Organization: United Way of Tarrant County’s Area Agency on Aging

Organization Description:
The Area Agency on Aging of Tarrant County (AAATC), located in Fort Worth, TX, works with local organizations to develop and provide services that benefit older adults, people with disabilities and caregivers. We are part of United Way of Tarrant County and receive funding from the Texas Department of Aging and Disability Services. AAATC provides Supportive Services, Benefits Counseling, Long-Term Care Ombudsmen, Nutrition Program, Caregiver Services and an array of Evidence Based Programs.

Our Mission:
We are committed to enhance the quality of life for our Community, and empower people to thrive independently by:

• Creating and implementing innovative, exemplary services.
• Advocating and connecting individuals and families to resources that focus on healthy living.
• Establishing and maintaining supports and partnerships for our communities.

History:
For the past decade the Area Agency on Aging of Tarrant County has been a leader in the area of program innovation and evidence-based program implementation. We recognize that there is a strong correlation with dependency in activities of daily living and the increasing rates of chronic illnesses in older adults. Therefore, evidence-based interventions to address these problems are becoming increasingly important to improve the quality of life for our population. Currently we provide seven Evidence Based Programs (EBPs) including:

• A Matter of Balance (AMOB)
• Chronic Disease Self-Management and Diabetes Self-Management (CDSMP)
• HomeMeds
• Care Transitions (Coleman Model)
• Resources for Enhancing Alzheimer's Caregiver Health II (REACH II)
• Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
• Stress-Busting Program for Family Caregivers

Partners and Funders:
The AAATC receives Older Americans Act funding from the Texas Department of Aging and Disability Services, and numerous competitive grants from the Administration for Community Living to implement EBPs. In addition, some of the EBPs mentioned are also part of the Live Well initiative which is funded by United Way of Tarrant County.

We understand we could not do this work alone, therefore over the years AAATC has formed partnerships with key organizations in our area including: Meals on Wheels of Tarrant County, Senior Citizen Services of Greater Tarrant County, North Texas Chapter Alzheimer’s Association, James L. West, The Women’s Center of Tarrant County, Tarrant County Public Health Department, 3 hospital systems and 4 academic institutions, and many more.

Successes:

Since implementing these programs, we have reached over 18,000 individuals and currently have the largest implementation of HomeMeds in the nation and the largest A Matter of Balance Program in Texas. In addition:

• 9,070 homebound older adults have been screened for hazardous medication regimens using the evidence-based HomeMeds™ program. Over 1/3 have been referred to a pharmacist for intervention.
• 2,780 Alzheimer’s caregivers have received caregiver education through our REACH II program.
• 5,438 have graduated from A Matter of Balance and Chronic Disease Self-Management and Diabetes Self-Management Programs.
• Over 800 individuals have participated in our Care Transitions Program and 94.7% were not readmitted to the hospital within 30 days of being discharged.

Lessons learned:

EBPs provided to homebound populations with increased functional impairment have demonstrated higher reductions in health care utilization. CDC QOL instrument is being used across EBPs and providers and is sensitive to change regardless of target population. Utilization of Collective Impact model across provider organizations that share a common agenda and measurement systems is critical for scalability and long-term success.

Recognition/References:

United Way and the Area Agency on Aging was honored to receive and be part of all three US Administration on Community Living discretionary grants in 2015 to expand our AMOB, CDSMP, HomeMeds, REACH II and Stress-Busting Program for Family Caregivers. Other awards include:

• The Rosalyn Carter Institute for Caregiving chose the REACH II program as a national demonstration site.
• National Association of Area Agencies on Aging (N4A) top innovation prize for REACH II in 2015.
• HomeMeds was recently named one of 2016 N4A aging achievement award recipient.

Program Contact: Donald R. Smith VP Community Development & Director, Area Agency on Aging
Email: don.smith@unitedwaytarrant.org
Phone Number: 1-888-730-2372
Website: www.unitedwaytarrant.org/aaatc
Organization: Partners in Care Foundation

Organization Description:

Partners in Care Foundation (Partners) is an NCQA-accredited 501(c)(3) not-for-profit think-tank and proving ground with the mission to shape a new vision of health care by partnering with organizations, families and community leaders in the work of changing health care systems, changing communities and changing lives. Partners drives care redesign in payer and provider systems that improve quality of care, especially through linkages with community Partners. In addition, we provide direct services to disabled and chronically ill adults that improve health and quality of life, prevent inappropriate use of institutional care, and increase appropriate use of care.

