Evidence-Based Leadership Council

Program

Area Agency on Aging of Tarrant County

United Way of Tarrant County

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.

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 (MOB)
- 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 grant 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 pharmacists 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 get 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 expands 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.

Area Agency on Aging OF TARRANT COUNTY

United Way of Tarrant County

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Evidence-Based Leadership Council

Program

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.

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.
- **Data sharing and collaborative planning for metrics:** The path to more contracts depends on an organization's or network's ability to demonstrate results.
- **Accreditation open doors for new contracts:** Obtaining accreditation was a key step in winning and keeping contracts.
- **Activate all executive team and board members' skills and field experience:** *Partners*' staff includes executives with experience in healthcare (e.g. hospitals, skilled nursing, hospice)
- **Payer-CBO collaboration is key to building referral volume:** We identified a crucial need to have a strong working relationship with buy-in to the benefit of the contract and dedication to CQI.
- **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.

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
- Yan, T., Wilber, K., Simmons, J. (2011). Motivating high-risk older adults to exercise: Does coaching matter? Home Health Care Services Quarterly, 30(2): 84-85. PMID: 20182959
- Alkema, G.E., Wilber, K.H., Simmons, W.J., Enguidanos, S.M., Frey, D. (2007) Prevalence of potential medication problems among dually-eligible older adults in Medicaid waiver services. The Annals of Pharmacotherapy, 41(12): 1971-1978. PMID: 17986518
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Partners in Care FOUNDATION

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Evidence-Based Leadership Council

Program

Fairhill partners

Organization Description

Fairhill Partners is a 501(c)(3) nonprofit organization, owning 9.5 acres in the City of Cleveland, OH. Fairhill Partners began operations in 1987, having grown out of the vision of a small group of organizations with complementary missions of providing direct and ancillary 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. Additional space is available for expanding this concept. In addition to the multi-organization presence on the campus, Fairhill provides a homeless shelter for first time homeless older persons, and a 55+ market rate residential community that is focused on older relatives raising children. This "Social purpose real estate" approach today includes 20+ organizations that call Fairhill home, 15 residential units and one 8-10 person homeless program.

Direct services and educational programs offered by Fairhill Partners address kinship care, adult family caregiving, self-management workshops, fall prevention workshops, peer-led fitness and enrichment activities, safety and security programming and much more. Access Your Benefits connects people with screening for, and assistance in applying for, many public benefits, such as SNAP, Medicaid, energy assistance, and the Golden Buckeye card.

Fairhill Partners is governed by an independent Board of Directors.

History

Fairhill began implementing EBPs in 2006, starting with Matter of Balance. CDSMP was added next and today Fairhill also offers Diabetes Self-Management; Pain Self-Management, Positive Self-Management, and Tomando Control de Su Salud. CATCH Healthy Habits, offered though OASIS, connects older adult volunteers with children, K-5, who participate in an afterschool, summer camp or Vacation Bible School program that address nutrition and physical activity.

We chose Matter of Balance to implement first because falls are a highly visible challenge for Greater Cleveland's older persons and because once training is completed and the license is granted, there are currently no ongoing license fees. The Stanford programs were chosen due to the extremely credible research results that demonstrate the impact of the programs. The replicability of the template, six weeks, once a week for two and half hours becomes familiar and comfortable for sites and leaders alike, increasing access.

Partners and Funders

Fairhill Partners currently has a contract with one managed care insurer to deliver A Matter of Balance workshops as a pilot project. We are delivering A Matter of Balance, CDSMP, DSMP and Pain Management in partnership with several health systems, but arrangements for ongoing financial support are highly varied and most are short term. Foundation grants and contracts with the Area Agency on Aging for Title IIID services are the largest sources of support for the EBPs.

As a subcontractor in a larger CDC grant, Fairhill Partners is also working to support "clinic to community" relationships. We have pilot projects delivering CDSMP and DSMP with 2 multi-clinic hospital systems and a multi-clinic neighborhood health practice.

Successes

We anticipate 150-225 Matter of Balance completers annually. About 270 persons annually complete one or more of the Stanford self-management programs. Our goal is to reach 500 or more completers annually with one or more evidence-based programs.

We're proud that our Leaders and coaches are representative of our community; most of our workshops are truly peer-led by effective, volunteer community members.

