ARCHSTONE
FOUNDATION

Archstone Foundation and
The Aging & Public Health Section of
The American Public Health Association

present the

2015
Award for Excellence in Program Innovation




APHA Annual Meeting
Chicago, Illinois

award presentation

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2015
Award for Excellence in Program Innovation

APHA Annual Meeting

Chicago, Illinois

Aging & Public Health Section
Awards Program

Monday, November 2, 2015

2:30 - 4:00 pm

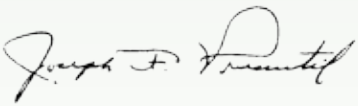
McCormick Place Convention Center
Room W175c

foreward

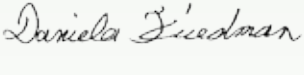
The Award for Excellence in Program Innovation was established by an endowment from Archstone Foundation to the Gerontological Health Section, now known as the Aging & Public Health Section, of the American Public Health Association, to recognize best practice models in gerontology and geriatrics. Programs that innovatively link academic theory with applied practice in the field of public health and aging are considered annually for this award. It is our hope that these model programs will be replicated and will continue to be evaluated in an effort to enhance services to the aging population throughout the United States.

To Irena Pesis-Katz, PhD, Chair of the Archstone Foundation Award Selection Committee, and the other members of the selection advisory committee, we extend our deep appreciation for their efforts in reviewing the nominations and selecting the outstanding program to receive this year's award.

To the winner of the 2015 Archstone Foundation Award for Excellence in Program Innovation, all the nominees, and to all who participated in the award process as applicants or reviewers, we offer our best wishes for continued success in their commitment to develop service models in the field of aging and public health.



Joseph F. Prevratil, JD
President & Chief Executive Officer
Archstone Foundation



Daniela Friedman, MSc, PhD
Chair, Aging & Public Health Section
American Public Health Association

The 2015 Archstone Foundation
Award for Excellence in Program Innovation Winner is:

UCSD STUDENT-RUN FREE CLINIC PROJECT
ELDERCARE PROGRAM
University of California, San Diego
La Jolla, California

The 2015 Honorable Mention Recipient is:

EASTERN VIRGINIA CARE
TRANSITIONS PARTNERSHIP
Riverside Health System
Newport News, Virginia

UC San Diego

Student-Run Free Clinic Project Eldercare Program

University of California, San Diego
La Jolla, California

UCSD

BACKGROUND

In 2011, approximately two million older adults in the United States (U.S) were homebound; of whom, only 12% received primary care home visits. Today, only about 4,000 physicians in the U.S. make house calls, even though house calls provide a unique opportunity to gain valuable insight into their patient's lives, allowing them to provide more comprehensive care. In the home, physicians can unmask discrepancies with medications, conduct first-hand qualitative assessments of a patient's capability in daily life, and assess patient safety. The potential for illicit drug and alcohol abuse, fall risks, indications of incontinence, or dementia, may also be present in the home, but not readily apparent during an office visit. One study showed that 82% of physicians agreed there was a role for house calls for geriatric patients.

PROGRAM

The University of California, San Diego (UCSD) Student-Run Free Clinic Project (SRFCP) cares for 2,000 patients, including 1,000 with serious chronic illness. In partnership with the community, its mission is to provide respectful, empowering, high-quality health care with the underserved, while inspiring the next generation of health professionals. SRFCP patients are uninsured, do not qualify for government-sponsored programs, or are underinsured.

A goal of the SRFCP was to create an Eldercare Program that includes a home visit program – a program that offers free health care services to underserved elderly patients with mobility or transportation issues, and a goal of maximizing patient health, functionality, autonomy, and well-being. The SRFCP Eldercare Program serves approximately 100 geriatric patients who have no other access to care. Older patients served are 74% women and 26% men, with 85% Latino, 11% Caucasian, 1% African American, 2% Asian, and 1% Other/Unidentified. Less than 5% are street homeless, with the majority of patients considered poor and working poor. Most of the patients have one or more chronic illnesses; the five most common diagnoses include hypertension, diabetes, hyperlipidemia, depression, and asthma.

