Over many years, a number of academic/community partnerships have worked independently to develop, evaluate and bring to scale participant-centered, evidence-based self-management and health promotion programs offered in community settings for older Americans. Many of the programs developed by these partnerships have since become critical pieces of the infrastructure that supports older adults with chronic health conditions. Indeed, community-based self-management support is an integral component of the Chronic Care Model. This model presents elements that can improve health outcomes for people with chronic conditions, highlighting the need for connections between healthcare and community resources, integrating patient-centered, evidence-based services that empower patients. And while these programs have succeeded in finding their place in this system working independently so far, the growth and maturation of the programs, combined with the changing environment of healthcare, have prompted new collaboration among the organizations that manage and disseminate these programs. Specifically, the creation of the Evidence-Based Leadership Collaborative (EBLC).

The Evidence-Based Leadership Collaborative (EBLC) is currently a group of thirteen individuals representing a total of 20 evidence-based programs (CAPABLE, Chronic Disease Self-Management suite of Programs, Matter of Balance, EnhanceFitness, EnhanceWellness, Healthy IDEAS, PEARLS, Fit & Strong!, HomeMeds, and Healthy MOVES) as well as five leaders from organizations providing multiple evidence-based programs (Florida Health Networks, Tarrant County Area Agency on Aging (TX), Elder Services of the Merrimack Valley (MA), Fairhill Partners (OH), and Open Hand (CA)). EBLC members are employed by community-based organizations, foundations, healthcare systems, universities and governmental entities and have been directly involved for many years in the development, evaluation and scaling of their individual programs as well as implementation through community-based organizations. The individual program developers met informally for several years and in 2012 formed the EBLC. In 2013, community-based organization leaders responsible for implementing multiple evidence-based programs were asked to join and be part of
All the programs represented by EBLC program developers meet the Administration for Community Living’s (ACL) criteria for highest level of evidence. In addition to the ACL, the Centers for Disease Control and Prevention (CDC) Arthritis Program, Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidence-Based Programs and the Agency for Healthcare Research and Quality Innovations Exchange recommend these programs and find them to be the strongest of evidence-based programs. The programs represented by the EBLC are utilized by more than 2,000 agencies in the United States with nearly 400 agencies using more than one program. The mission of the EBLC is to increase delivery of evidence-based programs that improve the health and wellbeing of diverse populations. Together, the council represents more than 300 combined years of experience in developing, evaluating, scaling, implementing and sustaining evidence-based self-management programs. All of the programs have proven effectiveness in published scientific research and all programs have been brought to scale. The EBLC is committed to the following values: • Person Centeredness – individuals are actively involved in programs and making a difference • Effectiveness – evidence-based programs focus on outcomes/results • Collaboration – multi-sector, multi-organizational and interdisciplinary (belief that health is achieved in the community, close to home and through broad-based collaborations) • Equity and access – social justice, respect of diversity • Sustainability These values will guide the EBLC as it works towards it’s vision of an ever increasing number of adults engaged in evidence-based programs that inform, activate and empower them to measurably improve their health and maintain independence.

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Program: Chronic Disease Self-Management Program

History:

In 1992, Stanford University School of Medicine received five-year research grants from the federal Agency for Health Care Research and Policy and the State of California Tobacco-Related Diseases office. The purpose of the research was to develop and evaluate, through a randomized controlled trial, a community-based self-management program that assists people with chronic illness. The study was completed in 1996. Following this, a second study was conducted within the Kaiser Permanente Health Care System. The Program was written by Dr. Kate Lorig, Virginia González MPH, and Diana Laurent MPH, along with Halsted Holman MD, Stanford Professor of Medicine; David Sobel MD, Regional Director of Patient Education for the Northern California Kaiser Permanente Medical Care Program; Albert Bandura PhD, Stanford Professor of Psychology; and Byron Brown Jr PhD, Stanford Professor of Health Research and Policy. The program was administered by Stanford until 2017 when it was transferred to the Self-Management Resource Center. From the very beginning, people with chronic conditions helped formulate the program content. In all, 22 focus groups were held and participants were often consulted to make the program better. The process of the program was based on self-efficacy theory. More than 25 years later, there are many studies. The program has been updated four times, always based on feedback from participants and leaders, the latest national standards and self-efficacy theory. Over the years, approximately 1 million people have participated in the program.

Program Description:

The Chronic Disease Self-Management Program (CDSMP) is a workshop given once a week, for six weeks, for two and a half hours per session. Workshops take place in community settings such as senior centers, churches, libraries and hospitals.