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 have to tell them, sorry the minimum number of participants to start with session one is 10 (or 8 for MOB).
- 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 in the past year.
- In our experience, working with payors, it takes so long to get Medicare to approve any outreach/marketing materials used for Medicare or dual eligibles that the entire pilot project could be over before approval is granted. It can easily take 6 months to get a simple flyer approved.

fairhill partners

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Evidence-Based Leadership Council

Program

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

Organization Description

Elder Services of the Merrimack Valley, Inc., a private non-profit agency, was incorporated in 1974 to serve older residents living in the Merrimack Valley (Northeastern Massachusetts). Our mission is to insure 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. Our original implementation of programs was funded primarily through subcontracts through the EoEA under federal grants, including Administration on Aging and Administration for Community Living grants between 2009-present. In addition, Elder Services manages a number of contracts/programs for Mass Health, private foundations (including the Tufts Health Plan Foundation and Harvard Pilgrim Health Care Foundation), and public organizations. We are currently transitioning to a model where more revenue is derived from contracts with health care partners (primarily health care plans) reimburse

ESMV for program completers and infrastructure costs. We directly manage and/or fund over forty (45) different programs, contract with over 75 community agencies, and oversee 120 contracts chosen for quality and cost.

Successes

As a result of growth and spread since 2006, ESMV now oversees statewide training and implementation for evidence-based programs. To facilitate this, 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-informed nutrition program; (9) Participation in community based self-management programs by over 4,000 older adults since September 2012; (10) 2014 ACL Falls Grantee.

Lessons Learned

In assessing ongoing barriers and challenges, ESMV and its 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 exist in expanding the training and technical assistance capacity of the HLCE. These include partnering with self-insured or other large employers to offer programs as workplace benefits.

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

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Evidence-Based Leadership Council

Program

Florida Health Networks
Wellness Solutions in Your Neighborhood

Organization Description

Florida Health Networks (FHN) is an associated organization of Health Foundation of South Florida (HFSF) that grew from the Foundation's initial investment in the South Florida Regional Collaborative (HARC). In 2015 FHN was created for the purpose of providing administrative and business relations support to the 11 Planning and Service Areas in the State of Florida. Presently FHN partners with the 11 Aging and Disability Resource Centers and their provider network in Florida. In collaboration with numerous partners, FHN supports the delivery of a diverse menu of evidence-based programs proven to improve health outcomes and to decrease health care cost. FHN networks have 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 on the basis of 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.

Florida Health Networks
Wellness Solutions in Your Neighborhood

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Evidence-Based Leadership Council

Program

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 3,400 volunteers, together with 260 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 internationally. 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 program, helps older adults at all levels of fitness become more active, energized, and empowered to sustain independent lives. EW, a participant-centered motivational intervention helps individuals navigate a wide array of barriers. These award winning programs are currently implemented to support healthy living at over 65 sites locally and in 40+ 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 70,000 unduplicated participants. We currently support more than 500 licensed system users at approximately 200 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 sister evidence-based programs, including MaineHealth's A Matter of Balance, University of Washington's PEARLS, and the suite of seven evidence-based falls prevention programs offered nationally by 21 US 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
- Group Health Cooperative
- Silver and Fit

EnhanceFitness sites receive reimbursement as a Group Health Medicare Advantage Plan product offering in Washington State. Group Health 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 41 states plus the District of Columbia, at over 1,100 locations under almost 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 July 2016, EF has served over 64,000 unduplicated participants. Since 1998, EW has been offered in 9 states at 77 sites under 25 licensed organizations. As of July 2016, EW has served over 7,000 participants. (Note: Health outcome successes are detailed in our EBLC Program pages.)

Lessons Learned

- Desire for collaboration and partnership linking CBOs and clinical healthcare is strong
- Provider transition and referral processes need to be well understood and 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 consent forms and systems

Recognition/References

In 2006, the US Health and Human Services' Administration on Aging (AoA) included EF as one of the approved programs for the Choices for Independence grants, placing it in the AoA's highest tier of evidence-based programs. In 2007, the CDC Arthritis Program (CDC-AP) reviewed and classified EF as "arthritis-friendly" and it was adopted as a recommended intervention by the Arthritis Program. Sampling of 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

SOUND generations

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