History:

HomeMeds is a medication management evidence-based program (EBP) developed by Partners to enable non-nurse care managers and social workers to identify and resolve certain medication problems common among frail elders living in the community. It includes a computerized risk assessment and alert process, plus a pharmacist review and recommendation for improvement. The program was first developed and tested in the 1990s and first implemented in 2003. Healthy Moves, an evidence-based physical activity program designed by Partners in 2002 to enhance health outcomes for frail, high-risk and diverse older adults receiving care management services in the home. After being tested as a pilot project in 2004, then replicated and evaluated, it was officially designated as an EBP by the federal Administration on Aging and the National Council on Aging. Additional EBPs offered by Partners include the suite of Stanford’s CDSME programs, Powerful Tools for Caregivers, Matter of Balance, Arthritis Foundation Exercise Program and AE Walk with Ease, Savvy Caregiver and the UCLA Memory Course.

Partners and Funders:

• Contracted with a major managed care plan to offer their California members in-person, online, and self-study toolkit EBSMPs.
• Developed and leads the Partners at Home Network (PAH Network), a collaborative comprised of 15 public and private community-based organizations (CBO) in 16 California counties.
• Received state funding from 2006-2014 to spread CDSME throughout California.
• In 2015, received $684,000 from the US Department of Health and Human Services Administration for Community Living to implement evidence-based falls prevention programs across California.
• Helped form the Los Angeles Alliance for Community Health & Aging (LAACHA), a regional collaborative comprised of more than 90 organizations aiming to promote EBPs.
• Functions as the statewide evidence-based health promotion Technical Assistance Center for the California Departments of Aging and Public Health.
**Successes:**

- Since 2014, we have funded 775 workshops with 10,081 participants.
- *Partners* created a Contact Center built for telephonic and mail outreach to individuals with multiple chronic conditions. The Contact Center outreach specialists (OS) are bi-lingual (English/Spanish) and are trained in motivational interviewing techniques to engage members in programming through their own intrinsic motivations.
  - In its first 9 months of 2015, the Contact Center received 42,966 referrals from a managed care plan. Of the 4,604 members who the OSs spoke with, 1,469 agreed to participate in a self-management program.

**Lessons learned:**

In building partnerships with health care payers and in developing a statewide Network of CBO providers, Partners addressed a number of challenges new to non-profit social service organizations.

- **Develop a business case statement and value proposition:** These are attractive to health care payers that demonstrated mission and ROI benefits. Including staffing, legal, and IT strategic plans in your case are crucial.
- **Data sharing and collaborative planning for metrics:** The path to more contracts depends on an organization’s or network’s ability to demonstrate results. Partners has established a growing Metrics and Quality team that oversees data collection, analysis, and ongoing NCQA-accreditation needs.
- **Accreditation open doors for new contracts:** Obtaining accreditation was a key step in winning and keeping contracts. Accreditation allows us to benefit the Payer by qualifying for them to place us under the Medical Loss Ratio (MLR) provision of the Affordable Care Act (ACA), which requires payers to spend 85% of premiums on clinical care and quality improvement efforts such as case management.
- **Activate all executive team and board members’ skills and field experience:** Partners’ staff includes executives with experience in healthcare – hospital, skilled nursing, adult day health, hospice and physician groups. The board has representation from health plans, medical groups, health systems and hospitals. Both the board and executive team have made important connections for the contracting effort.
- **Payer-CBO collaboration is key to building referral volume:** Once the contract was in place, we identified a crucial need to have a strong working relationship with buy-in to the benefit of the contract and dedication to continuous improvement. In addition to holding regular meetings with health payer program staff, our team has begun to track referrals by each plan case manager to identify leaders/champions and those who appear to be less convinced of the value of the services. We are building a prototype Playbook for rollout for future contracts.
- **A strong network delivers quality work and opens doors to new managed care contracts:** Contracts with health care payers often requires us to create new systems for program delivery capable of reaching broad geographies. Partners has developed a growing provider network to whom we provide regular coaching and support to ensure the managed care deliverables and quality goals are maintained. Our network’s reach is attractive to payers and continue to afford us new opportunities to improve patient health statewide.
Recognition/References

Awards:
• Healthy Moves and HomeMeds have been awarded the highest evidence level rating by the US Administration for Community Living.
• HomeMeds is included with a strong evidence rating on the US AHRQ Innovation Exchange

