provided better blood pressure control, better glucose control and reduced hospital readmissions. In addition to the human benefits in quality of life, the hospital benefits from cost-avoidance. During one six-month period, a pre- and post- study of 30 patients enrolled in the program prevented the loss of \$240,000 to the hospital.

Program staff have assisted in developing similar programs in the region. For example, staff have provided training and support for replication programs in the outlying rural areas of western North Carolina. One replication program is staffed by church volunteers and uses a Mission Saint Joseph's pharmacy resident to provide patient education and medication reviews. The pharmacy resident is supervised by the MAP pharmacists.

The hospital originally paid for the cost of the program through its community benefit program. Start-up funds also came from the K.B. Reynolds Trust.

### **OUTCOMES**

- 120 low-income Medicare patients receive free medications each year, provided by pharmaceutical companies.
- Free medications provided by pharmaceutical companies over a three year period are valued at approximately \$800,000.
- The health status and quality of life for enrolled older adults are improved by better glucose control, better blood pressure control, and lifestyle changes due to health education.
- Hospital readmissions are reduced with cost-avoidance to the hospital.

### **PRODUCTS**

- Special software is being developed by Pfizer, Inc.

#### **FOR FURTHER INFORMATION CONTACT:**

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## 2001 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION WINNER

### **Groceries to Go** **Elder Services Network**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**Frail older adults maintain their psychological and functional independence through assistance of a grocery delivery service. Training of volunteers emphasizes meeting social needs of recipients in addition to delivering groceries. Frequent public communications and the formation of an Advisory Board have generated grass-roots community support and made recruiting volunteers easy.**

#### **ORIGINAL PROGRAM DESCRIPTION**

Groceries to Go is a grocery shopping and delivery service for older adults who cannot accomplish these tasks for themselves. Operated by the Elder Services Network in Mountain Iron, Minnesota, the program provides a weekly shopping and delivery service for persons over age 60 years. Special efforts are made to reach individuals with the greatest need: frail, disabled, functionally impaired, limited hearing, visually impaired, rural and/or isolated persons.

The program provides access to fresh fruit and vegetables and dairy products on a weekly basis. Users of the service make their own choices from a prepared master list and phone their shopping list to the program office once a week. Volunteers gather the groceries at the designated store and deliver them. The participants then submit payment by check to the store.

The program recruits and trains volunteers to deliver the groceries. Volunteers are given background checks, trained in good listening, and encouraged to spend time visiting with program participants when delivering groceries as a means to help diminish feelings of isolation and loneliness. The majority of volunteers are themselves older. Volunteers are required to have their own automobile insurance, thereby alleviating the need for the program to carry insurance for delivery purposes.

The start-up program was funded by grants from the Area Agency on Aging (AAA), United Way, Northland Foundation, Seniors' Agenda for Independent Living, and Iron Range Resources and Rehabilitation Board. Participants do not pay for the service.

Participants have completed satisfaction surveys, with a 65% return rate, and have reported favorable comments. Overall, participants were positive about the program, and many sent contributions to help the program. The program allows older adults to retain their personal dignity and feelings of self-worth, to remain independent, and to feel that they are still viable members of the community.



## **CURRENT STATUS AND FUTURE PLANS**

Delivery of groceries to frail older adults continues to be the primary focus of the program, with the goal of helping vulnerable elders stay in their homes. During the first two years of the program, 125 people used the service. In 2001, 143 people were served by 69 volunteers. The program has also expanded to three additional communities in the area. Five states have sought information on the program, and it has been replicated in North Dakota, Kansas, Wisconsin, New York, and California.

The original program received a start-up grant from AAA, but the program now has a contract with AAA and with the county. Under the contract with the county, Medicaid waivers provide funds. In addition, the program seeks to raise five percent of program costs from donations. The parent organization, Elder Services, offers five programs, and overhead and administrative costs are shared across those five programs.

Grassroots community support has been vital to the success of the program. Various senior services groups and senior housing programs have been supportive. In addition, Elder Services produces monthly newsletters and brochures, and distributes a Senior Resource Guide annually. Press releases are published in the local newspaper to keep the community informed. Groceries to Go has an Advisory Board that has been supportive, and grassroots community support has made it relatively easy to recruit volunteers.

