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BUSINESS INSTITUTE

Connecting Communities and Health Care

Evidence-Based
Leadership Council

Nora Super

Chief, Programs & Services, and Director, Aging and Disability Business Institute, n4a

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Pre-Conference Intensive: New Directions and Opportunities in Evidence-Based Programming

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Aging and Disability Business Institute

Mission:

The mission of the Aging and Disability Business Institute is to build and strengthen partnerships between aging and disability community-based organizations (CBOs) and the health care system.

Long-term outcome:

Increase in the number of CBOs successfully implementing business relationships (contracts) with health care payers.

Goals:

- Build a national resource center
- Develop an assessment tool to determine the capacity of CBOs
- Provide training and technical assistance
- Conduct an outreach and educational campaign targeting the health care sector
- Develop and implement a strategy to establish a new norm of business partnerships between CBOs and health care entities

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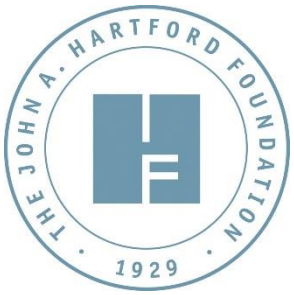
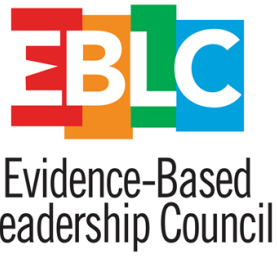
Business Institute Funders

- The John A. Hartford Foundation
- The Administration for Community Living
- The SCAN Foundation
- The Gary and Mary West Foundation
- The Colorado Health Foundation
- The Buck Family Fund of the Marin Community Foundation

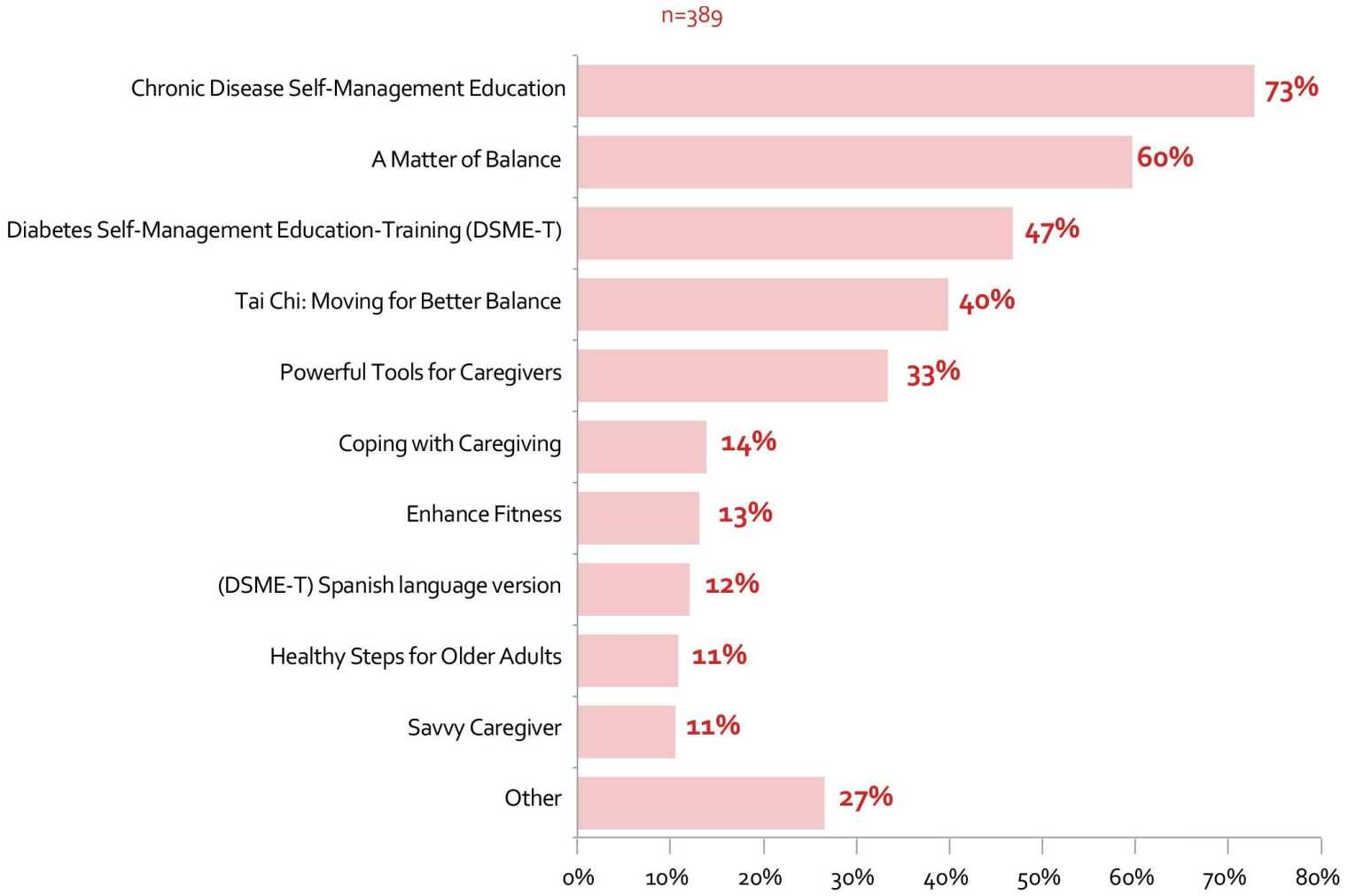


Business Institute Partners

- National Association of Area Agencies on Aging
- Independent Living Research Utilization/National Center for Aging and Disability
- American Society on Aging
- Partners in Care Foundation
- Elder Services of the Merrimack Valley/Healthy Living Center of Excellence
- National Council on Aging
- Meals on Wheels America
- Evidence-Based Leadership Council



Most Common Evidence-Based Programs Offered By AAAs According 2016 n4a Survey



n4a
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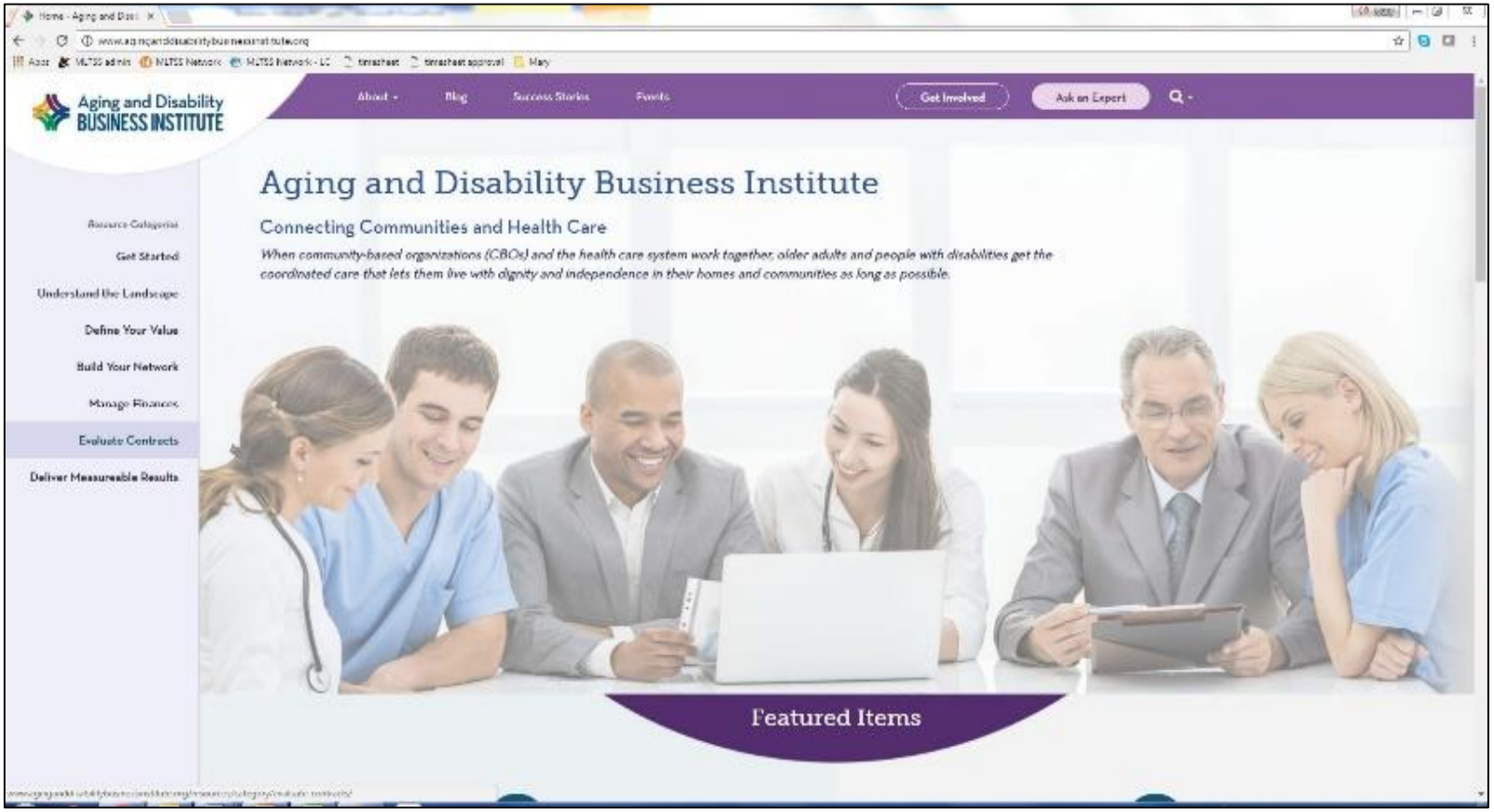
aginganddisabilitybusinessinstitute.org