The SRFCP Eldercare Program includes:

- A comprehensive approach that addresses social determinants of health; utilizes the free clinic philosophy of empowerment; and offers a humanistic approach that sees the community as a teacher with each patient encounter;
- A transdisciplinary model that includes ongoing primary and outpatient specialty medical care, restorative dental care, social work - case management, legal support, mental health services, family support, pharmacy, and acupuncture, all free of charge to the patient;
- Home visits for those unable to attend the clinic;
- A peer-facilitated, Spanish-language weekly empowerment group to help older adults take charge of their health;
- Evidence-based programs for balance and fall prevention;
- Curriculum to teach first and fourth year medical students about caring for older patients and conducting home visits;
- Curriculum for middle school students to learn about older adults and ageism; and
- National faculty development trainings for physicians and dentists on addressing the health needs of the underserved.

The curriculum developed for first and fourth year medical students addresses opportunities and challenges when working with older patients. These may include ageism, dementia, mental health and wellbeing, working with families, supporting meaning and purpose, polypharmacy, social determinants of health, health literacy, and the role of the physician in empowering older patients.

The middle school curriculum enables students to learn to be health promoters. In doing so, students spend nearly two weeks learning about challenges and benefits related to aging. They learn about ageism, conduct an interview with an elder family member or friend, learn to talk with someone with limited hearing or dementia, hear about chronic conditions that affect elders, and how to safety proof a home.

OUTCOMES

The SRFCP Eldercare Program outcomes include maintaining and increasing functionality, autonomy, health, and overall patient wellness. Outcomes are achieved by addressing fall risk, which allows seniors to feel more mobile and confident, and by connecting seniors to activities like the empowerment group run through the SRFCP, to increase functionality.

The SRFCP has been able to demonstrate improved diabetes, hypertension, hyperlipidemia, and quality of life outcomes in its overall patient population, including the elderly. It has also been able to show that SRFCP diabetic clients, especially the elderly, were very food insecure. Consequently, the SRFCP provides food and diabetes education, and has been able to show that patients' diabetes distress has improved.

In addition to patient outcomes, medical students and medical school faculty develop a baseline of knowledge of the unique needs of older adults, and an appreciation for the challenges they face and their ability to overcome them.

PARTNERSHIPS

One of the most impressive aspects of the SRFCP is the degree of collaboration between UCSD's School of Medicine, other UCSD schools, and outside academic partners. Physicians and students affiliated with partner institutions play a crucial role in the success of the SRFCP. Community partners also make the program possible. The SRFCP and the Eldercare Program are based in inner city public schools and community churches – these long-standing, trusted relationships make the program possible. Corporate partners offer necessary supplies such as diabetes strips at half-price, low-cost labs, and access to medical procedures at no, or low-cost. Patient Assistance volunteer navigators help patients complete applications for patient assistance. Last year the SRFCP helped its patients access $1.7 million of free prescriptions through pharmaceutical company Patient Assistance Programs. The SRFCP leveraged $7 of donated prescriptions for every $1 spent.

DISSEMINATION

To date, the SRFCP model has been replicated in more than 15 cities across the United States. The SRFCP's and Eldercare Program's co-founder and Director, Ellen Beck, MD, also helped found a national student society of SRFCPs. The SRFCP hosts national and international visitors who have heard of the project's success. Teams from well-respected medical systems have visited the SRFCP to learn from the model, are made aware of the Eldercare Program, and are working with Dr. Beck to establish SRFCP sites. Over the past years, there have been at least 25 visits.

To learn more about the University of California, San Diego (UCSD) Student-Run Free Clinic Project Eldercare Program, please visit https:meded.ucsd.edu/freeclinic

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Eastern Virginia Care Transitions Partnership

Riverside Health System
Newport News, Virginia

BACKGROUND

Patients, particularly older patients and people with multiple chronic conditions, experience frequent transitions of care, which often result in ineffective care and readmissions. Twenty percent of hospitalized Medicare beneficiaries are readmitted to the hospital within 30 days. Of these, 50% have not seen a health care or social service provider between the time of discharge and their rehospitalization. Fragmentation, and poor communication during transitions between settings, can lead to serious patient safety, quality of care, and health outcome concerns. In more detailed analysis of 30 day readmissions, it is also evident that most root causes of readmission are due to social factors, like adequacy of supports for housing, transportation, nutrition, and medication management. Many health systems lack the knowledge and infrastructure to meet these needs.