## **OUTCOMES**

- In 2001, the program served 143 older adults, most of whom were vulnerable and at risk for institutionalization.
- Community volunteers have helped make it possible for people with functional limitations to remain in their homes.
- Groceries to Go has expanded to additional locations.
- Program information has been distributed to other states, and the program has been replicated in five other states.

## **PRODUCTS**

- A Senior Resource Guide, monthly newsletters and brochures keep older adults informed and generate community support.

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## **2001 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION**

### **Centralized Geriatric Nursing Assessment Service Community Health Services, DuPage County Health Department**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**A gerontology assessment model emphasizes health promotion rather than aging as a chronic and deteriorating process. This assessment model has been integrated into public health nursing services. By creatively addressing the dilemma of increased demands on the public health system due to changes in health care reimbursement and earlier hospital release of patients, public health nursing is serving the needs of older patients.**

#### **ORIGINAL PROGRAM DESCRIPTION**

Changes in health care reimbursement have resulted in older adults being discharged from hospitals and home health agencies while still in need of medical care. Increasingly, these clients are referred to local public health agencies for follow-up. With public health nursing resources declining, no funding available for senior services, and the older population increasing, the DuPage County Health Department designed a new service model to improve the quality and efficiency of in-home nursing services.

A centralized geriatric nursing assessment service was developed to serve older residents of DuPage County. All clients aged 60 or over who are being discharged from home care or hospitalization are referred to the Health Department's Gerontology Program. Each person receives a telephone pre-screening by a nurse with training and experience in gerontology. If the client has risk factors that place her health at risk, the gerontology nurse makes an in-home visit to conduct a comprehensive nursing assessment.

Clients with minor needs are followed up by the gerontology nurse via telephone, and then discharged when appropriately linked to community resources. Those with more complex needs who require additional in-home visits are referred to a public health nurse who can follow-up with that client for 3-6 months.

The centralized gerontology assessment model emphasizes health promotion to improve health status. The Health Department has resisted the tendency to view aging as a chronic and deteriorating process, emphasizing early intervention to maximize health functioning, promote self-sufficiency, and prevent further decline.

Original funding for the one-year pilot program came from an internal county public health budget allocation.

## **CURRENT STATUS AND FUTURE PLANS**

The service model has been shifted from the Gerontology Program and integrated into the general public health practice offered through the Family Health Unit, providing a more holistic family-centered approach. The assessment role has been expanded to other nurses, with five public health nurses operating out of five geographically dispersed satellite offices. Typical contacts include an in-home assessment followed by two follow-up phone calls. The majority of clients, approximately 60%, are then referred to outside services. Referral partners include senior centers, mental health agencies, legal services, home health agencies, and other community-based services.

With decentralized services, the central office now serves as a consultant and maintains records on outcomes. The pilot program had separate funding during the first year, but services are now provided by the Family Health Unit. The program is self-sustaining within existing budget allocations.

## **OUTCOMES**

- The gerontology assessment model emphasizes health promotion to improve health status.
- The program served 20 people during 2001.
- The geriatric assessment model has been integrated into the Family Health Unit, providing a more holistic approach and stable funding.

## **PRODUCTS**

- The Health Department has developed a process emphasizing early intervention to maximize health functioning, to promote self-sufficiency, and to prevent further decline.

### **FOR FURTHER INFORMATION CONTACT:**

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## **2001 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION**

### **The S.A.G.E. Project The Area Agency on Aging**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**The project is unique in that multiple agencies collaborate to coordinate care for frail older adults and operate without a formal agreement. The Area Agency on Aging provides resources for a nurse assessor to be involved in hospital discharge planning. A multi-agency task force communicates the care plan and solves clinical and administrative problems across agency boundaries.**

#### **ORIGINAL PROGRAM DESCRIPTION**

The S.A.G.E. project is a collaborative partnership that provides multi-level coordination between participating agencies in order to coordinate health care delivery, reduce fragmentation of care, and improve linkage to community resources. Collaborative partners include a large urban Area Agency on Aging (AAoA) and Summa Health System, including its Center for Senior Health and SummaCare Health Plan. This long-term effort, established in October 1995, integrates acute medical care services, a multi-faceted geriatric clinical services program, a Medicare-Risk managed care HMO, and the aging network of community-based long-term care services.