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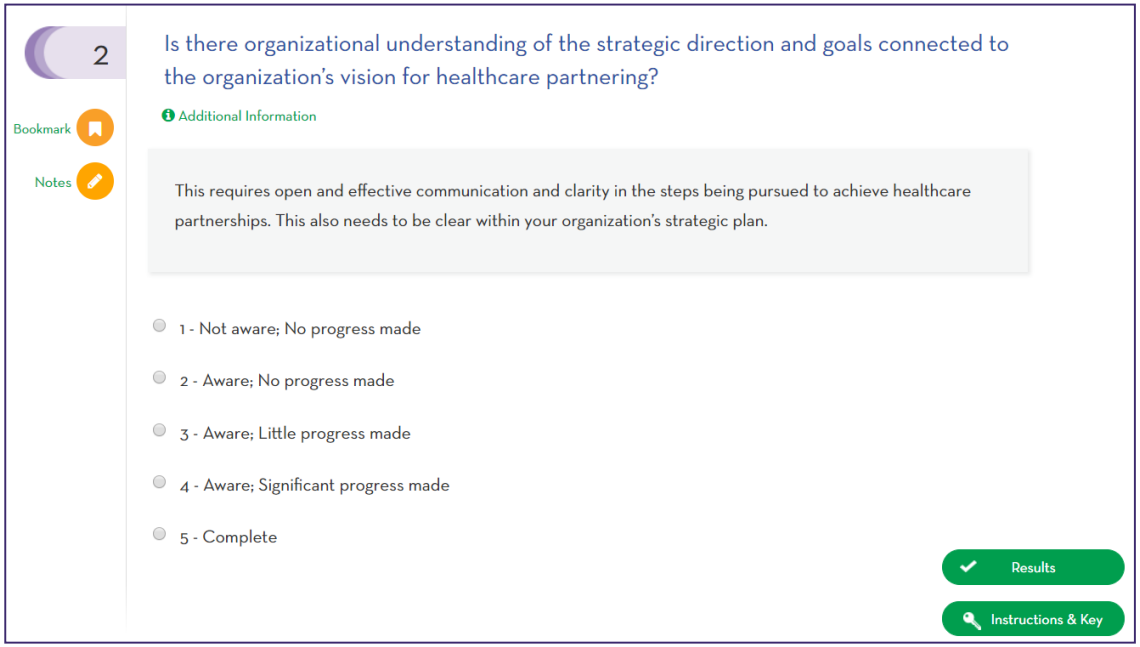
Readiness Assessment Tool

- Change Readiness
- Strategic Direction Readiness
- Operational Readiness
- Management Readiness
- Leadership Readiness
- External Market Readiness
- Partnership Development Readiness



Aging and Disability Business Institute Launches Survey to Take the Pulse of CBO-Health Care Partnerships

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EBLC Overview – Stephanie FallCreek, Co-Chair

Informal community of practice formalized in 2012 as the Evidence-Based Leadership Council (EBLC).

Mission

Increase delivery of multiple evidence-based programs that ***measurably*** improve the health and well-being of diverse adult populations.

Vision

An ever increasing number of adults engaged in evidence-based programs that inform, activate and empower them to improve their health and maintain independence.

www.EBLCprograms.org

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Implementation of Evidence-Based Programs through the Aging Network: Where We Are and Where We Are Going: EBLC Leaders' Perspectives

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Introductions.

- Susan Hughes, PhD. (Moderator)
- Director, Center for Research on Health and Aging; Professor, School of Public Health, UIC.
  - Designer: Fit & Strong! Exercise/disease management for older adults with arthritis
  - F&S now offered in 13 states
  - Founding member of EBLC
  - F&S approved by NCOA, CDC and NIOSH, American Physical Therapy Association
  - Most recently approved by NCOA as a chronic disease management and falls reduction program.
  - Now working with National Recreation and Parks Association to disseminate nationally through that network
  - My great pleasure to introduce the Panel members and moderate this session

Kate Lorig, Dr.PH

- Director, Patient Education Research Center, Stanford University
- Developer of the Stanford suite of 19 chronic disease management programs
- Chronic Disease Self Management Education currently offered by 73% of respondents to n4a survey; diabetes version offered by 47%

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Patti League,RN

- Wellness specialist and National Program Manager for a Matter of Balance.
- Provides training and TA to implement the program which reduces fear of falling among older adults
- AMOB has 1000 master trainers in 40 states, reached 50,000 older adults
- AMOB is being offered by 60% of respondents to recent n4a survey

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June Simmons, MSW

- Founder and CEO, Partners in Care Foundation
- Social entrepreneur, extraordinaire
- Developer: Homemeds for medication management
- Network Convener: 24 local universities, social service agencies and public organizations working on 46 projects

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Format

- We will have Kate present first, followed by Patti League and June Simmons
- we will allow 5-10 minutes of Q&A between presenters
- I will present a few slides on EBLC, will throw up a slide with a number of discussion topics and we will open the session up to YOU

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Self-Management Resource Center

SMRC Programs

- Stephanie FallCreek, DSW on behalf of Kate Lorig DrPH
- Kate@selfmanagementresource.com

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Resource Center

www.selfmanagementresource.com

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Evidence-Based
Leadership Council

Mission

- To develop, evaluate and translate into practice, evidence based programs for people with chronic conditions, cancer survivors, and caregivers
- To have these programs available in multiple formats and languages
- To work with the EBLC to assist community agencies in offering multiple evidence based programs

SMRC
Self-Management Resource Center

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What is an Evidence Based Program?

Evidence-based programs have been tested in controlled settings, proven effective and translated into practical models.

- Tested in trials using experimental or quasi-experimental designs
- Full translation has occurred in a community site; and
- Dissemination products have been developed and available to the public

SMRC
Self-Management Resource Center

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History

- 1970s Arthritis Self-Management
- 1980's Chronic Disease Self-Management
- 1990's Diabetes Self-Management, Positive Self-Management, CDSMP On-Line, Pain Self-Management
- 2000+ Cancer Thriving and Surviving, Mailed Tool Kits,
- Diabetes on-line, All programs updated.
- 2017 Stanford Patient Education Research Center become the Self-Management Resource Center (SMRC)

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Future Plans

- Workplace CDSMP will be released in the fall
- Building Better Caregivers will be released late fall or early 2018 (English and Spanish)

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What have we learned?

- Involve the public in every stage
- Be responsive but not too responsive
- Fidelity is more important than convenience
- Never say it can't be done
- The public is always right

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Self-Management
Resource Center

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A Matter of Balance:

Addressing falls in the community
Together We Can Do It!

Patti League RN
National Program Manager
A Matter of Balance/VLL Model
MaineHealth's Partnership for Healthy Aging
110 Free Street
Portland Maine

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Falls and Fear of Falling

Fear: an unpleasant often strong emotion caused by anticipation or awareness of danger

- **1/3 to 1/2 of older adults acknowledge fear of falling**

- **Fear of falling is associated with:**
  - *Depression*
  - *decreased mobility and social activity*
  - *increased frailty*
  - *increased risk for falls as a result of deconditioning*

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Welcome to A Matter of Balance!

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A Matter of Balance- Where we Started

- Research by the Roybal Center for Enhancement of Late-Life Function at Boston University 1

- Designed to reduce the fear of falling and increase the activity levels of older adults who have concerns about falls.

- **2003-2006** AoA launched a three year public/private partnership to increase older people's access to programs that have proven to be effective in reducing their risk of disease, disability and injury. Grant #90AM2780.

  - **Lay Leader Model was created and validated**

1. Tennsdedt, S., Howland, J., Lachman, M., Peterson, E., Kasten, L. & Jette, A. (1998). A randomized, controlled trail of a group intervention to reduce fear of falling and associated activity restriction in older adults. *Journal of Gerontology, Psychological Sciences,* 54B (6), P384-P392.

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A Matter of Balance Class

Designed to benefit community-dwelling older adults who:

- Are concerned about falls
- Have sustained a fall in the past
- Restrict activities because of concerns about falling
- Are interested in improving flexibility, balance and strength
- Are age 60 or older, community dwelling and able to problem-solve

During 8 two-hour sessions, participants learn:

- To view falls and fear of falling as controllable
- To set realistic goals for increasing activity
- To change their environment to reduce fall risk factors
- To promote exercise to increase strength and balance

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A Matter of Balance

What Happens During Sessions?

- Group discussion
- Problem-solving
- Skill building
- Assertiveness training
- Sharing practical solutions
- Videos- *Fear of Falling: A Matter of Balance and Exercise: It's Never too Late*
- Exercise training-*Exercises are introduced in session 3 and are a part of each session 3-8*
- Creating an action planner for reducing fall risks

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Cognitive Restructuring

(Bandura and Lachman, 1997)

Cognitive Restructuring – method of turning negative thoughts into positive thoughts

- Define barriers and obstacles when engaging in a new behavior
- Identify strategies for overcoming the barriers
- Plan realistic/feasible experiences so you can experience success

Antonyms to fear: confidence, self assurance, self-confidence, courage, serenity, calmness

A Matter of Balance/Volunteer Lay Leader Outcomes

6 weeks	6 months	12 months
Falls Efficacy* **	**Falls Efficacy*** **	**Falls Efficacy ** **
Falls Management* **	**Falls Management*** **	**Falls Management*** **
**Falls Control ** **	**Falls Control * **	**Falls Control * **
Exercise level * modified PACE**	**Exercise level * modified PACE**	**Exercise level NS PACE**
**Concern about falling interfering with Social Activities ** **	**Concern about falling interfering with Social Activities * **	**Concern about falling interfering with Social Activities + **
Monthly Falls NS	**Monthly Falls*** **	**Monthly Falls*** **
+ Marginal p= .0516 *p<.05 **p<.01 ***p<.001		

Healy, T. C., Peng, C., Haynes, P., McMahon, E., Botler, J. & Gross, L. (2008). The Feasibility and Effectiveness of Translating A Matter of Balance into a Volunteer Lay Leader Model. Journal of Applied Gerontology, 27 (1), 34-51.

(Significant Outcomes in Bold)

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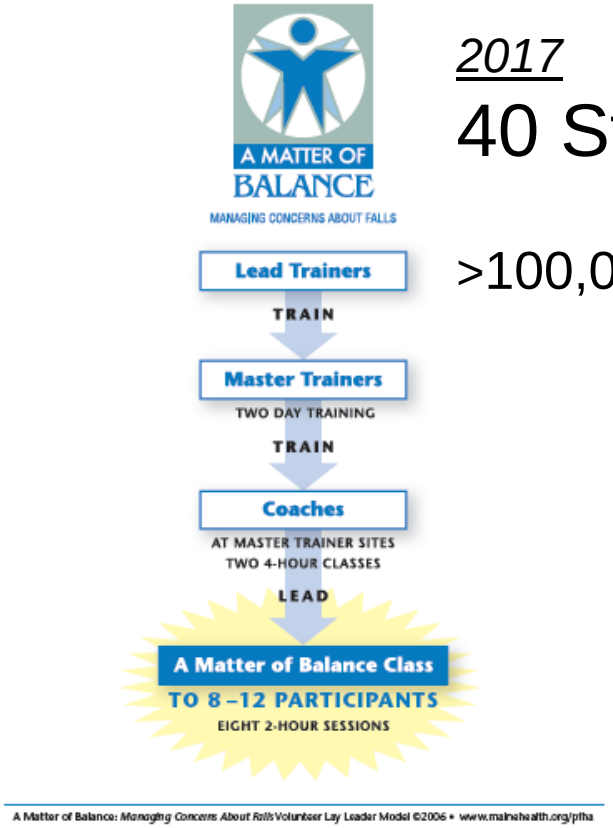
Where we are now-Dissemination Volunteer Lay Leader Model



2017

40 States

>100,000 participants served

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Translations :A Matter of Balance/VLL

- **Spanish-** Coach/Participant workbook DVDs with Voiceover from Terra Nova Films
- **Chinese-** Coach and Participant workbook DVDs Cantonese/ Mandarin Voiceover from Terra Nova Films
- **Low Vision-** Coach instruction materials; Participant workbook in 12 & 20 font; Audio Exercise CD; Audio Participant workbook
- **Portuguese-** Participant Workbook with DVDs scripts *Coach Handbook coming soon*
- **Vietnamese-** Participant Workbook with DVDs scripts
- **Russian-** Participant Workbook with DVDs scripts
- *Japanese and Korean translation in the works*

Plans: Video Update: New faces coming

- Fear of Falling: A Matter of Balance
- Exercise: It's Never too Late

These two videos set the tone for the discussions in A Matter of Balance- being updated. Reshooting of participants and the narrator underway with Terra Nova Films in Illinois.