Newsletters/Reports:
• Yan, T., Wilber, K., Wieckowski, J., Simmons, J. (2009). Results from the Healthy Moves for Aging Well Program: Changes of the health outcomes, Home Health Care Services Quarterly. 28(2&3): 100-111

Program Contact: June Simmons
Email: jsimmons@picf.org
Phone Number: (818) 837-3775 ext. 101
Website: www.picf.org
**Organization: Fairhill Partners**

**Organization Description:**

Fairhill Partners mission is: *Connecting people to opportunities for lifelong learning, intergenerational relationships, and successful aging. A nonprofit 501(c)(3) organization situated on 9.5 acres in Cleveland, Ohio, Fairhill Partners since 1987. It grew out of the vision of a small group of organizations with complementary missions of providing direct and related services to older adults, their lay and professional caregivers, and others who serve them. The group determined that like-minded agencies “living” together in a professional community would encourage collaboration and make best use of available resources. Today, Fairhill Partners is governed by a Board of Directors.*

Fairhill Partners offers programs and services for kinship families and adult family caregivers, peer-led activities, evidence-based self-management workshops, physical activity and fall prevention workshops, and much more.

**History:**

Fairhill Partners began offering A Matter of Balance workshops in 2006 and Chronic Disease Self-Management workshops in 2007. These evidence-based workshops help older adults manage their fear of falling, increase their activity levels, set their own goals to take better care of their health, and improve their quality of life and independence.

Because chronic diseases and falls are among the major causes of death and disability among people aged 60 years and older, Fairhill Partners has added Diabetes Self-Management, Chronic Pain Self-Management, Building Better Caregivers, and Walk with Ease workshops. In addition, Fairhill trains staff and volunteers to be Master Trainers, able to train staff and volunteers to be leaders and coaches of the workshops. Fairhill’s trainers are focused regionally but also provide statewide or other offsite training.

**Partners and Funders:**

Fairhill Partners has grown its evidence-based programs through a 12-year partnership with the Western Reserve Area Agency on Aging and delivers workshops to older adults at more than 70 sites in four Northeast Ohio counties.

Fairhill Partners contracts with Cleveland State University School of Nursing to train all if their Community Health Worker students to be Chronic Disease Self-Management leaders. In addition, it has contracted with the Ohio Department of Aging to Master Train staff, contractors, and volunteers.
We also deliver A Matter of Balance and the Self-Management Resource Center programs in partnership with two health systems.

As an Encore Initiative grantee, Fairhill Partners has collaborated with the Cleveland Foundation to recruit, train and deploy leaders and coaches and bring workshops to underserved Cuyahoga County neighborhoods. In addition, as a collaborator in a multi-agency CDC REACH grant, Fairhill Partners is working to train leaders and coaches in communities where access to health care is a challenge. In collaboration with the City of Cleveland Department of Aging and EMTs, Fairhill Partners delivers fall-prevention workshops in areas of most need.

Fairhill Partners also has collaborated in multiple research projects on the effectiveness of evidence-based programs.

**Successes:**

Fairhill Partners continues to grow its evidence-based programs in Northeast Ohio. In 2018 Fairhill engaged and empowered more than 1,000 participants in one or more evidence-based programs in urban, suburban, and rural areas. In addition, it trains both older adult volunteers and paid staff as Master Trainers who are able to train staff and volunteers to be leaders and coaches of the workshops.

**Lessons learned:**

- Outside of securing payment per person or per workshop, the single greatest challenge working with health systems and/or payors is how to increase “uptake” from referral to showing up at a workshop.
- A related issue is the system/providers frustration when they finally get 6 or 7 people to a workshop and you must tell them, sorry the minimum number of participants to start with session one is 8 or 10.
- Securing BAAs with health care providers/systems/payors can be tedious. Things get bogged down in the respective legal departments. We have successfully executed three BAAs.

**Recognition/References:**

Fairhill has been included in several articles in local publications, such as Boomer Magazine, Shaker Life, Heights Observer, and Crain’s. Our evidence-based work has also been discussed live on WCPN, local NPR affiliate and Channel 20 feature.