The target population is primarily low income, frail older adults residing in the community in Northeastern Ohio. Many have multiple chronic medical and social needs and are at risk of hospitalization, nursing home placement, or death, due to declining functional and health status.

The S.A.G.E. project attempts to bridge the boundaries between the acute medical sector and the social services sector by working together to provide more comprehensive and effective care that recognizes the biopsychosocial needs of individuals, particularly those suffering from chronic disease and disability. A registered nurse (RN) assessor has been added and serves as a liaison between agencies. The nurse assists in discharge planning. The Area Agency on Aging provides the salary for the nurse assessor.

An Interdisciplinary Community Aging Network (ICAN) Task Force is a working task force involving every major segment of the health care delivery system. Members of the task force are actively involved in the client's care and work together to develop a plan and ensure its implementation. A geriatrician is an integral member of the geriatric assessment team and is able to communicate with the primary care physician and obtain support for the care plan.

The S.A.G.E. project is unique in that it operates solely with informal agreements and no formal contracts. The project also operates with no formal funding, but rather in-kind staff contributions.

By collaborating, the agencies involved are able to assist frail, elderly individuals and their families to achieve a higher quality of life by improving their functional status, maintaining their independence in the community as long as possible, and avoiding or delaying institutionalization.

### **CURRENT STATUS AND FUTURE PLANS**

The program continues to operate on an informal basis, with no formal contract, but with resource support provided by the participating agencies. The program has expanded to three additional hospitals, each with its own nurse assessor. The clinical geriatric program has also been replicated in other areas, with promotion from the AAoA.

Summa Medical Center is a major teaching hospital, and geriatric training is now an established rotation for medical students. Summa Health System has also now established a post-acute service line.

### **OUTCOMES**

- In 2001, 591 people were referred to AAoA for discharge planning, representing a 221% increase in one year.
- The project has expanded to three hospitals, and the clinical geriatric program has also been replicated in other areas.
- Data are recorded on process outcomes but not clinical outcomes.
- The project received recognition for the Outstanding Community Partnership at the 2002 annual conference of the Ohio Association of Area Agencies on Aging.

### **PRODUCTS**

- Presentations at national and regional meetings are made by professional staff to disseminate information about the program and its outcomes.

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## **2001 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION**

### **Senior Wheels**

**Senior Resources of Guilford**

#### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**Faith community volunteers provide transportation to medical services for older adults needing medical transportation. Social support is an important element, with volunteer drivers often assisting frail riders in preparing for appointments or picking up prescribed medications. Drivers are recruited from faith-based congregations and report personal satisfaction from contributing to the well-being of frail older adults in their community.**

#### **ORIGINAL PROGRAM DESCRIPTION**

Many older adults find that transportation problems prevent them from meeting their medical needs. Senior Wheels eliminates transportation as a barrier and provides improved access to necessary health services for elders. The goals of the program include:

- Increasing the number of seniors receiving primary and preventive medical care.
- Reducing the level of frustration experienced by frail persons in obtaining medical care.
- Maintaining the physical health of seniors, enabling them to continue to live independently.
- Assisting the medical community to offer quality patient care by reducing the number of cancelled appointments due to lack of transportation.

Senior Wheels has formed a partnership with the local faith community. Local congregations “adopt” one day each month to provide volunteer drivers to older adults requesting transportation. A team captain from each participating church coordinates the volunteers from the congregation. Drivers, using their own vehicles and auto insurance, pick up riders and return them home after medical appointments. A social support system is a major element. Drivers often assist frail riders, such as in preparing for an appointment, getting to and from the car, or picking up prescribed medications at a pharmacy.

The initial program was started in 1997 with grant funding for a three-year period. Funding sources included inter-faith communities, corporations, client contributions, and fund-raising events.

### **CURRENT STATUS AND FUTURE PLANS**

The program continues to expand, in both the number of clients served and the number of volunteer drivers. The original funding period of three years was extended to an additional year. The agency continues to be involved in fund-raising in order to avoid charging users.