There are three core skills, action-planning, problem-solving, and decision-making, as well as tips and tools for dealing with 1) fatigue, sleep, pain, difficult emotions and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) and healthy eating.

The process in which the program is taught is what makes it effective. Classes are highly participative, where mutual support and success build the participants’ confidence in their ability to manage their health and maintain active and fulfilling lives. Workshops are facilitated by two highly-trained leaders, one or both of whom are non-health professionals with chronic diseases themselves. These facilitators
are often-times volunteers, and all have attended an intense 24-hour training that includes reviews of the entire workshop content, practice teaching and working through scenarios concerning problems that might occur in workshops. The leaders facilitate the workshop from a highly detailed manual. People with a variety of chronic health problems, including mental health problems, attend the workshops together. Each participant in the workshop receives a copy of the companion book, Living a Healthy Life with Chronic Conditions.

**Program Outcomes:**

Original research (1) showed that the treatment group demonstrated significant improvement:

- In all four health behavior variables ($P < 0.01$)
  - Number of minutes per week of stretching/strengthening and aerobic exercise
  - Increased practice of cognitive symptom management
  - Improved communication with their physician.

- In five of the health status variables ($P < 0.02$)
  - Self-rated health
  - Disability
  - Social/role activities limitation
  - Energy/fatigue
  - Health distress. The treatment group also had fewer hospitalizations ($P < 0.05$) and spent, on average, 0.8 fewer nights in the hospital ($P = 0.01$).

**Availability:** The CDSMP is available in English, Spanish, French, Chinese, Italian, Japanese, and many other languages. There are three evidence-based adaptations of the program. One for use in workplaces, the Workplace Chronic Disease Self-Management Program (wCDSMP) and one that is delivered as a mailed tool kit, and a third is Better Choices Better Health that is delivered online.

**Program References:**


6. Ory MG, Ahn S, Jiang L, Smith ML, Ritter PL, Whitelaw N, Lorig KL. Successes of a national study of the chronic disease self-management program: Meeting the triple aim of health care reform. Med Care: 51(11):992-8, 2013 Nov View abstract In all there have been more than 40 studies.

For further studies see https://www.selfmanagementresource.com/resources/bibliography/cdsmp

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Program: Diabetes Self-Management

Program History:

The Diabetes Self-Management Program (DSMP) was first developed in Spanish at Stanford University School of Medicine. A study was conducted funded by the National Institutes of Health. After showing successful outcomes, Stanford received a grant from the California HealthCare Foundation for a randomized, controlled study to test the workshop's effectiveness for English-speakers. The study was completed in 2008. Recently a third large study was conducted by Stanford, the National Council on Aging and Anthem. In 2017 the program was transferred to the Self-Management Resource Center. Program content meets all standards of the American Diabetes Association and in approximately 25 places the program has been accredited by ADA or AADE and is eligible for Medicare reimbursement. The program does not conflict with existing programs or treatment. There are no recommendations for medical treatment; participants are referred to their physicians or diabetes educators. If the content of the workshop conflicts with instructions they receive elsewhere, they are advised to follow their physician’s orders and discuss discrepancies with the physician. The program is continually updated to meet the current ADA standards and there have been two major updates. The program is available in English, Spanish, Chinese and a few other languages. It has been adapted for use on the Internet.

Program Description:

The Diabetes Self-Management Program (DSMP) is a workshop given once a week, for six weeks, for two and a half hours per session. Workshops take place in community settings such as senior centers, churches, libraries and hospitals. Physicians, diabetes educators, dietitians, and other health professionals continually reviewed all workshop materials.

There are three core components: action-planning, decision-making, and problem-solving. Subjects covered include: 1) techniques to deal with the symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear and frustration; 2) healthy eating; 3) appropriate exercise for maintaining and improving strength and endurance; 4) appropriate use of medication; 5) working more effectively with health care providers; 6) balancing blood glucose, 7) preparing for sick days, and 8) recognizing and dealing with hypoglycemia.

The process by which the program is taught, based on self-efficacy theory, is what makes it effective. Workshops are highly participative, where mutual support and success build the participants’ confidence in their ability to manage their diabetes and maintain active and fulfilling lives. Workshops are facilitated by two highly-trained leaders, one or both of whom are non-health professionals with
diabetes themselves. These facilitators are often-times volunteers, and all have attend an intense 24 hour training that includes reviews of the entire workshop content, opportunities to practice teach and working through scenarios of problems that might occur in the workshops. The leaders facilitate the workshop from a highly detailed manual. Each participant in the workshop receives a copy of the companion book, Living a Healthy Life With Chronic Conditions.