**Program Contact:** Stephanie FallCreek, DSW

**Email:** SFallCreek@fairhillpartners.org

**Phone Number:** (216) 421-1350

**Website:** [http://fairhillpartners.org](http://fairhillpartners.org)
Organization: Elder Services of Merrimack Valley and North Shore

Organization Description:

Elder Services of the Merrimack Valley and North Shore, Inc., a private non-profit agency, was incorporated in 1974 to serve older residents living in the Merrimack Valley and North Shore. Our mission is to ensure that choices of programs and services are available and accessible to meet the diverse needs and changing lifestyles of older adults. We believe home-based care, community services, and supportive living programs maintain the dignity of human life by promoting self-determination and by encouraging the maximum independence of the people they are designed to serve. We are respected as a leader in the field of elder care and have demonstrated our commitment to older adults through our advocacy, education efforts and innovative programs. Elder Services is staffed by 300 full and part-time professionals who specialize in working with older adults, their families and community agencies, other non-profit/public agencies, and over 400 volunteers involved in various elder care services.

History:

Elder Services began implementing evidence-based programs in 2006, starting with the Stanford Chronic Disease Self-Management Program. We opted to being offering evidence-based programs primarily because of the evidence demonstrating improved patient activation and improved health. It was also important that these programs could be offered by trained lay leaders, including peers and volunteers, so that the programs could be more easily sustained than programs requiring clinicians. Since 2006, we have added multiple other programs, including but not limited to, Diabetes Self-Management, Pain Self-Management, Cancer Thriving and Surviving, A Matter of Balance, Healthy IDEAS, and Enhanced Wellness.

Partners and Funders:

Elder Services is the Aging Services Access Point (ASAP) under contract with the Executive Office of Elder Affairs and the designated Area Agency on Aging for the Merrimack Valley. In addition, Elder Services manages several contracts/programs for Mass Health, private foundations, and public organizations. We directly manage and/or fund over forty (45) different programs, contract with over 65 community agencies, and oversee 120 contracts chosen for quality and cost. Most of these programs and services are targeted to elders in the greatest economic and social need.

Successes:

ESMV has formed the Healthy Living Center of Excellence (HLCE), a collaborative of 90 community-based organizations across Massachusetts with a goal of integrating long-term support services such as evidence-based programs into health care delivery systems. Among the documented successes of the HLCE are: (1) Training of over 600 program leaders in evidence-based programs; (2) serving as the
Statewide Training and Technical Assistance Center for Chronic Disease Self-Management programs for ten years; (3) Achievement of all deliverables under various Federal grants focused on healthy aging programs; (4) Serving as the training and technical assistance arm of the Department of Public Health’s Prevention and Wellness Trust Fund; (5) Exceeding reach targets under ARRA funding by more than 21%; (6) Becoming the first collaborative in the nation accredited by American Association of Diabetes Educators for reimbursable diabetes management offered by community health workers in community settings; (7) Selection of ESMV as one of the first organizations to test new ways to improve care for people with Medicare as part the Community Based Care Transitions Program; (8) Serving as the National Training Center for Healthy Eating, an evidence-based nutrition program;

Lessons learned:

In assessing ongoing barriers and challenges, HLCE has developed the following key learnings: • The HLCE programs and services are now accepted as a valuable resource to health care partners. The challenge is that the traditional means of referring patients into such programs require reengineering approaches since the primary care providers have little time and ability to integrate this into their practices. Further work is necessary to refine referral processes; • Additional work is necessary to reach health care partners not yet engaged and demonstrate the value proposition of these programs; • Significant opportunities outside of health care existing in expanding the training and technical assistance capacity of the HLCE

Program Contact: Jennifer Raymond, JD
Email: jraymond@esmv.org
Phone Number: 978-946-1298
Website: http://healthyliving4me.org
Organization: Florida Health Network

Organization Description:

Florida Health Network (FHN) is an associated organization of Health Foundation of South Florida (HFSF). FHN represents the 11 Planning and Service Areas in the State of Florida and partners with the 11 Aging and Disability Resource Centers and their provider network. In collaboration with numerous partners, FHN delivers a diverse menu of evidence-based programs proven to improve health outcomes and to decrease health care cost. FHN has a total of eleven Health and Wellness Hubs with a grand total of 54 satellite hubs offering a menu of evidence-based programs and building sustainable partnerships in their communities.

History:

FHN menu of services includes three categories of programs: 1) Stanford self-management education programs in English, Spanish and Haitian Creole; 2) Falls prevention and balance/strength training including: Matter of Balance: A Lay Leader Model (English, Spanish); Tai Chi for Arthritis and Falls Prevention; EnhanceFitness and Walk with Ease (English, Spanish); and 3) Health coaching (one-on-one) self-management support including: EnhanceWellness and PEARLS HFSF began supporting a wide range of evidence-based programs in 2008. Its focus and partners were initially in South Florida and in 2014 became Florida Health Networks with statewide partnerships.