PROGRAM

Recognizing that social and economic factors drive hospital readmissions, Riverside Health System sought partnerships with community service providers to ensure that discharged patients have adequate supports in their homes and communities. Area Agencies on Aging (AAA) are well-positioned to address social needs that contribute to poor health and hospital readmissions.

Together in 2013, Bay Aging, an AAA, and Riverside Health System initiated a unique partnership, the Eastern Virginia Care Transitions Partnership (EVCTP). EVCTP encompasses 20% of Virginia, including both rural and urban areas, many of which are Medically Underserved Areas. In many of the counties, 30% or more of the total population is age 65 or older.

EVCTP is a formal community partnership of health systems, AAA's, independent physicians' groups, and other public and private health and human service providers. EVCTP began with funding from the Center for Medicare and Medicaid Services (CMS), and was charged with lowering hospital readmissions, increasing the quality of health care, and lowering health care costs.

EVCTP utilizes the Coleman-Care Transitions Intervention® (CTI), a four-week, evidence-based process designed to empower and support patients to take a more active role in their health care, and where

health coaches begin by meeting with patients and their caregivers in the hospital. EVCTP also expands upon the CTI model by providing enhanced home and community-based services such as transportation, Meals on Wheels, chore services, caregiver support, and education on advance care planning.

The Eastern Virginia Care Transitions Partnership goals and objectives include:

- Reduce unnecessary 30-day all-cause hospital readmissions by 20%;
- Improve quality of life and health care for patients from the hospital to home, or other care settings; and
- Use an evidence-based program to improve patient health outcomes and document measurable savings to Medicare.

OUTCOMES

EVCTP participated in the CMS Community-Based Care Transitions Program (CCTP), and was sixth in the nation for meeting the goals for reducing all-cause readmissions, and moving from a baseline all-cause readmission rate of 18.2% in 2010 to 14.8% in 2015. A total of 16,059 clients have been enrolled in the EVCTP, with 2,176 readmissions avoided, a total savings of $20,887,834. EVCTP was also the recipient of awards for innovation from the National Association of Area Agencies on Aging and the Virginia Chamber of Commerce.

PARTNERSHIPS

EVCTP began as a pilot program initiated by Riverside Health System and Bay Aging, with funding from CMS. It consists of a unique partnership between five health systems, 11 hospitals, three managed care organizations, 69 skilled nursing facilities, and five AAAs.

EVCTP has enhanced agreements with hospitals for secure data sharing systems; trainings for governance, management, and clinical teams; a single, centralized source for billing, tracking readmissions, and other metrics; and integration into health systems' electronic health records and health information exchanges.

DISSEMINATION

EVCTP was selected by the Virginia Center for Health Innovations to expand the CTI Model statewide by 2016. Protocols are standardized across the current partner hospitals and can easily be replicated across the state. EVCTP is developing a plan to expand statewide.

To learn more about the Eastern Virginia Care Transitions Partnership, please visit www.evctp.org

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call for nominations

As of **November 1, 2015**, the Aging & Public Health Section of the American Public Health Association will accept nominations for the 2016 Archstone Foundation Award for Excellence in Program Innovation. The award was established in 1997, to identify best practice models in the field of health and aging, and to provide recognition and an opportunity to highlight the work at the annual meetings of the American Public Health Association.

Programs that effectively link academic theory to applied practice in the field of public health and aging are eligible for nomination. Nominees should also have documented results, but have been in operation less than 10 years. Preference will be given to nominees who have not received prior awards or special recognition.

In two single-space typed pages please describe the program to be nominated. The narrative should include information about the problem being addressed, the population served, the project's design, partnerships or collaboration, funding, and measurable benefits and outcomes. Only one program may be nominated per agency or organization.

An independent panel will review all nominations. The criteria for award selection will include:

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

The winner is expected to attend a special Aging & Public Health Section Awards Program at the 144th Annual Meeting of the American Public Health Association in Denver, Colorado, October 29 - November 2, 2016. In recognition of this achievement, and to assist with the travel expenses, the winning organization will receive a $500 cash award. Honorable mention(s) may also be awarded to one or more nominees submitting distinguished programs as determined by the review panel.