**Program Outcomes:**

Original research (1) shows that six months after the workshop, participants had significant improvements in A1C, depression, symptoms of hypoglycemia, communication with physicians, healthy eating, and reading food labels (P < .01). They also had significant improvements in patient activation and self-efficacy. At 12 months, DSMP intervention participants continued to demonstrate improvements in depression, communication with physicians, healthy eating, patient activation, and self-efficacy (P < .01). In a more recent study, participants demonstrated one-year reduction in A1C, depression, symptoms of hypoglycemia, and an increased adherence to medication receiving recommended laboratory tests. There was also an $832 reduction in costs compared to matched controls.

**Program References:**


View article For further studies see https://www.selfmanagementresource.com/resources/bibliography/diabetes Program

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Program: EnhanceFitness

Program History:

In 1994, researchers at the University of Washington Health Promotion Research Center (UW HPRC) and Group Health Cooperative (a health maintenance organization) collaborated with Sound Generations (formerly Senior Services) a non-profit community-based organization, to conduct a trial of a multicomponent disability prevention program. One hundred older adults were recruited for a 6-month study at a Washington State senior center. Evaluative measures showed that the intervention group significantly improved on several health-related and functional measures compared to the control group. Following completion of the study, Sound Generations was chosen to hold the license for the program and oversee its dissemination to additional sites. Sound Generations’ dissemination strategy has been to license, train, and support community-based delivery sites that adopt EnhanceFitness. In 2013, Y of USA was licensed as a national partner and in 2015, American Council on Exercise (ACE) collaborated with EnhanceFitness in development of an online continuing education program focused on chronic disease and safe exercise instruction for EnhanceFitness instructors. This strategy has been quite successful in balancing the need to maintain fidelity to the program’s protocols with the mission to expand the program’s reach in a sustainable way.

Program Description:

EnhanceFitness is an ongoing class, held three times per week in hourly sessions. Classes include exercises commonly used to build and maintain physical health in older adults – cardiovascular endurance work, dynamic and static balance movements, strength training, and stretching exercises. Strength training focuses on both the upper and lower body muscles, using soft cuff wrist and ankle weights. Cardio training can range from walking for 20 minutes to having 20 minutes of aerobic exercises, with (optional) music. Classes are appropriate for near frail to more active adults with exercises adapted for those who are more frail. For example, exercises can be completed while sitting rather than standing. The class is led by a certified fitness instructor who also completes a 12 hour in-person training led by an EnhanceFitness Master Trainer. Class sizes depend on available space but are never larger than 25. Typical class sizes range from 10 to 15 participants.

Program Outcomes:

The original research study (2) showed a: • 13% improvement in social function; • 52% improvement in depression; • 35% improvement in physical functioning. Members of the control group, who did not participate in the program, but who attended other senior center activities, deteriorated in these
measures over the same period (2). A 2013 retrospective study (3) found that: • EF participation was associated with an estimated total medical cost savings of $945 (95% CI: $1,480, $411) p=.05. Specifically, participants in an unplanned inpatient setting saw savings of $545 (95%CI: $817, $272) and those in a skilled nursing facility setting saved $139 (95% CI: $276, $3). • EF participation helped decrease unplanned hospitalizations; one unplanned hospitalization was prevented during the outcome period for every 20-25 participants. • Participants saw a decreased mortality rate; 1.4% versus 2.9% among controls. A 2015 study Group Health Research Institute Study (4) found that: • In fully adjusted Cox proportional hazards models, consistent (hazard ratio [HR], 0.74; 95% confidence interval [CI], 0.63–0.88) and intermittent (HR, 0.87; 95% CI, 0.8–0.94) EnhanceFitness participation were both associated with a reduced risk of falls resulting in medical care. Consistent use of EF was associated with the greatest reduction in risk of a medical fall, lowering risk by 20% to 30%.

Program References/Recognition:

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


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Program: EnhanceWellness

History:

In 1995, researchers from the Center for Health Studies, Group Health Cooperative of Puget Sound, began an evaluation of the impact of a 1-year, senior center-based chronic illness self-management and disability prevention program on health, functioning, and healthcare utilization in frail older adults. Evaluation of the program, EnhanceWellness (formerly the Health Enhancement Program), followed 201 disabled adults, aged 70 and older, to track improvements in their performance of activities of daily life (ADL). The results, later published in the Journal of the American Geriatrics Society (1), showed that the program led to improved ADL functioning in those who were disabled and thereby offered a promising strategy for limiting or reversing functional decline in disabled older adults. Following completion of the study, Sound Generations (formerly Senior Services) was chosen to hold the license for the program and oversee its dissemination to additional sites. Sound Generations’ dissemination strategy has been to license, train, and support community-based delivery sites that adopt EnhanceWellness. It has a software program, Enhance®WellWare, to guide staff through the service process as well as provide reports for the participant, staff and for funders.