The decision was made based on the following factors:

• Epidemiological profile of older adults.

• Identified priority areas in epidemiological review: self-management; falls prevention and physical activation; and depression management.

• Gap analysis in the geographical area showed desert of evidence-based health and prevention programs in priority areas

• Explored evidence-based programs that would have the greatest impact in the health and wellbeing of older adults in the community

• Decided on a menu of evidence-based programs that were available, had robust replication manuals, trainings and support to take them to scale in the community.

Partners and Funders

The partnership with a network of community-based programs started in 2008 with Health Foundation’s nationally recognized Healthy Aging strategic initiative and the Foundation’s investment of $7.5 million from the Foundation’s Endowment. Since 2014 two ACL grants were awarded to build the statewide
capacity to deliver evidence-based CDSME and falls prevention programs. Presently FHN holds a contract with a Medicare Advantage Group and have a second one under negotiation. FHN partners with Aging and Disability provider networks and their network of community-based organizations.

**Successes:**

Health Foundation contracted with an external evaluation team to track the successes of HARC. The local evaluation team used the Re-Aim framework and following are highlights from their six-year report: The total number of workshop attendees from all programs over all six years was 40,365. Since individuals could take and participate in multiple evidence-based programs yearly, a total participant (unduplicated) count was 29,817. On average, 30% of participants participated in two or more programs yearly. HARC programs have been offered in 420 unduplicated sites throughout Broward, Miami-Dade, and Monroe Counties. When examining the number of sites, LHP/TCS and MOB/ADE were offered in the most sites throughout South Florida with 266 and 258 sites. Additionally, the most common site used was a public meeting space such as a community center, park, or library. Across all programs, over the seven-year period of program implementation, participants reported an increase from pre-test to post-test healthy behaviors and skills. Participants in the self-management programs, LHP/TCS, DSMP-E/DSMP-S, reported significant increases in being able to use self-management techniques. In EF, there were increases in participants’ strength and functional mobility as measured with chair stands, arm curls with weights, and time to complete an eight-foot circuit. MOB/ADE programs showed improvements in participants’ confidence to avoid fall-related injuries and exercise at least three times a week. For HI, participants who received all components of the intervention showed decreased depressive symptoms.

**Lessons learned:**

In assessing ongoing barriers and challenges, FHN has developed the following key learnings:

- Health plans are very complex organizations with complex decision making, so when they see a proposal to deal with a chronic disease, they tend to fall back on their poor experience with disease management and, as a complex organization, it is hard to get a fair hearing. Medicare Advantage Plans (MAPs) understand they need to look for new models of service delivery in order to meet the CMS goals. This does not mean that MAPs are ready to fully sign on to this new process, but it does mean that external factors are forcing them to begin looking for solutions.
- Properly organized and managed, community-based services have the potential to achieve what traditional medical providers have not been willing to achieve. Working as a network has enabled Florida to brand the work of ADRCs as Wellness Providers. Aging and Disability Resource Centers around the State have different histories adopting and implementing evidence-based programs. Working as a network has enabled us to move as a learning collaborative and given each partner the opportunity to learn from each other and build their capacity.
- Aging and Disability Resource Centers have understood the urgent need of branding the work of ADRCs as Wellness Providers.

**Program Contact:** Carol N. Montoya
**Email:** cnmontoya@flhealthnetworks.org
**Phone Number:** (305) 804-9767
**Website:** www.floridahealthnetworks.org
Organization: Sound Generations

Organization Description:

Sound Generations (formerly Senior Services) is the most comprehensive non-profit multi-service organization serving older adults in Washington State. Established in 1967, we promote positive aging for thousands of seniors and their families each year through our integrated system of quality programs and senior centers. More than 2,500 volunteers, together with 200 employees, make our work possible and efficient. As an organization, undoing institutional racism, removing barriers to service, and focusing on the underserved in King County’s refugee, immigrant, and communities of color remain top priorities.