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Lessons learned

- Connecting with community partners to share message
- Involving healthcare partners-
  screen, assess, refer →outcomes
- Creating a continuum of classes- keeping people on the path to wellness
- Translations can increase your reach
- Connections with Medicare Advantage plans
- Maintaining connections with MOB sites across the country sharing challenges and successes

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www.mainehealth.org/MOB

MaineHealth
Partnership for Healthy Aging

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HomeMeds, Healthy Moves, and HCBS Networks

Our role in Population Health Management

Evidence-based Programs Connecting Health Care to the Home and the Whole Person

June Simmons, CEO
Partners in Care Foundation

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Where We Started

- Way back when….1st generation John A. Hartford Foundation EB models:
  - Healthy Moves for Aging Well
  - HomeMeds

  - PROGRAM DESCRIPTIONS:

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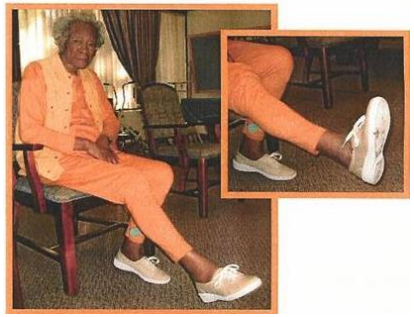
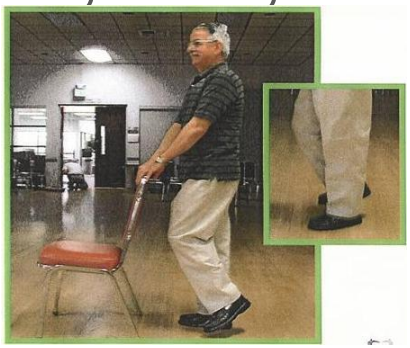
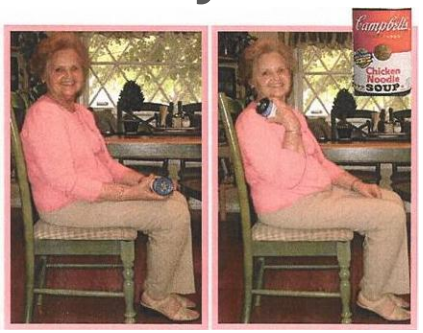
Healthy Moves for Aging Well

In-home physical activity program that addresses the inactivity of nursing-home eligible older adults receiving care management (Medicaid HCBS Waiver).

Expands the role of care managers and gives them the tools to engage their frail clients in simple, safe, functionally-linked







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Outcomes – 3 Month Follow-up

- Significant improvement in both arm curls and step-in-place ($p<.05$)
- Decrease in depression (from n=484 to n=371)
- Statistically significant reduction in number of falls ($p<0.01$), (n=328)

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HomeMeds℠

- HomeMeds is designed to enable **community-based organizations (CBOs)** to keep people at home & out of hospital by addressing medication safety
- Focus on **potential adverse effects** (falls, vitals, confusion) … *then* determine if medications may be part of the cause
- Started as practice change with **workforces that already go to the home** – more cost effective use of existing effort
- Evolving into **targeted home visit** under contract with health plans and managed care groups (HomeMedsPlus)

AoA Administration on Aging

The John A. Hartford Foundation 1929

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Risk-Screening Protocols

HomeMeds is a TARGETED intervention addressing a **limited** group of medication related problems identified by national ***expert consensus panel*** [1]

- Targets problems that can be identified and resolved in the home.
- Chosen to produce positive response by prescribers
- Minimize "al*ert overload": based on signs/symptoms.*
- Alternative treatment is available

1. Unnecessary therapeutic ***duplication***
2. Use of ***psychoactive*** drugs in patients with a reported recent ***fall*** and/or ***confusion***
3. Use of non-steroidal anti-inflammatory drugs (***NSAID***) in patients at risk of peptic ulcer/***gastrointestinal bleeding***
4. ***Cardiovascular*** medication problems -High BP, low pulse, orthostasis and low systolic BP

[1]A model for improving medication use in home health care patients . Brown, N. J., Griffin, M. R., Ray, W. A., Meredith, S., Beers, M. H., Marren, J., Robles, M., Stergachis, A., Wood, A. J., & Avorn, J. (1998). Journal of the American Pharmaceutical Association, 38 (6), 696-702.

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Where We Are Now

- Moved from original focus on scaling across community settings and care management
- NOW working to expand into full partnerships with health care systems – payers/providers
- Aligning around payment & quality incentives
- Focus on falls prevention, readmission reduction and nursing home diversion/repatriation and
- Health Self-Management/health plan partnership

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Why should community agencies work on EB self-management & medication safety?

- **CBOs can play a new role:** Connecting the home and whole person with healthcare:
  - Growing recognition of power of social determinants of health
  - **Home** provides unique perspective otherwise unavailable to healthcare providers
  - Medications are major factor in **readmissions and ER use**
  - **Quality measures** for health plans and providers relate to issues such as fall prevention, high-risk medication use and pain management – HEDIS, Medicare Advantage Star Ratings
  - Payment increasingly tied to quality and health outcomes

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HOMEMEDS℠ PLUS

- Building a paid home visit around HomeMeds and full assessment

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Medications are the Bridge to Health Care #1 Driver of Avoidable ER/hospital use

- EXAMPLE – RESULTS OF HOMEMEDS
- 49% of waiver clients had at least one potential medication problem (N=299)
  - 24.2% w/ therapeutic duplication (N= 149)
  - 14.3% fall or confusion w/ psychotropic medications (N=88)
  - 14.1% w/ cardiac problems (N=87)
  - 12.8% w/ inappropriate NSAIDs (N=79)
- Average 60% resolved after pharmacist intervention

Evidence-BASED HEALTHY AGING PROGRAM

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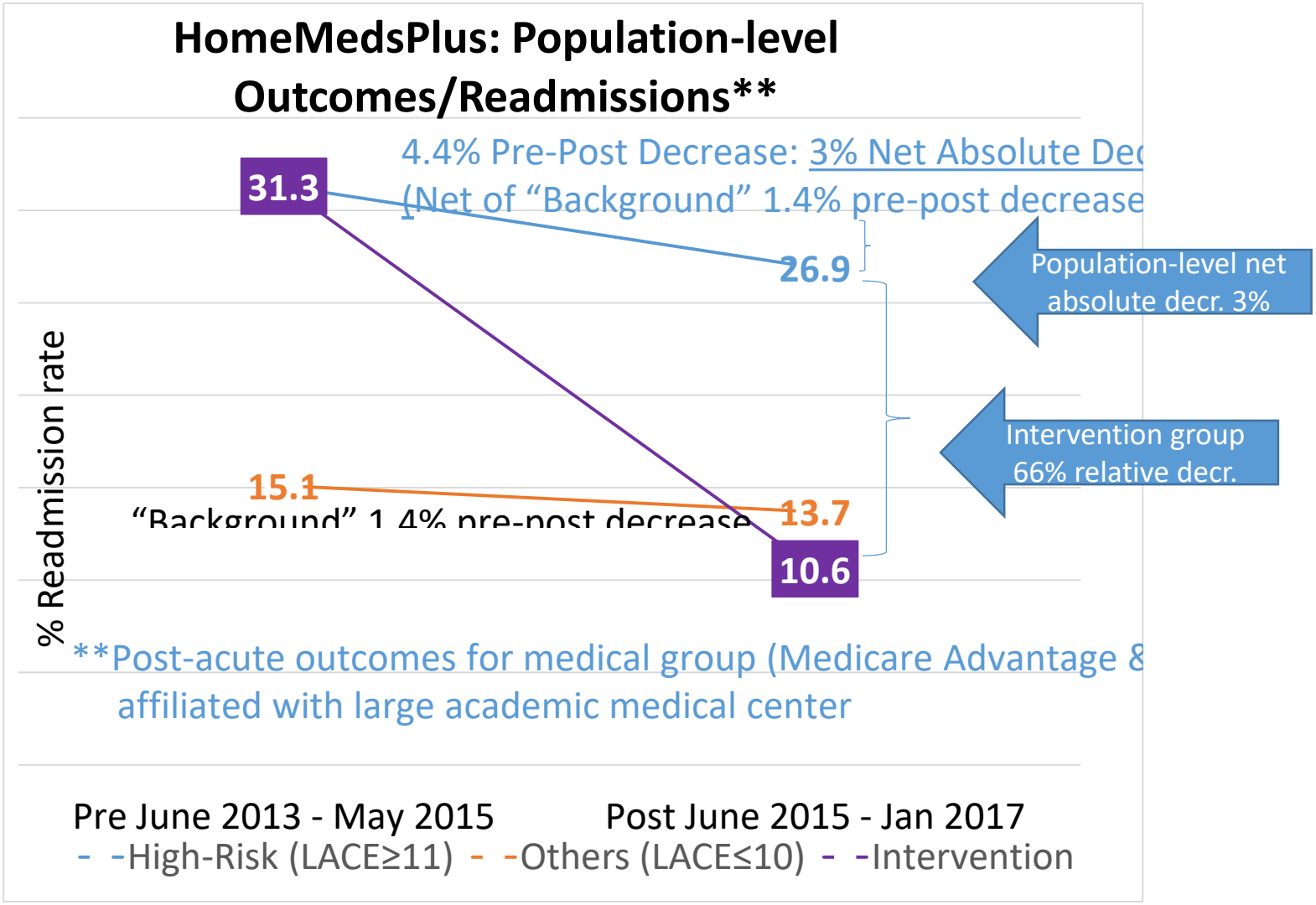

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Future Plans

- Creating Regional HCBS Delivery Systems for health
- Partnering with health payers and providers
- Single contract to access multiple agencies with broad geographic coverage but consistent interventions and a single management center
- Combines local brand and neighborhood fit with shared rising to health regulations
- Providing EB programs – self-management & CM

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Dynamic Contact Center to Grow Self-Management Enrollments

- A new tool to engage health plan members

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“Campaigns”

1. Identify a class to be offered w/in 30 days
2. Map members w/in 7-mile radius
3. Send letter about the program
4. Robo-Call members in that geography
5. If interested, offer:
    1. In-person CDSMP workshop
    2. Online CDSMP workshop
    3. Stanford Toolkit (if don’t accept either type)
6. *Rural or areas w/o trained leaders – offer online, then toolkit*

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Partners in Care FOUNDATION changing the shape of health care

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Lessons Learned

- EBLC has a very important role to play – we need to join hands across the nation
- Health plans and CBOs are evolving together to craft systems for meaningful integration
- The integration is new so requires new resources, systems and innovations on both sides
- HomeMeds is the key bridge for CM & Contact Center is key for workshops
- Forward movement is the name of the game
- We are learning more every day and so are the health plans and providers of care

What can EBLC do for you?