Program Description:

Enhance®Wellness (EW) connects participants with a personal health and wellness coach (sometimes called “counselor”) to improve physical, emotional and social well-being. 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. Using problem-solving strategies, participants clarify goals, responsibilities and activities as they work toward health-related behavioral change. This program works well as a hub to refer to other health promotion interventions and resources. EnhanceWellness happens in three steps: screen, plan, and action: • An EnhanceWellness screen identifies personal strengths and risks. Together the EnhanceWellness coach and the participant review a detailed health questionnaire. • The action plan focuses on areas the participant chooses to work on and with consent, may be shared with the participant’s health care provider • The participant then moves into action with the support of their EnhanceWellness coach, who offers ongoing encouragement, feedback, and monitoring. Additional services may include problem solving, health education, and referral to support groups, including individual and family counseling, if indicated. EnhanceWellness is a reliable complement to formal healthcare services for older adults. It
has been modified to a six-month program, unless the participant chooses to continue, selecting additional health challenges to work on.

Program Outcomes:

The original randomized control trial (1) results showed:

- The total number of inpatient hospital days during the study year was significantly less in the intervention group compared with controls (total days = 33 vs 116, P = .049), (i.e. 72% decrease in hospital days).
- The number of hospitalized participants increased by 69% among the controls and decreased by 38% in the intervention group (P = .083).
- 35% decrease in psychoactive drugs

Further research (2) found, fewer participants were:

- Depressed (8.8% vs 15.9%)
- Physically inactive (15.8% vs 38.6%)
- High nutritional risk (24.3% vs 44.1%)
- Experiencing restricted activity days (35% vs 48%)

Preliminary results in current National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) funded research (3) with participants aging with physical disability shows improvements in satisfaction with social role, self-efficacy for disability management, pain interference, fatigue, depression, anxiety, sleep disturbance, physical function, physical activity and fall efficacy.

Program References:

- 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.


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Program: Fit & Strong!

History:

Fit & Strong! was developed by researchers and exercise experts at the University of Illinois at Chicago who found in previous work that osteoarthritis (OA) is the leading cause of disability among older adults. People who have OA can have painful lower extremity joints; as a result, they often become sedentary and de-conditioned. To reverse this trend, Fit & Strong! provides a tailored multi-component exercise program that is coupled with health education for disease management for this population. Fit & Strong! is currently offered to thousands of older adults by providers in 27 states. Fit & Strong! helps participants to: 1) gain a clear understanding of what OA is and how an exercise program that is tailored to their needs can help them manage arthritis symptoms; 2) learn to safely and effectively perform exercises that gradually increase in frequency, duration, and intensity over time; and 3) develop a tailored, multiple component physical activity routine that is sustainable after the program ends. Fit & Strong! has been rigorously evaluated in an RCT with 200+ participants, in a long-term effectiveness trial, and in a dissemination study. Significant findings are presented in the Program Outcomes Section. The program is licensed by the University of Illinois at Chicago and is based in the University’s Center for Research on Health and Aging where staff work with providers to disseminate the program across the United States, and more recently, globally.

Program Description:

Fit & Strong! meets three times per week for eight weeks. Each session lasts for 90 minutes. The first 60 minutes are devoted to exercise (flexibility, aerobic, and progressive lower extremity strength training), and the last 30 minutes are devoted to a structured health education/group problem-solving curriculum that motivates participants to use physical activity to manage their arthritis symptoms. In week six participants meet with the instructor to negotiate individualized exercise adherence contracts that foster ongoing maintenance of a balanced physical activity routine of their choice after the 8-week program ends. Fit & Strong! classes are appropriate for older adults who have lower-extremity joint pain and stiffness related to OA or other lower extremity mobility/balance challenges. Classes are led by either nationally certified exercise instructors or by persons who have served as successful instructors for other group evidence-based health promotion programs.
Program Outcomes:

A randomized controlled trial (1) compared the effects of participation in Fit & Strong! (N = 115) to a control group (N = 110) at baseline, two, six, and 12 months following randomization. Program participants showed statistically significant improvements relative to the control group, at two months (end of formal program) in:

- Confidence in their ability to exercise safely with arthritis (78% increase)
- Participation in exercise (86% increase) and
- Lower extremity stiffness (33% increase)

These benefits were maintained at six months, at which time participants experienced the additional significant benefits of increased confidence in their ability to adhere to exercise over time, a significant decrease in lower extremity joint pain, and a marginally significant increase in their confidence in their ability to manage arthritis pain (2).