History:

Sound Generations holds a unique place in evidence-based work. We are a multi-service organization delivering a suite of EBLC programs in King County, WA, while simultaneously managing the research, implementation and scaling of our Project Enhance programs. Project Enhance’s Enhance®Fitness (EF) and Enhance®Wellness (EW) are the heart of our Health & Wellness department. EF, a low-cost, evidence-based group exercise fall prevention program, helps older adults at all levels of fitness become more active, energized, and empowered to sustain independent lives. Based on the Chronic Care Model, EW’s participant-centered approach uses motivational interviewing techniques and validated assessment tools in multiple domains to guide health action plan creation and accountability. These award-winning programs are currently implemented to support healthy living at over 75 sites locally and in 44+ states nationally. We also deliver complementary, evidence-based programs throughout King County, including A Matter of Balance, PEARLS, Living Well with Chronic Conditions (CDSMP), Diabetes Self-Management Program, Chronic Pain Self-Management Program and Powerful Tools for Caregiving.

Project Enhance has two decades of experience in data collection, data management, and analytics, specifically for evidence-based programs. In 2011, we replaced our centralized paper-based data management process with the launch of an online multi-tenant data entry system. This system now maintains a dataset for our programs that goes back to 1997, including uniquely-identified demographic and program activity and outcomes data for over 100,000 unduplicated participants. We currently support more than 750 licensed system users at approximately 400 organizations nationwide who use these systems to manage and report on their own implementations of EF and EW. Based on the success of these systems, Sound Generations has been contracted to develop, manage, and support systems for other evidence-based programs, including Maine Health’s A Matter of Balance, University of Washington’s PEARLS, and the suite of evidence-based falls prevention programs offered nationally by US HHS Administration for Community Living grantees. Providing high-quality, user-friendly data management and reporting tools for evidence-based programs is a major strategic focus of Project Enhance.
Partners and Funders

Sound Generations Health & Wellness enjoys strong partnerships with a diverse set of partners. We have experience working with governmental and non-governmental organizations, locally and nationally. Some of our partners include:

- CDC’s Arthritis Program
- National Council on Aging
- YMCA of USA
- State government agencies
- University of Washington, Health Promotion Research Center
- University of Washington, Rehabilitation Medicine
- Kaiser Permanente of Washington
- American Specialty Health’s Silver&Fit

EnhanceFitness sites receive reimbursement as a Kaiser Permanente of Washington (KPWA) Medicare Advantage Plan product offering. KPWA provides reimbursement for each plan participant class session attended. Similarly, class sites nationally can sign up for the Silver and Fit program at no charge and receive direct reimbursement from American Specialty Health for session attendance. Reimbursement offsets fitness instructor fees and provides sustainability for affiliate organizations.

Successes:

Since the years following the original study, from 1999 to today, EF has been offered in 47 states plus the District of Columbia, at over 1,300 locations under more than 300 licensed organizations. In 2013, the Y of USA became a national dissemination partner. In 2015, American Council on Exercise became a national continuing education partner. As of December 2018, EF has served over 90,000 unduplicated participants. Since 1998, EW has been offered in 11 states at 33 licensed organizations. As of December 2018, EW has served over 8,500 participants. (Note: Health outcome successes are detailed in our EBLC Program pages.)

Lessons learned:

- Desire for collaboration and partnership linking community-based organizations (CBOs) and clinical healthcare is strong
- Provider transition and referral processes need to be well understood and may need to be retooled to include external program information/connections to CBOs
- Security of patient/participant information requires input of Legal and IT departments of both organizations to integrate systems

Recognition/References

EnhanceFitness:
- US HHS ACL Title IIID evidence-based Physical Activity and Fall Prevention program
- CDC Arthritis Program (CDC-AP) designated “arthritis-friendly” evidence-based intervention

EnhanceWellness:
- Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) Legacy Program
- US HHS Agency for Healthcare and Research Quality Health Care Innovations Exchange Innovation that improves Quality and Reduces Disparities
- US HHS ACL Title IIID evidence-based Chronic Disease Self-Management Education program.
Project Enhance national awards include:

- International Council on Active Aging, 2006 Industry Innovators Award
- US DHHS Secretary’s 2005 Innovation in Prevention Award, Non-Profit Category
- US Administration on Aging, You Can! Program Champion, 2005
- NCOA/Health Promotion Institute, 2004 Best Practice Award

Program Contact: Paige Denison
Email: paiged@soundgenerations.org
Phone Number: 206-268-6739
Website: [www.soundgenerations.org](http://www.soundgenerations.org) and [www.projectenhance.org](http://www.projectenhance.org)