For evaluation purposes, the program tracks the number of people served, the number of volunteer drivers involved, and the number of rides provided. Interns from gerontology and social work programs at nearby universities assist with compiling and analyzing data.

### **OUTCOMES**

- The program continues to expand. It served approximately 225 older adults per month in 2001, for a total of 2,664 users.
- In 2001, 425 volunteer drivers served frail older adults with medical transportation needs. The volunteer base is stable, with 65% of volunteer drivers continuing over six years. Volunteers report a sense of personal satisfaction with their role.

### **PRODUCTS**

- Program model information has been disseminated to several organizations that expressed interest in replicating the program.

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## **Kinship Support Network**

Edgewood Center for Children and Families

### **WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**This program supports older caregivers who are raising their grandchildren.**

**Support services include: health care, mental health counseling, peer mentors, respite care, and emergency food or housing assistance.**

**Outcome data have shown improved health and mental health for grandmothers, and improvements in health, mental health, social competencies, and school performance for grandchildren.**

### **ORIGINAL PROGRAM DESCRIPTION**

The Kinship Support Network, started in 1993, is the nation's first comprehensive public-private partnership to support older persons who are raising their relatives' children as an alternative to foster care. The goal of the program is to help older grandmother caregivers to improve health and mental health status during program participation.

The target population is grandmothers in San Francisco, predominantly African American, who are raising their grandchildren. The typical caregiver is a 60-year-old grandmother raising children who have lost their parents due to abuse, neglect, substance abuse, or incarceration. Research data have shown that grandmother caregivers who enroll in the Kinship Support Network have poorer health and poorer mental health than other women their age.

Grandmother caregivers can obtain peer case management, respite care, emergency food or housing assistance, mental health counseling, and health care services. Grandparents can also access parenting education, support groups, after-school tutoring, and enrichment activities for the children in their care.

Funding for the Kinship Support Network is provided through a diverse blend of public contracts and private donations. Funds are received from the county Office on Aging, mental health agency, child welfare department, and children's services department. The program also seeks foundation grants, donations, and volunteer support. Families are served within the private agency, allowing them to bypass the public welfare system and maintain their dignity.

When the Kinship Support Network was created, Edgewood simultaneously founded a research institute to document caregivers' needs and to evaluate program outcomes. The Institute has partnered with researchers at the University of California at Berkeley to conduct longitudinal research on kin caregiving. Three significant measurable outcomes have been documented:

- Grandmother caregivers in the program significantly improved their physical and mental health, as measured by pre-post tests. In contrast, older female caregivers enrolled only in the public child welfare system showed stable or declining health and mental health during the same period.
- Participating caregivers reduced family needs in 30 of 31 areas, as measured by pre-post tests.
- Children in the program improved their health, mental health, social competencies and school competencies, as measured by pre-post tests. Children also had fewer problems with anxiety/depression, withdrawal, sleeping, and interpersonal issues.

#### **CURRENT STATUS AND FUTURE 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. Thirteen California counties have formed local Kinship Support Networks, with technical assistance from the Edgewood Center. The Center plays an active role in dissemination, providing both group assistance and individual technical assistance to communities launching their own kinship programs.

#### **OUTCOMES**

- The program served about 250 grandmother caregivers in 2001.
- The program co-sponsored the first National Kinship Care Conference in 1997. A regional follow-up conference was held in 2000.
- The program has been recognized as a national model and has been shared in several other states.

#### **PRODUCTS**

- A Kinship Operations Manual, a staff training manual, an advocacy video, research Fact Sheets, and brochures have been produced and distributed.

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## 2002 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION

**SeniorNavigator.com**  
SeniorNavigator.com

### WHAT IS SPECIAL ABOUT THIS PROGRAM?

**This project combines the “high-tech” approach with “high-touch”. A website provides health and aging information and guides to local community services. Volunteer and professional “information ombudsmen” connect older adults without computer access to information and services.**

### ORIGINAL PROGRAM DESCRIPTION:

SeniorNavigator.com came on-line in February 2001 as a website to help older adults connect with the information and services they need to remain independent. The program combines the “high-tech” approach and the “high-touch” approach by providing both computer-based information and connections to volunteers and professionals who serve as “information ombudsmen” in accessing the needed information.