At 12 months, significant benefits were maintained on confidence to exercise safely with arthritis and continued exercise participation that were accompanied by marginally significant reductions in lower extremity stiffness and pain.

Effect sizes for the efficacy and physical activity engagement outcomes were strong at all time points. A large effectiveness trial (3) with 534 participants also found a significant increase in physical activity over baseline levels at two months that was maintained at 18 months, and accompanied by maintenance of significant improvements over the same time period in:

- Lower extremity joint stiffness, pain, and function
- Lower extremity strength (timed sit-stand test)
- Mobility (6-minute distance walk)
- Anxiety and depression

Findings from a comparative effectiveness trial evaluating a new physical activity plus weightmanagement version of Fit & Strong! are now available, demonstrating benefits of the new program on weight and joint paint and function outcomes at two months that were maintained at six months (4). In addition to the weight-management version, Hispanic, and low-vision versions of Fit & Strong! have also been tested. The Hispanic version showed improvements in lower extremity strength and lower extremity pain, stiffness, and function at two months that were maintained at six months (5).

Program References:


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Program: Healthy IDEAS

History:

About 15-20% of US adults aged 65 and older experience depressive symptoms such as sadness, inactivity, trouble concentrating or making decisions, and sleep problems. Not only does depression negatively affects the quality of life of older adults, it can be life threatening. Home- and community based service providers especially care coordinators and case managers, typically serve the older adults at greatest risk of having undetected and untreated depression: those who have multiple chronic health problems and functional disability, lack financial resources, and are socially isolated. Responding to this public health need in 2002, the Healthy IDEAS program was developed through an academic-community partnership led by interdisciplinary faculty at Baylor College of Medicine and the Houston VA Health Services Research Center and leaders of Care for Elders community agencies.

The program aimed to:
- Reduce the severity of depressive symptoms in older clients of community agencies
- Reach frail, high-risk and diverse older adults, often overlooked and under-treated
- Train agency staff to provide and deliver an evidence-based intervention for depression to older adults in their caseloads
- Improve linkages between community aging service providers and healthcare professionals through appropriate referrals, better communication and effective partnerships.

Program Description:

Healthy IDEAS (Identifying, Depression, Empowering Activities for Seniors) is an evidence-based program that incorporates four evidence based components into the ongoing delivery of care-management or caregiver-support services to older individuals in the home environment:
- Screening for symptoms of depression and assessing their severity
- Educating older adults and caregivers about depression
- Linking older adults to primary care and mental health providers
- Empowering older adults to manage their depression through a behavioral activation approach that encourages involvement in meaningful activities

It is implemented over a 3-6-month period, through at least three face-to-face visits in the client's home and at least three telephone contacts. Healthy IDEAS ensures older adults get the help they need to
manage symptoms of depression and live full lives. Thus, clients with more severe depression symptoms may require more contacts or attention beyond an initial intervention period. With support from his/her care manager, each client chooses realistic goal(s) to obtain positive outcomes (e.g., pleasure, feelings of accomplishment) and to decrease negative outcomes (e.g., feeling sad, tired, lonely).

**Program Outcomes:**

Healthy IDEAS is a national model with measurable results and demonstrated benefits for older adults, service providers and community mental/behavioral health practitioners. Evidence of effectiveness to decrease functional disability associated with depression was demonstrated by the program evaluation.

Older Adults (at 6 months) (1):
- Significantly more participants knew how to get help for depression (68% versus 93%) (p=.0033)
- Reported increasing activity helped them feel better (72% versus 89%) (p=.0332)
- Reported reduced pain (16% versus 45%) (p=.003)
- Fewer symptoms of depression (p<.01)
- Better ability to recognize and self-treat symptoms (p=.0174)
- Improved well-being through achievement of personal goals (p=.0020)

Participating community agency providers completed anonymous surveys after program implementation and reported the following (2):
- Service Providers experienced:
  - Expanded capacity to address depression
  - Better communication and stronger partnerships with mental health providers
  - Opportunity to deliver a proven, successful program that addresses critical client needs
  - Improved staff knowledge and confidence in helping clients
- Community Mental/Behavioral Health Partners experienced:
  - Increased opportunity to work with diverse populations of older adults
  - Strengthened connections to community agencies

**Program References:**

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Program: Healthy Moves

Program History:

Physical activity for older adults has tremendous benefits and is recognized as one of the most powerful health promotion interventions to improve seniors’ ability to function and remain independent in the face of active health problems. Unfortunately, few, if any programs, have been developed and evaluated that apply important research findings to in-home physical activity for older adults living in the community, especially very frail seniors. Additionally, care management programs have generally not addressed physical activity as part of their formal assessment and care planning. This is largely because there have been no clear and safe prescriptions for the frail. Healthy Moves was developed for the geriatric care management setting because in-home providers are natural vehicles for distributing health tools to the most high-risk seniors. With the right training and tools, care managers can enhance their scope of work by teaching their clients the Healthy Moves exercises at their visits.