Nominations are to be submitted electronically, no later than **April 1, 2016** to:

Irena Pesis-Katz, PhD
Chair, Archstone Foundation Awards Committee
Senior Director, PHM Informatics and Payment Innovation
Associate Professor, Clinical Nursing and Public Health Sciences

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selection committee

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College of Public Health

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Associate Professor
Associate Dean for Academic Affairs
School of Public Health
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Adjunct Professor
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Emory University

Denys Lau, PhD
Deputy Director
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Outcomes and Informatics (C-PHOi)
School of Nursing
University of Rochester

Karon L. Phillips, PhD, MPH, CAPS
Research Associate
MPAQ International, LLC

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Annie Nguyen, PhD, MPH
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Karon Phillips, PhD, MPH
Micah Segelman, MA
Mathew Lee Smith, PhD, MPH, CHES, CPP
Kathy Sykes, MA
Steven P. Wallace, PhD

past award winners

2014

Mobile Medicare Health Clinics
University of the Pacific
Thomas J. Long School of
Pharmacy and Health Sciences
Stockton, California

2013

Age-Friendly New York City
A Partnership between
the Office of the Mayor,
the New York City Council and
the New York Academy of Medicine
New York, New York

2012

**Livable Community
Collaborative City of Kingsport**
Kingsport, Tennessee

Healthy Steps in Silicon Valley
The Health Trust
San Jose, California

2011

**Program to Encourage Active and
Rewarding Lives for Seniors
(PEARLS)**
University of Washington Health
Promotion Research Center (HPRC)
Seattle, Washington

2010

**Area Geriatric Education
Scholars Program for
Upper Peninsula Youth (AGES)**
Upper Peninsula Health
Education Corporation
Marquette, Michigan

2009

**PREPARE: Disaster and
Emergency Preparedness
for Long-Term Facilities**
Mather LifeWays
Institute on Aging
Evanston, Illinois

2008

**Guided Care: Improving
Chronic Care for
High Risk Seniors**
The Roger C. Lipitz Center
for Integrated Health Care
Department of Health Policy
& Management
Johns Hopkins Bloomberg
School of Public Health
Baltimore, Maryland

2007

**The Dancing Heart: Vital Elders
Moving in Community
Memory Loss Program**
Kairos Dance Theatre
Minneapolis, Minnesota

2006

Brain Get Your Mind Moving
New England Cognitive Center
Hartford, Connecticut

2005

Legacy Corps for Health and Independent Living
University of Maryland,
Center on Aging
College Park, Maryland

2004

Dignified Transportation for Seniors
Independent Transportation Network
Westbrook, Maine

2003

Alzheimer's Health Education Initiative
Alzheimer's Association
Los Angeles, California

2002

Kinship Support Network
Edgewood Center for Children and Families
San Francisco, California

2001

Groceries to Go
Elder Services Network
Mountain Iron, Minnesota

2000

Experience Corps
Johns Hopkins Medical Institutions,
Center on Aging and Health
Baltimore, Maryland

Assistive Equipment Demonstration Project
University of Massachusetts,
Gerontology Institute
Boston, Massachusetts

1999

Senior Wellness Project
Northshore Senior Center
Seattle, Washington

1998

A Matter of Balance: An Intervention to Reduce Fear of Falling
Boston University, Royal Center for Enhancement of
Late-Life Function
Boston, Massachusetts

Aging & Public Health Section

The American Public Health Association (APHA) champions the health of all people and communities. Members represent all 50 states, 40 countries, and all public health disciplines. The Aging & Public Health Section, originally known as the Gerontological Health Section, was established in 1978. The mission of the Aging & Public Health Section is to promote the health and well-being of individuals as they age by improving health, function, quality of life, and financial security. Section members fulfill this mission through research, practice, education, and advocacy, all of which impact aging services, communities, health systems, policies, and public health programs.

Archstone Foundation

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, JD, President and CEO, Archstone Foundation has awarded more than $99 million in grants since it was established in 1985.

"We offer our best wishes
for continued success
in your commitment
to develop service models
in the field of aging."

ARCHSTONE
FOUNDATION

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