- Website
  - Information | Articles, links, program overviews and comparisons, etc.
  - Resources | Readiness tools, assessments, marketing, evaluation
- Technical Assistance
  - Complete the online TA Survey | “Training and Consulting” section of website
  - Flexible availability | Hourly, onsite, via phone, etc.
- Affiliation
  - Benefits | 20 free listings on locator, discounts on TA, “Affiliate Only” resources.
  - Join online | $125/year or $300/3 years

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EBLC in Action - Learnings

Shared Website

eblcprograms.org

- Enable agencies to find and contact local licensed EBPs
- Help prospective adopting organizations connect with other agencies implementing EBPs
- One-stop shop for information on EB programs:
  - Training and licensing information
  - Readiness tools and planning information
  - Matrices comparing programs, by topic area
  - Evaluation and quality assurance tools
  - Research and bibliography
  - Testimonials/Case Studies

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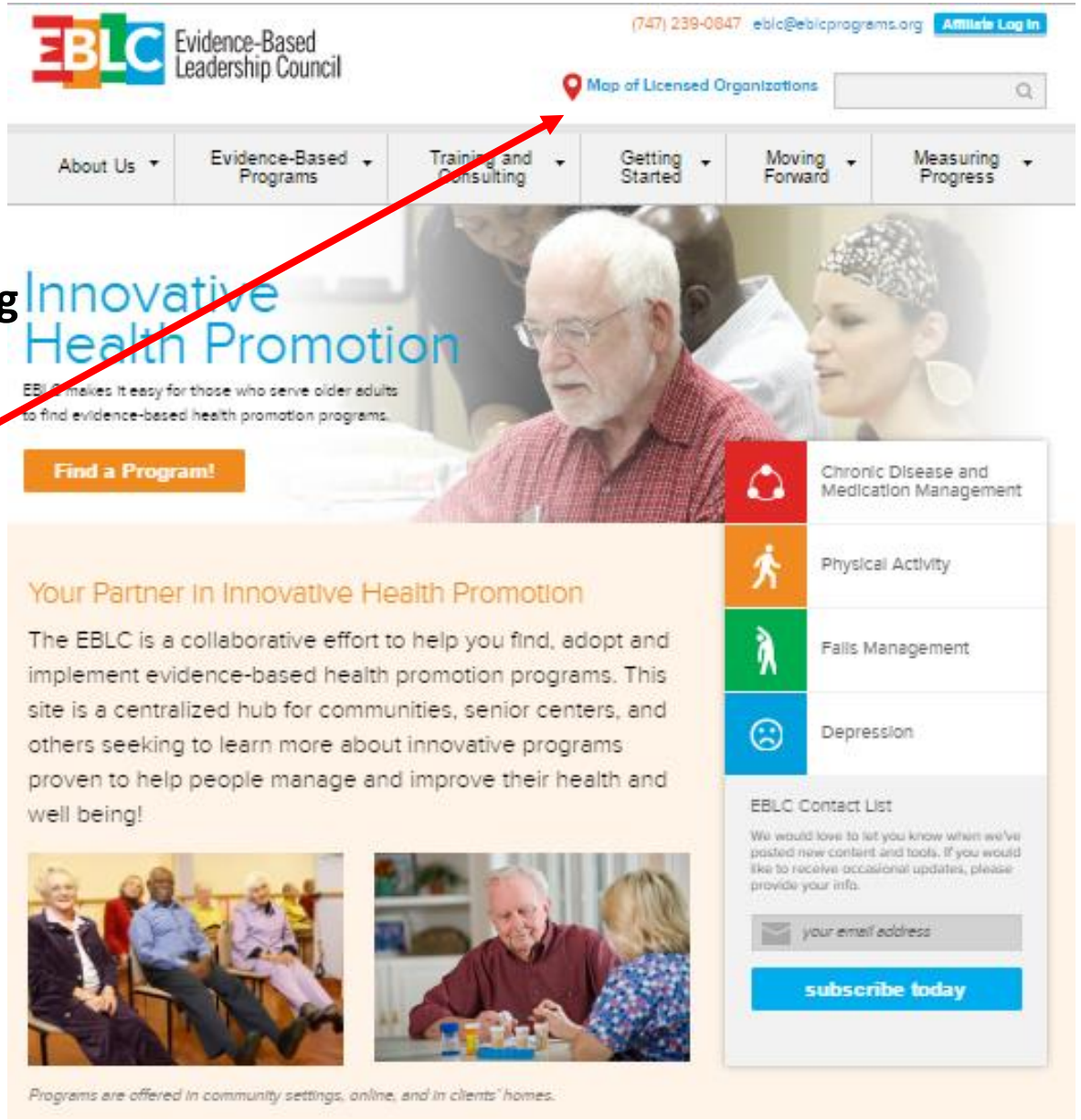
EBLC Website Home Page
www.eblcprograms.org

To access the Locator click here



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Screenshot of the Program Locator

Search by:

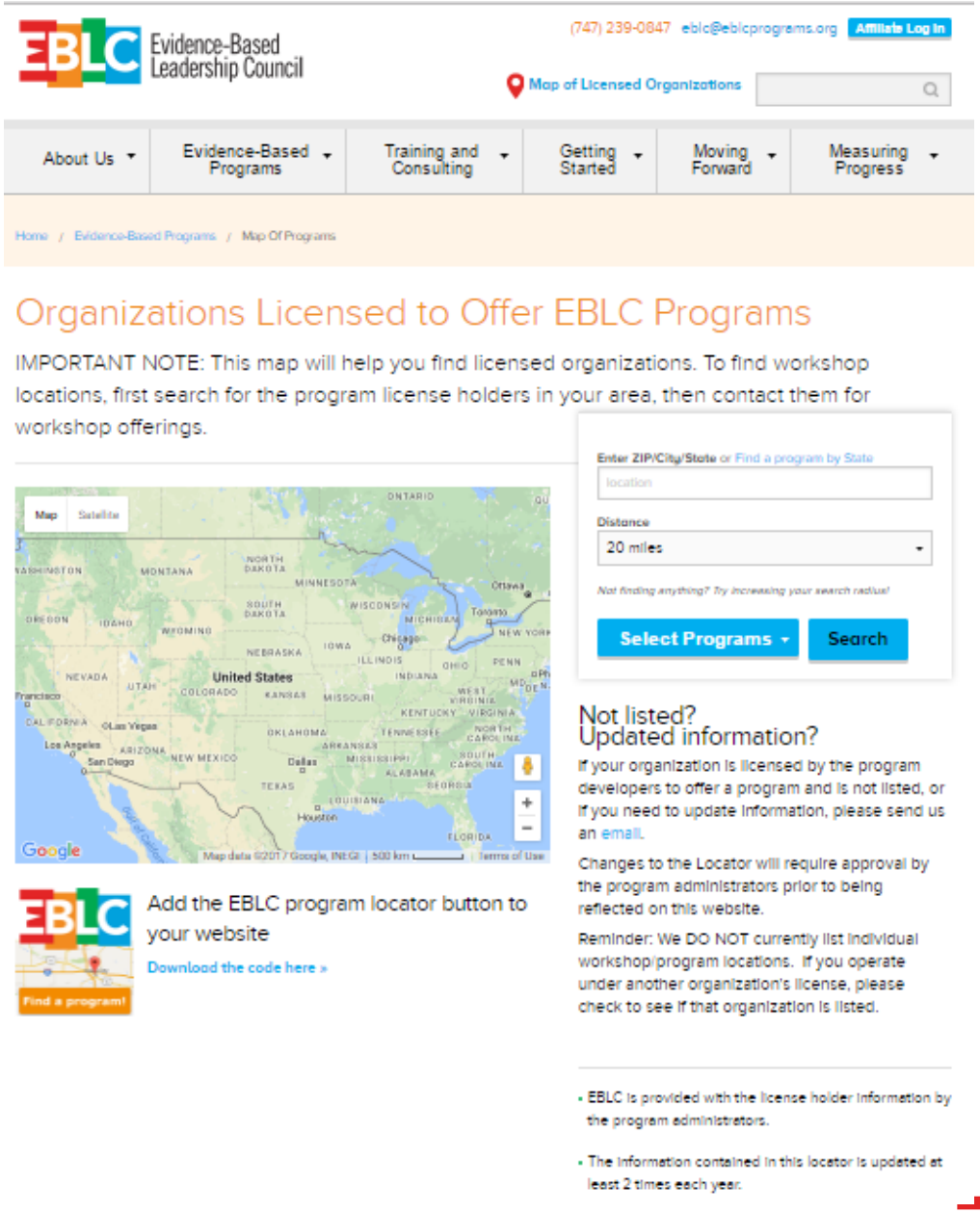
- Zip code + radius
- State

Narrow Search by:

- Program
- Program type

Pay to List Your Locations:

- Coming soon!