Healthy Moves was created by Partners in Care Foundation, Inc., along with other community partners in southern California, to help older frail adults maximize their independence by building strength, increasing flexibility, and helping to reduce the risk of falls.

Program Description:

Healthy Moves is a simple and safe evidence-based physical activity program designed to enhance health outcomes for frail, high-risk, and diverse older adults receiving services in the home. The program utilizes care managers from community-based care management agencies to teach the program’s exercises to their older clients in their home. At their regularly scheduled visits, Care Managers partner with volunteer motivational coaches from the community and/or local universities to enroll clients into the program by assessing their ability and readiness to participate safely and by using motivational interviewing techniques to engage each client in setting a goal. Only a 15 minute session is needed with each client to encourage their identification of personal goals needed to be motivated to incorporate the movements into their daily routines.

The Healthy Moves program is an integrated model consisting of two evidence-based components:

1. Physical Activity Component: modeled and adapted from the Senior Fitness Test work of Rikli and Jones (1999)
2. Behavior Change Component: lifestyle change counseling method called Brief Negotiation developed by Prochaska and DiClemente (1983)

Guidelines concerning the number of repetitions per movement are distributed to all participating clients and they are encouraged by their care managers and motivational phone coaches to do the movements three to five days per week, multiple times per day. Trained motivational phone coaches contact the clients weekly or bi-weekly for a three month period to reinforce new behavior change.

The program incorporates a pre-test and three month post-test using a physical fitness assessment and self-rated health questions measuring changes in the level of pain, depression, fear of falling, number of falls, fall injuries, and readiness to increase physical activity.

**Program Outcomes:**

Implementation research conducted on Healthy Moves for Aging Well has shown:

- That participants (n = 338) had statistically significant declines in the number of falls and level of pain. These declines were found among participants who improved their exercise performance (1)
  - Pain was reduced from an average of 5.5 at pre-test to 5.1 at post-test (p=.04)
  - Falls were significantly reduced (p<0.0001): 7% had more than one fall prior to baseline: 3% had more than one fall at post test: 5% improvement in the number with no falls at all.
- A 76% client retention rate
- Significant improvement in both arm curls and step-in-place (p<.05)
- Decrease in depression (from n=484 to n=371)
- 78% of those who completed the study said they were very or somewhat likely to continue exercising without a motivational coach (2)

Results of a feasibility study showed most participants, including older adults, home care aides, and site directors had a positive perception and high satisfaction with the program. One hundred percent of older adult participants reported that they would recommend the program to others.

**Program References:**


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Program: HomeMeds

Program History:

Medication-related problems and errors endanger the lives and well-being of a high percentage of community-dwelling elders, leaving them with poorly controlled cardiac symptoms, or at risk for falls, dizziness, confusion, or other side effects. Data show that almost 50% of nursing-home eligible Medicaid waiver clients have potential medication problems, such as taking generic and brand name versions of the same drug or falls related to psychoactive medications. HomeMeds is designed to enable community agencies to address this important safety and quality of life issue.

• 1993-2003: The Visiting Nurses Association of LA (VNA/LA; now Partners in Care Foundation) was one of the first home health agencies to employ a pharmacist to support patients and field nurses. Vanderbilt University researchers later convened a national consensus panel of experts, led by Mark Beers, MD, to formalize protocols for such pharmacist/staff collaboration. The program, originally called the Medication Management Improvement System, was developed for elders receiving home health care and proven effective in a randomized, controlled trial. (Funded by the John A. Hartford Foundation.)

• 2003-2007: Partners in Care Foundation (Partners) adapted HomeMeds for care management and computerized the screening tool under AoA Evidence-Based Healthy Aging Program funding.

• 2006-2010: Disseminated statewide and then nationwide in care management programs for elders. (Funded by the John A. Hartford Foundation.)