A website ([www.seniornavigator.com](http://www.seniornavigator.com)) serves as an Internet guidebook for Virginia’s older adults, their families and caregivers. The website provides information about particular health conditions, as well as extensive details about local health and aging services. SeniorNavigator.com also provides 2,000 links to pertinent websites. In addition, the website 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 other experts to people throughout Virginia.

The “high touch” component complements the website and provides access to information for those without computers or Internet service. Volunteers and professionals throughout Virginia have been trained as Community Senior Navigators, to act as “information ombudsmen”. They provide the human touch to help connect older adults to needed information and services. These ombudsmen are linked to official access sites in each community called “Senior Navigator Centers”.

The Senior Navigator program was developed using an action planning methodology. Prior to developing the website or the volunteer network, gerontologists were recruited from Virginia Commonwealth University, Virginia Polytechnic Institute and Union Theological Seminary to participate in the project design.

Community collaboration and extensive data collection played important roles in implementation. Fifteen regional steering committees from around the state, representing urban, rural and suburban communities, provided input. Focus groups were held with seniors and caregivers, and interviews conducted with over 100 health and human service professionals. Over 1,000 people in Virginia helped to develop the website and program components.

Partners and sponsors contribute through technical assistance, identifying local services and programs, updating data, contributing content articles, providing funding, facilitating access to professionals and volunteers, promoting the website, and training Senior Navigators. The partners work collaboratively with 25 Area Agencies on Aging, many state agencies, the information and referral system, and others.

### **CURRENT STATUS AND FUTURE PLANS**

SeniorNavigator.com has received inquiries from nine states and major metropolitan areas about how to create similar websites for older adults. In addition, various groups have expressed interest in duplicating the program for children and for people with disabilities. The disability community in Virginia is already actively using the website because of its vast network of resources and articles related to disabilities.

### **OUTCOMES**

- By 2002 the website had been accessed by nearly 7,000 individuals, and another 8,000 had been reached through presentations and events.
- The program has trained 10,000-12,000 volunteers and professionals throughout Virginia to serve as community Senior Navigators to assist older adults in finding information needed to help them remain independent and alleviate the need for institutional care.

### **PRODUCTS**

- The [www.seniornavigator.com](http://www.seniornavigator.com) website includes nearly 18,000 local service listings, over 400 health and long-term care related articles, and 2,000 links to pre-selected websites.

### **FOR FURTHER INFORMATION CONTACT:**

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## 2002 AWARD FOR EXCELLENCE IN PROGRAM INNOVATION HONORABLE MENTION

### Take Charge of Your Health for Older Adults DHR-Division of Aging Services

#### WHAT IS SPECIAL ABOUT THIS PROGRAM?

**This project developed and disseminated educational materials on nutrition, physical activity and wellness to those attending senior centers throughout Georgia. Collaborative relationships with university professionals facilitated the development of program materials and evaluation. Outcome data showed program participants improved their nutrition, physical activity and physical fitness.**

#### ORIGINAL PROGRAM DESCRIPTION

"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. Education materials were developed in 2000, and the training and intervention were conducted in 2001.

The target audience addressed was older adults living in the State of Georgia and attending senior centers. Nutrition education programs and leg exercises were offered at senior centers throughout Georgia. Program services were delivered by the Georgia Division of Aging Wellness Coordinators, registered dietitians, extension agents, senior center directors, and other professionals in the aging network.

Strategies to reach the audience included lively and fun scripts with colorful overhead transparencies. Key messages of the intervention materials are from Georgia's Coalition for Physical Activity and Nutrition (G-PAN). These messages include: *Take Down Fat*, *Take 5-A-Day*, and *Take Action*.

Funding was provided by the Georgia Department of Human Resources, Older Americans Act, and USDA Food Stamp Nutrition Education program. The program was offered at relatively modest cost. It is estimated that the program could be replicated at additional sites serving 25 seniors at \$1850 per site per year.

The evaluation component focused on those participating in Elderly Nutrition Programs where they received a congregate meal several times per week. As a group, these adults have low income and literacy skills.

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. Overall, this community-based program demonstrated improved nutrition, physical activity and fitness in 500 program participants.