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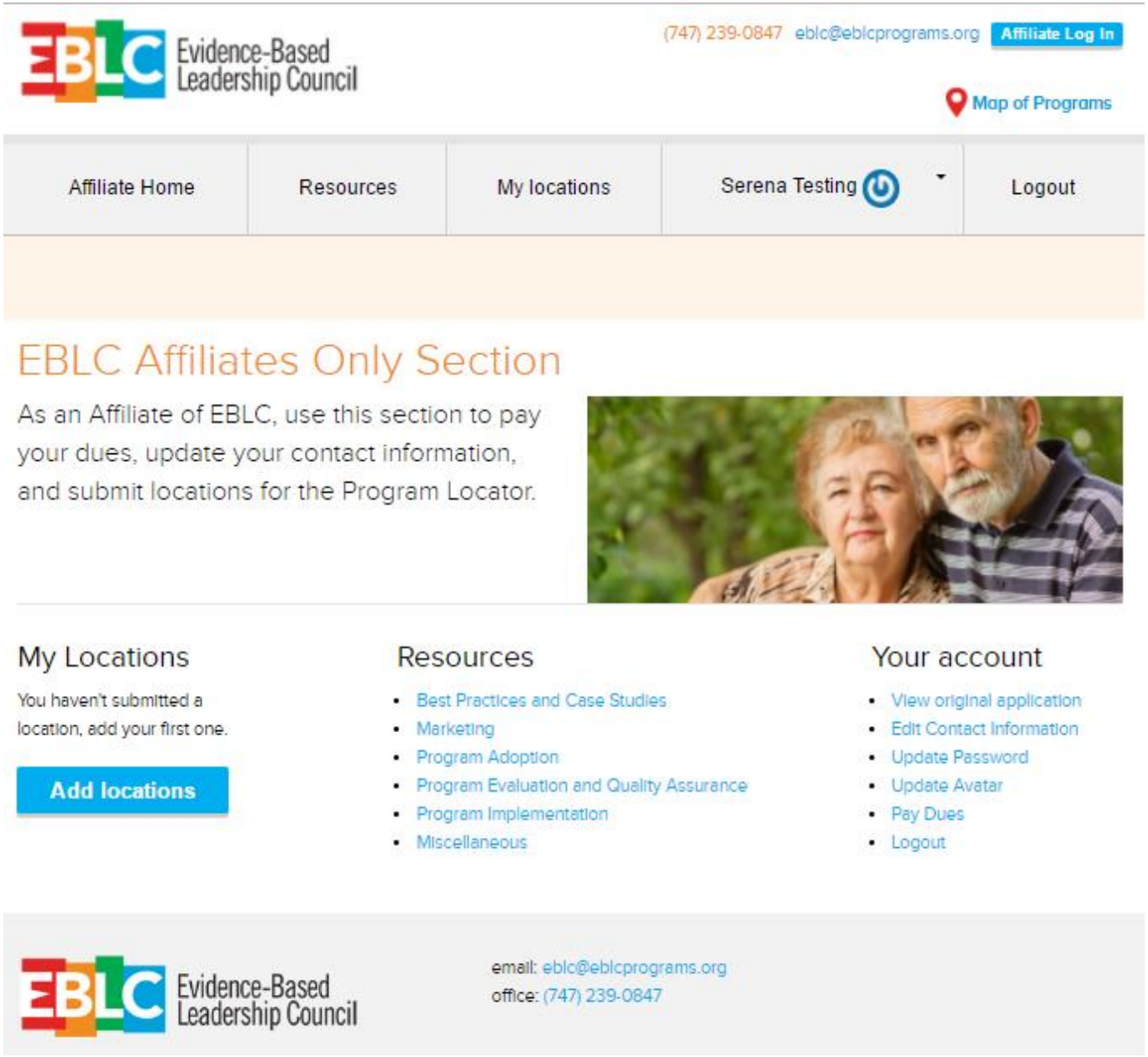
EBLC Affiliate Portal

Add your own workshop locations!

Access "Affiliate Only" Resources!



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Brainstorming Issues

- How do I choose which program/s to offer?
- How do I get my program up and running?
- How do I generate/assess demand for the program in my service area?
- What kinds of organizations should I partner with in offering the program?
- How should I market the program?
- How do I finance the initial offering?
- How can I maintain the program over time?

Thanks!

- Thank you all for coming!
- Please use the EBLC website early and often
- Let us hear from you and help us understand how EBLC can help you and your organization in the future.
- We also thank:

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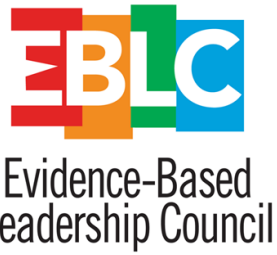
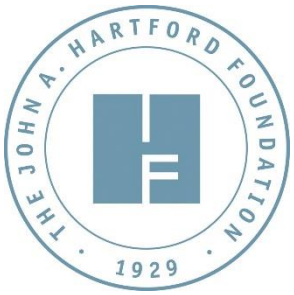
- Meals on Wheels America
- Evidence-Based Leadership Council



Business Institute Funders

- The John A. Hartford Foundation
- The Administration for Community Living
- The SCAN Foundation
- The Gary and Mary West Foundation
- The Colorado Health Foundation
- The Buck Family Fund of the Marin Community Foundation



Aging and Disability
BUSINESS INSTITUTE

EBLC
Evidence-Based
Leadership Council

Implementation of Evidence-Based Programs through the Aging Network
Where We Are and Where We Are Going: ACL's Perspective

Casey DiCocco

Administration for Community Living

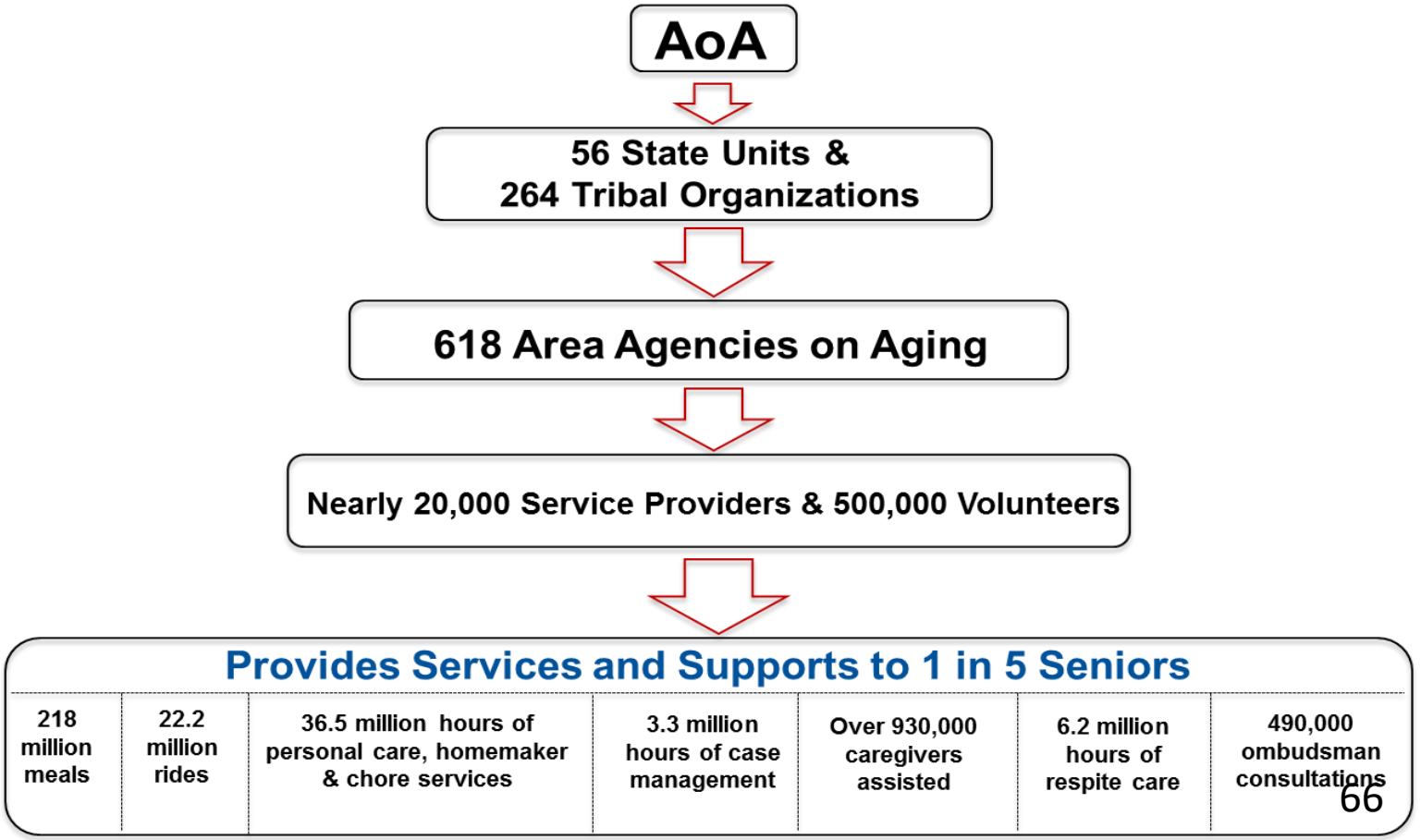



About the Administration for Community Living (ACL)

- **Mission** – maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers
- Commitment to one **fundamental principle** – people with disabilities and older adults should be able to live where they choose, with the people they choose, and participate fully in their communities

The Older Americans Act

Within ACL, the Administration on Aging (AoA) administers the Older Americans Act



TITLE III-D HISTORY

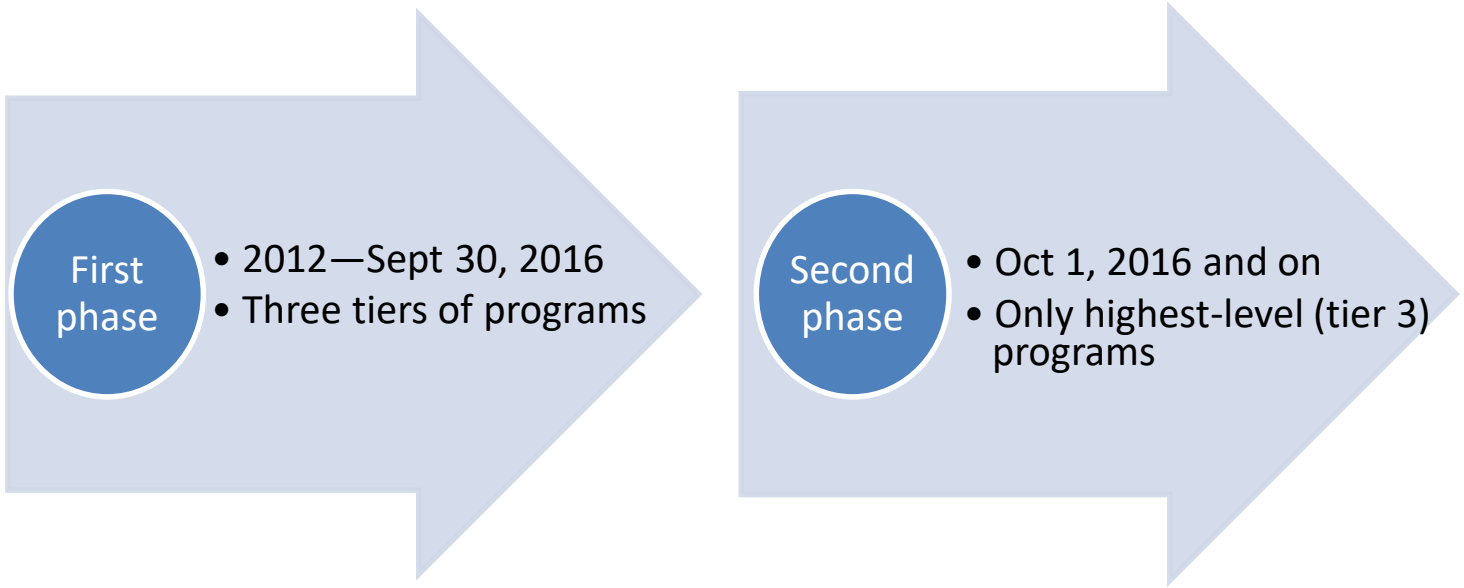
Older Americans Act Title III-D

- Discreet funding for disease prevention and health promotion programs
- Historically had been used for:
  - Health screenings
  - Health events/fairs/etc.
  - Materials or merchandise related to health promotion
  - Evidence-based health interventions