Program Description:

HomeMeds is an evidence-based, technology-enabled intervention that addresses medication safety among older adults by connecting home and community-based services to health care providers. The program addresses major gaps in care that leave home-dwelling older adults at risk for adverse medication effects. HomeMeds has been implemented by social workers and nurses in a variety of programs for older adults, including care transitions, Meals on Wheels, and Medicaid waiver programs designed to help keep frail older adults safe at home. The HomeMeds system addresses four types of medication-related problems:

1. Unnecessary therapeutic duplication (e.g., generic and brand name of same drug)
2. Falls, dizziness, or confusion possibly caused by inappropriate psychotropic drugs (e.g., tranquilizers, antipsychotics, antidepressants, sleep aids, antihistamines)
3. Cardiovascular medication problems related to high blood pressure, dizziness, low blood pressure or low pulse.
4. Inappropriate use of non-steroidal anti-inflammatory drug (NSAIDs) in those with risk factors for peptic ulcer or gastrointestinal bleeding.

HomeMeds was adapted from its original home health model to enable social workers and other non-medical personnel to implement the system, which has contributed to dissemination efforts. Service coordination staff members work with a consultant pharmacist to (1) verify the accuracy and appropriateness of the client’s current medication list, (2) identify problems that warrant re-evaluation by the physician, and (3) follow through with the client and physician to resolve identified problems. A computerized risk screening and alert process, using the medication list and clinical indicators (vital signs, age, falls, dizziness and confusion) helps identify potential medication-related problems.

Program Outcomes:

The original randomized, control trial, conducted in 1993 by Vanderbilt University (1), found:
- Medication use improved in 50% of the intervention patients, compared to 38% of usual-care controls (p=.05) when a pharmacist helped home health staff.

AoA-funded study (2) of three California Medicaid 1915(c) waiver sites found:
- Of 615 clients screened, 49 percent (N=299) had at least one potential medication problem.
- Record review and consultation with the client led the pharmacist to recommend either: (a) Continuing the medications because they were necessary for pain or symptom control; (b) Collecting additional information regarding vital signs and other clinical indicators; (c) Verifying the dose and frequency with which the client was taking the medication and revising the medication list accordingly; or (d) Changing medications or dosage.
- It was determined that 29% of waiver clients had a medication problem serious enough for the pharmacist to recommend a change in medications, including re-evaluation by the physician. For this intervention group (N=118), 61% of recommended changes for all medication problems were implemented.
  - Therapeutic Duplication 62% change
  - Psychotropic with Falls or Confusion 54.2% change
  - Cardiovascular Problems 45.8 % change
  - NSAIDs 50% change

Program References:


A summary of the HomeMeds system is posted on the AHRQ Innovations Exchange website with a strong evidence rating. HomeMeds is also included

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Program: A Matter of Balance

Program History:

A Matter of Balance: Managing Concerns About Falls is a program designed to reduce the fear of falling and increase the activity levels of older adults who have this concern. It is based upon research conducted by the Roybal Center for Enhancement of Late-Life Function at Boston University. In October 2003, Southern Maine Agency on Aging, MaineHealth’s Partnership for Healthy Aging, Maine Medical Center Division of Geriatrics, and the University of Southern Maine School of Social Work received funding from the US Administration for Community Living (formerly the US Administration on Aging) to translate A Matter of Balance into a program that uses volunteer lay leaders instead of healthcare professionals as facilitators. The new lay-led format would serve as an innovative national model for addressing fall prevention.

The volunteer lay leader model utilizes trained lay people, called coaches, to conduct the class. The A Matter of Balance Volunteer Lay Leader Model reduces the cost of the intervention. Thus, the program can be offered more frequently and in a wider variety of settings, thereby reaching a significantly higher number of older adults.

Program Description:

A Matter of Balance is a community-based, small-group (8-12 participants) program that helps older adults reduce their fear of falling and increase activity levels. It is a train-the-trainer program with highly trained Master Trainers training the Coaches (lay leaders). Coaches work in pairs to lead small group community classes consisting of eight two-hour sessions. The program includes behavior change strategies, as well as practical exercises. The behavior change curriculum addresses the fear of falling, helping participants to view falls and the fear of falling as controllable. Exercises are introduced and performed in 6 of the 8 sessions. Participants are involved in group discussion, problem-solving, skill-building, assertiveness training, sharing practical solutions, and exercise training. Participants develop well-defined goals that address ongoing exercise, reducing risk factors, and changing behaviors, all of which contribute to long-term reduction in the fear of falling.
A Matter of Balance was designed to benefit community-dwelling older adults who:
• Are concerned about falls
• Have sustained falls in the past
• Restrict activities because of concerns about falling
• Are interested in improving flexibility, balance and strength
• Are age 60 or older, ambulatory and able to problem solve

Program Outcomes:

After completing A Matter of Balance:
• 97% of participants are more comfortable talking about fear of falling
• 97% feel comfortable increasing activity
• 99% plan to continue exercising
• 98% would recommend A Matter of Balance

Preliminary findings of the participant outcome evaluation indicate that there were significant improvements for participants regarding their level of falls management (the degree of confidence participants perceive concerning their ability to manage the risk of falls and of actual falls); falls control (the degree to which participants perceive their ability to prevent falls); level of exercise; and social limitations with regard to concern about falling. These measures indicate that the program has been successful to date in reducing the fear of falling by increasing participants’ confidence that they can manage falls risk better and actual falls if they occur and that they can take action to help reduce the risk of falling. In addition, participants indicated that their concerns about falling are interfering less with their social activity, and they report that they have increased their exercise levels (1).

A 2013 retrospective study by CMMS (2) of evidence-based programs found:
• Cost reductions in unplanned hospitalization, skilled nursing, and home health
• $938 decrease in total annual medical costs

Program References:

2. Report to Congress: The Center for Medicare and Medicaid Services’ Evaluation of Community-Based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act, September 30, 2013.

Program Contact: Patti League
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Program: PEARLS

Program History:

Between 1999 and 2003, University of Washington investigators at the Health Promotion Research Center (HPRC) and community-based service providers conducted a randomized controlled trial funded by the CDC to test the effectiveness of the Program to Encourage Active, Rewarding Lives (PEARLS) Program in older adults living in the community. The main objective of this trial was to determine the effectiveness of the PEARLS Program to improve how less severe forms of depression (minor depression or dysthymia) are recognized and treated in older adults living with social isolation, multiple chronic medical problems and physical impairment.

The study evaluated the impact of PEARLS on participants’ levels of depression, quality of life and healthcare utilization. One hundred thirty eight individuals took part in this study. All were 60 years or older, were relatively housebound, had an average of five chronic medical conditions, and received care from community senior service agencies in metropolitan Seattle. Those who were treated with PEARLS were three times as likely to reduce their depressive symptoms as those not treated with PEARLS.

Program Description:

PEARLS is designed to be part of existing community-based agencies that already deliver care and provide resources to clients. The program is provided at home, which overcomes limitations in ambulation or transportation that are common in the populations it serves. By providing “house calls” for depression, trained agency staff (called PEARLS counselors or coaches) teaches participants skills to more effectively tackle the things in their lives that overwhelm them, and to in turn, improve their depressive symptoms. PEARLS is delivered in 6 to 8 one-hour visits over the course of a 4- to 5-month period, with sessions tapered from weekly to monthly to give participants an opportunity to practice and learn the skills. PEARLS cases are reviewed regularly by a supervising psychiatrist who can also address other causes of depression and, when necessary, work with the client’s primary care provider to begin or adjust medication treatments. For individuals with major depression in particular, the initiation of antidepressant medications can be an important treatment component of the PEARLS Program. PEARLS is currently being disseminated by the Health Promotion Research Center.
The Three Key Components of PEARLS:

1. Problem solving treatment: Participants learn to recognize symptoms of depression, understand the link between unsolved problems and depression, and apply a highly effective 7-step approach to solving their problems.
2. Social and physical activation: Participants develop a plan to engage in activities that interest them, since involvement in social and physical activities improves quality of life and mood of people with depression.
3. Pleasant activity scheduling: Very often, depressed individuals find it difficult to initiate activities that are enjoyable. PEARLS participants work with their counselor to identify and participate in activities they find pleasurable, which helps them manage their depression.

Program Outcomes:

The original research study (1) showed the following outcomes 6-months after PEARLS ended:
- 43% of PEARLS recipients had a 50% or greater reduction in depression symptoms (vs. 15% of the usual care group).
- 36% of PEARLS recipients achieved complete remission from depression (vs. 12% of the usual care group).
- Significant health-related quality-of-life improvements in both functional and emotional well-being, for PEARLS participants compared to usual care participants.
- This outcome demonstrated a trend toward lower hospitalization rates among those who received the PEARLS Program (27%) compared to those who did not (35%).

A second randomized controlled trial study (2) was conducted in 2008-2010 with all-age adults (mean age 43) with epilepsy and co-morbid depression (70% had major depression). This study also found significant improvements in depressive symptoms and emotional well-being for PEARLS participants compared to usual care, up to one year after the intervention ended. The PEARLS group also significantly reduced their suicidal thoughts. The Health Promotion Research Center continues to partner with community-based organizations and PEARLS program participants to conduct research to improve PEARLS implementation and dissemination (3, 4).

Program References:


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