#### **CURRENT STATUS AND FUTURE PLANS**

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 project materials and are using the education materials in their programs.

#### **OUTCOMES**

- A total of 600 older adults were reached by the program in the year 2001.
- Over 50% of participants attended 10 or more nutrition education lessons, while 38% of participants attended 10 or more of the leg exercise sessions.

#### **PRODUCTS**

- The project's education materials are available for sale. They include *Take Charge of Your Health—Active Older Adult Speaker's Kit* and *Placemat Leg Exercises*. The materials are available to anyone and are particularly useful for community agencies with Elderly Nutrition Programs.

#### **FOR FURTHER INFORMATION CONTACT:**

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**Elder Rehab by Students Program  
University of Arizona**

**WHAT IS SPECIAL ABOUT THIS PROGRAM?**

**A university research program paired student trainees with persons having mild to moderate Alzheimer's patients to provide fitness training, memory and language stimulation, and cultural and recreational activities. The program halted further decline among enrolled participants and provided a brief respite to caregivers. The program also provided valuable knowledge and experience to students.**

**ORIGINAL PROGRAM DESCRIPTION**

Elder Rehab by Students offered physical fitness, cognitive, language and "partnered volunteering" program for persons with mild to moderate Alzheimer's Disease living in the community. 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, as well as to slow the rate of cognitive decline. The program operated from September 1997 to June 2001 as a research project of the University of Arizona.

Student rehab partners provided one weekly session of fitness training, during which 10-12 different memory and language stimulation activities were administered. Participant 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 volunteer also engaged in a weekly session of community/volunteer work with the assigned participant. These weekly sessions alternated between cultural and recreational activity.

Outcomes were recorded for participants throughout their involvement in the program. By June 2001, at the completion of the fourth and final intervention year, four participants had been enrolled in the program for all four years. All four of these four-year participants remained at the same stage of dementia as they were four years earlier, with no further measurable declines. Three of these long-term participants remained at the mild stage of dementia and one at the moderate stage. In general, 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. Numerous photographs and videos of patients and students engaging in various activities provided further evidence of outcomes.



Caregivers benefited from the program 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 a student worked with their care recipient.

#### **CURRENT STATUS AND FUTURE PLANS**

Although the original research program ended in June of 2001, the University of Arizona Elder Rehab is working on ways to renew and expand the program.

#### **OUTCOMES**

- A total of 62 Alzheimer's patients were enrolled in the program during its four years of operation, 14 during the final year of 2001.
- Students made significant gains in their knowledge of Alzheimer's disease.
- Students also gained valuable experience that provided them with a competitive edge when applying for graduate school and jobs.

#### **PRODUCTS**

- The program is disseminated world-wide through the Elder Rehab website and the National Center for Physical Activity and Disability website.
- Presentations at national and international conferences, caregiver and staff in-service training workshops, and articles and videos have further publicized the program.
- Replication could easily be accomplished through a college or university with access to physical fitness facilities.
- Detailed instructions for administering the language, memory and fitness activities are available through the principal investigator for the cost of duplicating and mailing.

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# LESSONS LEARNED

The Excellence in Program Innovation winners offer valuable insights about how to succeed in the complex health and social services environment of the United States in the twenty-first century. The “lessons learned” from these winning programs reveal what professionals need to know to develop or fund health and support services for seniors that succeed and that continue over time.

In Fall 2002, the Gerontological Health Section of the American Public Health Association, in conjunction with the Archstone Foundation, sponsored a follow-up study of past award winners. Dr. Marcia Ory and Dr. Connie Evashwick conducted interviews with the 20 Award for Excellence in Program Innovation winners and honorable mention awardees from 1998 – 2001 under a grant from the Archstone Foundation to the Center for Health Care Innovation. The interviews probed for the factors that led to the programs’ success and sustainability over time. Below is a list of the key factors for success, with details following.