Evidence-Based Program Requirement

- New language added to ACL's Appropriation by Congress in 2012:
  - "Funding…may only be used for programs and activities which have been demonstrated through rigorous evaluation to be evidence-based and effective."

Phasing in the Evidence-Based Program Requirement

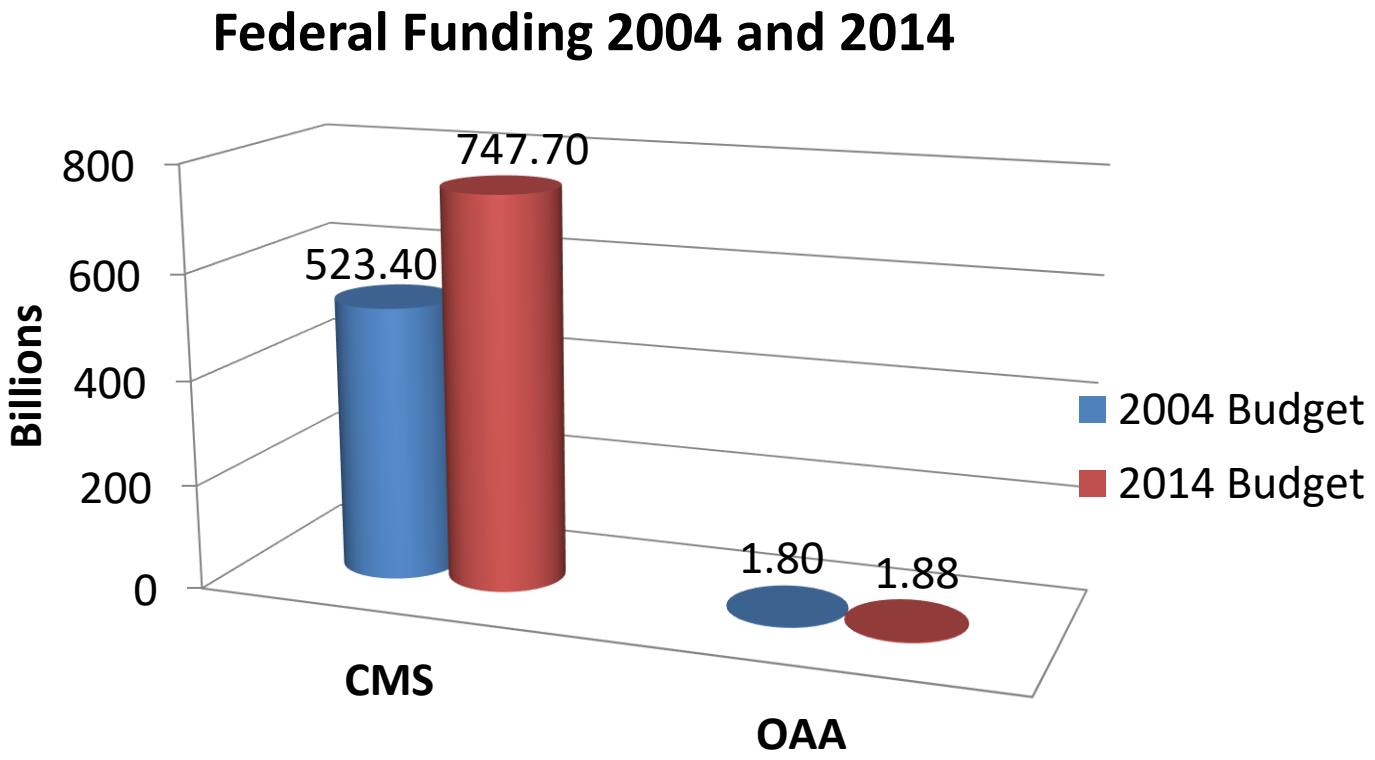


- Wanted to help states meet the evidence-based program requirements, without abruptly ending programs taking place

Title III-D Evidence-Based Program (EBP) Criteria

1. Demonstrated through evaluation to be effective for improving the health and wellbeing or reducing disease, disability and/or injury among older adults; and
2. Proven effective with older adult population, using experimental or quasi-experimental design; and
3. Research results published in a peer-review journal; and
4. Fully translated in one or more community site(s); and
5. Includes developed dissemination products that are available to the public.

Why is there an EBP Requirement?



- Proving the value of OAA investments to Congress
- Opportunity where AAAs can provide something payers want

Evidence-Based Program Uptake

- According to N4A, 93% of AAAs across the U.S. are offering Evidence-Based Programs
- 85% increase since 2007

ACL Perspective

- Recognize the significant challenge with this requirement
- Dedicated to helping states and AAAs implement appropriate programs
- Grateful for the resources from our non-governmental partners

Federal Data Collection Related to III-D

- Through the National Aging Program Information System (NAPIS), ACL requires States to report on the following for III-D:
  - Number of providers
  - Number of AAAs doing direct service provision
  - Persons served
  - Expenditure (Title III and Total)
  - Program Income
- ACL requires no other data at the federal level
- Title III-D is an “unregistered” service in the OAA, i.e., requires no individual or demographic data

ACL SUPPORT TO THE NETWORK ON EBP ROLL-OUT

Support to the Aging Network

- How has/will ACL support the Aging Network in finding/vetting/disseminating evidence-based programs appropriate for Title III-D funding?

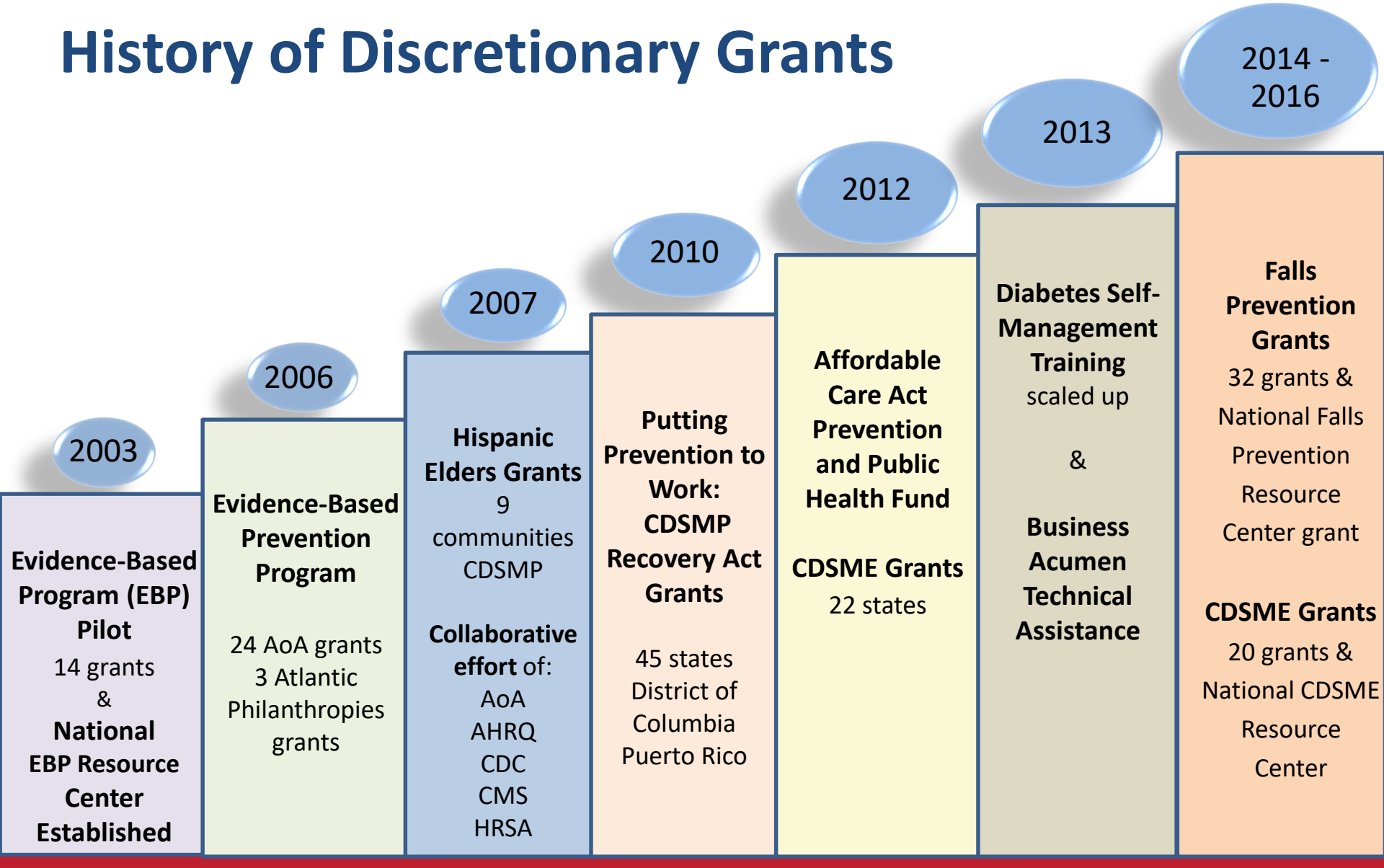
ACL Health Promotion Discretionary Grants

- Chronic Disease Self-Management & Diabetes Self-Management/Self-Management Support Programs
  - $8 million, annually

- Evidence-based Falls Prevention Programs
  - $5 million, annually

78

History of Discretionary Grants



NCOA Cost Chart

- In 2012, ACL and NCOA developed a chart with commonly used programs meeting highest-level criteria, with associated costs.