- Seek strong leadership
- Involve communities and key stakeholders
- Build on a supporting organizational infrastructure
- Engage in active marketing
- Gather outcome data
- Seek seed money for start-up
- Achieve financial self-sufficiency
- Maintain a shared organizational vision
- Involve a university
- Recognize behavioral change principles

1. **Seek strong leadership.** Innovations come from visionary people and are implemented by charismatic leaders. Almost all of the programs began quite small and with very limited resources. The charisma, skill, and dedication of the leader were often what kept them going until they reached maturity and were inculcated into the ongoing operations of a larger organization. This is consistent with the principle that organizations that sustain will have a driving force or leader who remains present. Even when the leader did change, the successor was an equal champion of the program. Many programs also had champions on boards or in executive leadership, in addition to the person directly responsible for operations.

2. **Involve communities and key stakeholders.** Organizations sustained over time engaged in grassroots community involvement. The importance of community and stakeholder involvement, well-documented as cornerstones of

successful community-based programs, were validated by the Excellence in Program Innovation Award winners. The principles of community organization seem well known and automatically implemented by those starting new initiatives: almost all had a community advisory board of some type. The programs were all based on needs of older adults clearly identified in the community or corporate hierarchy. The sense of commitment felt by the professional staff, the participating seniors, and the community and corporate stakeholder organizations carried the programs forward even when the funding was questionable or the organization or management in flux. None of these programs could be characterized as imposed on the community by external forces.

3. **Build on a supporting organizational infrastructure.** The majority of the award winners were community-based programs serving older adults. This often has the connotation of grassroots, informal organization. However, the detailed analysis of the programs leads to the conclusions that large size, encompassing service scope, and longevity of a parent organization all contribute greatly to the ultimate success of a new community initiative. We would not wish to discourage the entrepreneurial spirit. However, all of these innovative programs were housed in an established organization with resources and expertise, often available at no additional expense, that no doubt contributed to the successful launch of the new venture.

4. **Engage in active marketing.** Only two of the programs had formal marketing approaches, and these were lodged in corporate marketing departments that had broader responsibilities. However, all engaged in active outreach efforts. The techniques varied, but most were inexpensive, to keep the costs of the program low. Marketing included collaboration with other organizations to exchange referrals, ads at senior centers, flyers, and personal contacts of board members. Seeking external validation, such as applying for an award, was a valuable way of gaining recognition and external validation of the value of the program.

5. **Gather outcome data.** In contrast to the time when community-based organizations were not expected to document outcomes, the award-winning programs all kept data and conducted some type of evaluation: process, outcome, or both. They used the information for several purposes: to refine the service, to market, to secure additional funding, to contribute to the relevant body of knowledge. Several of those being interviewed mentioned, unsolicited, that gathering process and outcomes measurements and other evaluations had been seminal to attaining stability. Several mentioned the importance of a university connection, particularly at the outset of the program, to tap into research and evaluation expertise and resources.

6. **Seek seed money for start-up funds.** Grants were a common source of start-up funds. A grant, even if it only covered part of the direct expenses, provided the additional resources that an organization needed to try a new initiative and thereby minimize the risks, both financial and organizational. However, programs that have continued over time beyond a demonstration phase have found permanent sources of funding. For those programs funded

initially by grants, interviewees discussed the importance of converting from soft money to permanent funding, without relying on continued grant support that might be difficult to continue to obtain over time.

7. **Achieve financial self-sufficiency.** The concept of community-based programs serving older adults as a gesture of good will has evolved into a business model. These innovative programs have endured because they meet a need and have achieved financial stability in doing so. In several instances, organizational arrangements changed in order to achieve the financial support needed to maintain the service. Some have achieved financial stability by becoming a core service of the parent organization, and thus are funded internally, but nonetheless have achieved predictable funding. Other financial mechanisms ranged from contracts with external regulatory agencies to fees charged to clients.

8. **Maintain a shared organizational vision.** Relationships among organizations were important for many of the programs and the services they provided. Having a shared vision enables organizations to work together with or without formal agreements. Moreover, these informal relationships can be sustained over many years—especially where charismatic leaders are involved. A forum for discussion was mentioned as important in order to work out operational problems among organizations and thereby allow the service to continue. This is consistent with having a strong leader and a well-established organization that knows its mission and goals.