Title III-D Highest Tier Evidence-Based Health Promotion/Disease Prevention Programs

PROGRAM	WEBSITE/ CONTACT	PROGRAM GOALS & TARGET AUDIENCE	PROGRAM DESCRIPTION	DELIVERED BY	TRAINING REQUIREMENTS	PROGRAM COSTS	KEY WORDS
A Matter of Balance (MOB)	www.mainehealth.org/mob	• Reduce fall risk and fear of falling • Improve falls self-management • Improve falls self-efficacy and promote physical activity • **Target Audience:** Adults 60+ who are ambulatory, able to problem solve, concerned about falling, interested in improving flexibility, balance and strength and have restricted their activities because of concerns about falling	• 8 weekly or twice weekly sessions • 2 hours per session • 8-12 group participants • Emphasizes practical coping strategies to reduce fear of falling and teach fall prevention strategies • Structured group intervention activities include group discussion, problem-solving, skill building, assertiveness training, videos, sharing practical solutions and exercise training	• 2 coaches (volunteer lay leaders) teach the class to participants • Guest therapist visit (1 session for 1 hour)	• Master Trainers: 2-day training and on-going updates • Coach/Lay leader training: 8 hours and attend annual 2.5 hour training update	• **Licensing Cost**: None. Everything is included in the training fee • **Training Cost**: - Master Trainer session open to anyone (includes all materials): $1,500 per Master Trainer plus travel - Group training available at an agency's location upon request: a) 11-15 attendees: $16,000* plus $220/person for materials b) 16-20 attendees: $18,500* plus $220/person for materials ** plus travel, meals and lodging for 2 Lead Trainers* • **Post-training Materials Cost**: - Coach Handbook: $20 - Participant Workbook: $13 - Guest Therapist Handbook: $6	• fall prevention • group setting • self-management • health promotion

ACL's ADEPP

- The Aging and Disability Evidence-Based Programs and Practices (ADEPP) was an ACL initiative to help the public learn more about evidence-based programs and determine which may meet their needs
  - Lengthy vetting process for programs
  - Run through federal contract
- No longer accepting new applications from program developers

Drawing Upon Other HHS Agencies

- SAMHSA's National Registry of Evidence-Based Programs and Practices
- CDC's Compendium of Effective Fall Interventions: What Works for Community-Dwelling Older Adults
- NIH's Research-tested Intervention Programs (Filter by "Older adults")

National CDSME Resource Center

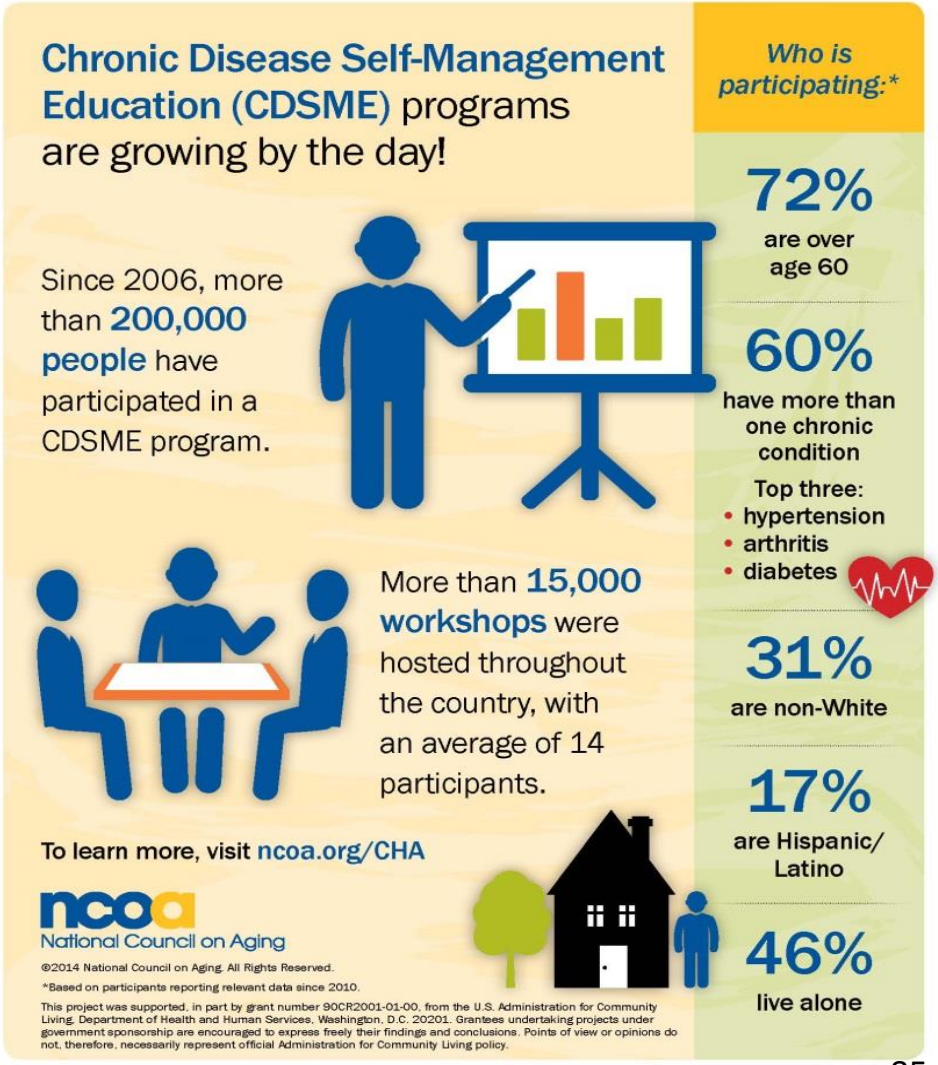
- ACL-funded co-operative agreement to provide leadership, expert guidance, and resources to promote and measure the value of, increase access to, and enhance the sustainability of evidence-based programs, particularly Chronic Disease Self-Management Education (CDSME) and self-management support programs that improve the health and quality of life of older adults and adults with disabilities.

National CDSME Resource Center, cont.

- The Resource Center also serves as a national clearinghouse and disseminates resources and best practices to increase the capacity of aging, disability, and public health networks and their partners to implement and sustain such programs.
- Resources available at: http://www.ncoa.org/center-for-healthy-aging/cdsme-resource-center/

National CDSME Resource Center, cont.

- Webinars on topics relevant to CBOs and evidence-based programs
- Numerous products for CBOs:
  - Cost Savings calculator tool
  - Sustainability issue brief
  - Business Planning modules
  - Other online training modules
- Healthy Aging Listserv & E-newsletters



National Falls Prevention Resource Center

- ACL-funded co-operative agreement to increase public awareness and educate consumers and professionals about falls risks and how to prevent falls.
- Serve as the national clearinghouse of tools, best practices, and other information on falls and falls prevention: www.ncoa.org/center-for-healthy-aging/falls-prevention/
- Support and stimulate the implementation, dissemination, and sustainability of evidence-based falls prevention programs and strategies

National Falls Prevention Resource Center

Evidence-Based Falls Prevention Programs: Saving Lives, Saving Money

THE CHALLENGE: Older Adult Falls in the U.S.

- 1 in 4 Americans aged 65+ falls each year
- Every 11 seconds, an older adult is treated in the emergency room for a fall
- Every 19 minutes, an older adult dies from a fall

- In 2013, the total cost of fall injuries was $34 billion (78% paid by Medicare)
- This total cost may reach $67.7 billion by 2020
- Even falls without injury can cause fear of falling, leading to physical decline, depression, and social isolation

Falls Are Common | **Falls Are Costly**

Falls in adults aged 65+ are the leading cause of head injuries and broken hips

THE SOLUTION: Proven Community-Based Programs

A Matter of Balance

8-session workshop to reduce fear of falling and increase activity among older adults in the community

- 97% of participants feel more comfortable talking about their fear of falling
- 99% of participants plan to continue exercising
- $938 savings in unplanned medical costs per Medicare beneficiary

Otago Exercise Program

Individual program of muscle strengthening and balance exercises prescribed by a physical therapist for frail older adults living at home (aged 80+)

- 35% reduction in falls rate
- $429 net benefit per participant*
- 127% ROI**

Stepping On

7-week program that offers older adults living in the community proven strategies to reduce falls and increase self-confidence

- 30% reduction in falls rate
- $134 net benefit per participant
- 64% ROI

Tai Chi: Moving for Better Balance***

Balance and gait training program of controlled movements for older adults and people with balance disorders

- 55% reduction in falls rate
- $530 net benefit per participant
- 509% ROI

Falls Free®
National Council on Aging

Learn more about these and other proven programs at ncoa.org/FallsPrevention

Sources:
Carande-Kulis, V., Stevens, J., Florence, C., Beattie, B.L., Arias, I. (2015). A cost-benefit analysis of three older adult falls prevention interventions. Journal of Safety Research, 52, 65–70.
Report to Congress in November 2012: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act. http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf

* Net benefit = Direct medical costs averted (e.g., emergency department visits, hospitalizations, rehab, homecare) after subtracting intervention costs
** ROI (return on investment) = Net benefit per participant divided by average cost of the program per participant; percentage of return for each dollar invested
***Now known as "Tai Ji Quan: Moving for Better Balance"

Maine

Falls Prevention Programs Save Money and Lives

Since 2016 more than 158 older adults and adults with disabilities have participated in Falls Prevention programs.

Evidence-Based Falls Prevention Programs target older adults and adults with disabilities who are at risk.

- 96% over age 60
- 36% are disabled
- 47% live alone
- 56% have more than one chronic condition

Top three chronic conditions in Maine are Arthritis, Heart Disease, and Depression.

To learn more, visit www.ncoa.org/fallsprevention

ncoa
National Council on Aging

Benefits to older adults in

ME

Health Care Dollar Savings

$131,884

saved through falls prevention programs for older Mainers

10%
reduction in the number of falls

32%
improved balance

41%
improved ability to reduce falls

89%
exercised at home

27%
had medications reviewed

48%
made changes to home to reduce falls risk

EBP Survey of State Units on Aging

- Early 2017, NCOA conducted a national survey on how states are meeting the Title III-D requirements and what EBP gaps exist in the network
- The National Falls Prevention Resource Center had been developing an initiative to bring falls prevention experts together to vet new or existing falls prevention programs
  - The CDSME Resource Center wanted to explore expanding the initiative more broadly, but first wanted to collect data about what was going on in the Aging Network related to EBPs

Survey Goals

NCOA/ACL wanted to know:

- How comfortable were states in ensuring that III-D requirements were being met?
  - How did the states review programs proposed by AAAs?
- What programs are being delivered across the country with III-D funds?
- Most significant programming gaps?
- Greatest TA needs?
- Other funding sources are being used?
- What populations are being served by EBPs?