9. **Involve a university—selectively.** Universities were involved in many of the programs, assuming roles ranging from the evaluator to the instigator. Universities help to secure start-up funding through grants and to publicize programs through presentations to professional audiences. However, maintaining a service program over time is not necessarily consistent with a university's priorities. Universities tended to fade out or lessen their involvement over time. Programs initiated primarily as research or training grants came to an official end, although the products remain available and viable. The programs that have been actively sustained over time have transitioned to other institutions as a base for ongoing operations.

10. **Recognize behavioral change principles.** To support start-up, an organization must recognize that a long-term vision, time and patience, are essential for ultimate success. For programs targeted at seniors, the community, as well as the professionals, must understand that older adults can and do indeed change. Thus, a program that promotes healthy lifestyles for older adults can have an impact. Similarly, the organization must believe in its own ability to change, and to translate academically-generated concepts into applied principles and operations. Several of those interviewed mentioned the importance of the commitment to the idea they were trying to implement and the need for time and patience before judging outcomes too quickly. Those programs that sustained over time were artful in merging the demands of a business model requiring relatively short-term success with the principles of long-term change.

**AMERICAN PUBLIC HEALTH ASSOCIATION  
GERONTOLOGICAL HEALTH SECTION  
AWARD FOR EXCELLENCE IN PROGRAM INNOVATION**

**APPLICATION**

The Gerontological Health Section Award for Excellence in Program Innovation was endowed by the Archstone Foundation for the purpose of identifying and recognizing best practice models in the fields of aging and public health. Award consideration is given to programs that have demonstrated effective practice in the field of public health and aging, with particular emphasis on those that link academic theory with application.

Applications are solicited through the Gerontological Health Section of the American Public Health Association. Annual submissions are due in April. The criteria for award selection include:

- ◆ In operation ten years or less (but long enough to have documented outcomes);
- ◆ Creativity in project design;
- ◆ Documented outcomes and benefits of the program;
- ◆ Replication potential; and
- ◆ Dissemination strategy.

Deadlines and submission address for a given year may be found on the web at [www.apha.org/sections/awards](http://www.apha.org/sections/awards) or [www.archstone.org](http://www.archstone.org).

# CONTACT INFORMATION

1998 Winner and Honorable Mention	1999 Winner and Honorable Mention
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2000 Winner and Honorable Mention	2001 Winner and Honorable Mention
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2002 Winner and Honorable Mention	
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## **THE ARCHSTONE FOUNDATION**

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. Under the leadership of Joseph F. Prevratil, J.D., President and CEO, the Archstone Foundation has awarded more than \$40 million in grants since it was established in 1986. The Foundation's current funding priorities include elder abuse prevention, falls prevention and responsive grantmaking to address emerging issues within the aging population. In fiscal year 2003, Archstone Foundation awarded 23 new grants and provided more than \$4.5 million in support of its mission. Additional information may be found at [www.archstone.org](http://www.archstone.org).

## **AMERICAN PUBLIC HEALTH ASSOCIATION Gerontological Health Section**

The American Public Health Association (APHA) is the world's largest and oldest organization of public health professionals, representing more than 50,000 members from over 50 public health occupations. The Gerontological Health Section (GHS) which is celebrating its 25<sup>th</sup> anniversary this year, was established in 1978 to stimulate public health actions to improve the health, functioning, and quality of life of older persons and to call attention to their health care needs. GHS members fulfill that mission in part 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 community health promotion, community organizing, program development and evaluation, and other ways of bringing public health innovations to older persons. GHS is also concerned with the health and social needs of the younger disabled as they make their transition into the health care delivery system organized for the aged. Further information is also available at [www.apha.org/sections](http://www.apha.org/sections) or [geronet.ucla.edu/ghsnet](http://geronet.ucla.edu/ghsnet).

## **THE CENTER FOR HEALTH CARE INNOVATION (CHCI) California State University Long Beach**

The Center for Health Care Innovation (CHCI) is one of 14 Centers located within the College of Health and Human Services at California State University Long Beach. CHCI was created in 1986 by an endowment from the Archstone Foundation. CHCI addresses issues of the health care system of the future through projects of research, education, demonstration, and information dissemination. Projects focus on at-risk populations of seniors, the chronically ill of all ages, teens, and youth. Long-term care and the continuum of care are current priorities. More information available at [www.csulb.edu/centers/chci](http://www.csulb.edu/centers/chci).

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