Survey Findings

- 31 State Units on Aging responded to the survey
- Most commonly III-D funded programs are CDSMP, Tai Chi, Matter of Balance, DSMP
  - However, 58 unique programs were identified
- Many states feel that gaps exist in terms of available evidence-based programs, including:
  - Desire for more diabetes and falls prevention options
  - Ability to scale programs
  - Programs that can serve rural populations more effectively

LOOKING AHEAD

Next steps

- Survey findings indicated a need for more technical assistance at the national level for scrutinizing evidence-based programs
- Resource Center aimed to convene national EBP experts to help deliver this TA to the Aging Network

Falls Prevention Program Review Council

- NCOA, supported by ACL, established the Evidence-based Falls Prevention Program Review Council in Fall of 2016
  - To identify effective community falls prevention programs that meet the Older Americans Act Title III-D
- The council of experts established guidelines and application processes for program reviews
- First round of reviews in January – May, 2017

Falls Prevention Program Review Council, Cont.

First round of reviews—programs approved:

CAPABLE

- program designed to help seniors live more comfortably and safely in their homes.

Fit and Strong!

- multiple component exercise program with group problem solving/education using a curriculum designed to facilitate arthritis symptom management, confidence in ability to exercise safely with arthritis, and commitment to lifestyle change

EnhanceFitness

- low-cost, highly adaptable exercise program offering levels that are challenging enough for active older adults and levels that are safe enough for the unfit or near frail.

Evidence-based Program Review Council – Next Steps

- Partnership with the Evidence-based Leadership Council
- Two calls for program submissions are expected in the Fall, 2017
  - Falls prevention programs
  - Health Promotion programs – with a special focus on:
    - Diabetes
    - Hypertension
    - Mental health
    - Nutrition Process
    - Oral health

Contact Information

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ILLINOIS COMMUNITY HEALTH AND AGING COLLABORATIVE

Presents

Illinois Pathways to Health

n4a Pre-Conference Intensive Session

July 29, 2017

Mission and Vision

- The Illinois Community Health and Aging Collaborative seeks to improve the health status of older adults and persons with disabilities in Illinois by leveraging the strengths of community-based organizations and elevating their provision of cost-effective, high quality, evidence-based healthy aging programs.

- We envision that evidence-based, healthy aging programs will be accessible to all adults across Illinois, making Illinois a healthier state in which to live.

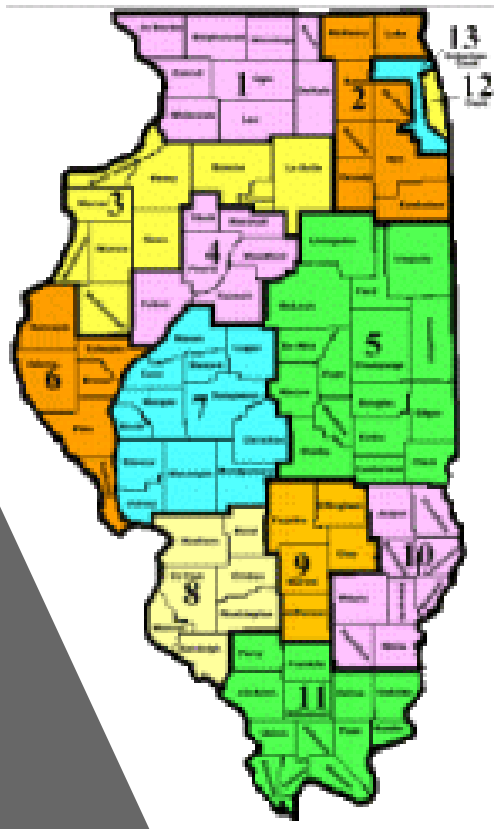
The Collaborative

- The Illinois Community Health and Aging Collaborative:
- Founded in 2013;
- Established in 2015 as a non-profit organization;
- Supported and governed by a Board of Directors comprising experienced, trusted, and progressive leaders in the field of health and aging in Illinois.

Our Founding Partners

- AgeOptions – the Area Agency on Aging for Suburban Cook County
- AgeSmart Community Resources- the AAA for Southwestern Illinois
- CIMPAR – Chicago Medical Practice and Research
- East Central Illinois Area Agency on Aging
- Illinois Aging Services, Inc.
- Northeastern Illinois Area Agency on Aging
- Rush University Medical Center
- Western Illinois Area Agency on Aging
- White Crane Wellness Center

13 Planning and Service Areas in Illinois



Illinois Pathways to Health

The Collaborative and our community-based partners provide…

Illinois Pathways to Health - a statewide integrated delivery system for evidence based programs. All members of the Illinois Community Health and Aging Collaborative are participating in the system.

Since 2006, our partners have enrolled over **15,000** older adults in a variety of evidence-based healthy aging programs.

Our strategic goal is to reach over **21,000** older adults and persons with disabilities by **2021**.

Our Strategic Plan

- ***Our 5-year strategic plan for Illinois Pathways to Health will:***
- Assess and **improve the capacity** of evidence-based health promotion programs in Illinois;
- Establish **reliable sources of payment** for healthy-aging programs;
- **Increase access** to evidence-based programs for older adults and adults with disabilities; and
- Measure and continuously **improve the quality and fidelity** of evidence-based programs.

Illinois Pathways to better health outcomes

- **Achieve the Triple Aim**:
  - Improve the patient experience of care (including quality and satisfaction);
  - Improve the health of older adults and adults with disabilities;
  - Reduce the per capita cost of health care.
- Empower adults to manage chronic diseases and disabilities;
- Empower adults to manage diabetes;
- Empower adults to manage activities of daily living at home;
- Reduce unplanned hospital admissions;
- Reduce emergency department admissions;
- Reduce admissions to long term care facilities;
- Prevent falls, manage falls, and increase self confidence.

Our Menu of Programs

- ***Illinois Pathways to Health*** offers older adults and persons with disabilities a menu of evidence-based programs to help them achieve their personal goals for health and wellness, including:
- ***Take Charge of Your Health*** (Chronic Disease Self-Management Program)
- ***Take Charge of Your Diabetes*** (Diabetes Self-Management Program)
- ***Tomando Control de su Salud*** (Spanish CDSMP)
- ***Tomando Control de su Diabetes*** (Spanish DSMP)
- ***Take Charge of Your Diabetes Plus*** *(8-week clinical wrap-around workshop for Medicare beneficiaries, with Medical Nutrition Therapy, accredited by AADE)*
- ***A Matter of Balance*** (Falls Prevention Program)

Program Partners in Illinois

- 13 Area Agencies on Aging
- Public Health Departments
- Community-Based Organizations
- Care Coordination Units
- Hospital Systems and Community Hospitals
- Centers for Independent Living
- Adult Day Services Centers
- Senior Centers and Nutrition Sites
- Independent Living and Assisted Living Facilities
- Fire Departments

Take Charge of Your Health

Progress Report: *Take Charge of Your Health*

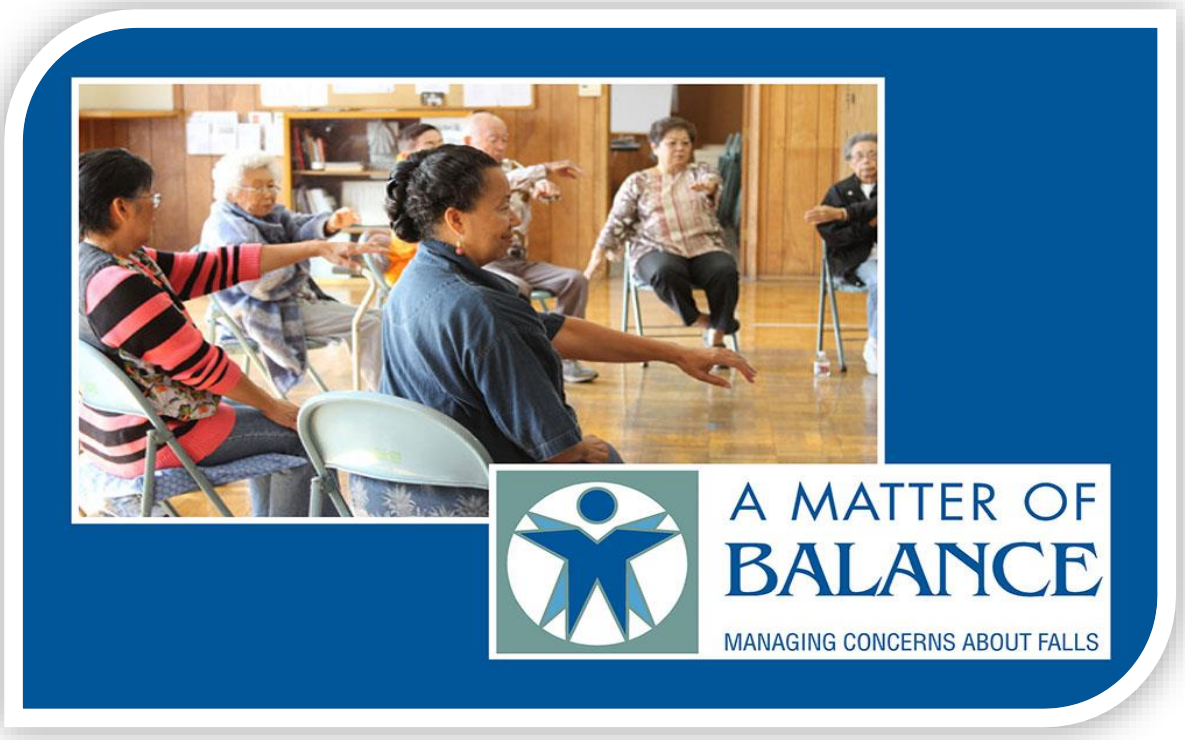
- ***Take Charge of Your Health*** workshops are available in all 13 PSAs in Illinois
- AgeOptions and partners report the following data for Take Charge of Your Health under a two-year grant with ACL as of 6-30-17:
- CDSMP: 92 workshops, 1079 registrants, 1055 participants, 742 completers
- DSMP: 43 workshops, 665 registrants, 637 participants, 524 completers
- Spanish CDSMP: 7 workshops, 112 registrants, 108 participants, 65 completers
- Spanish DSMP: 7 workshops, 86 registrants, 81 participants, 49 completers

Participants value *Take Chare of Your Health*

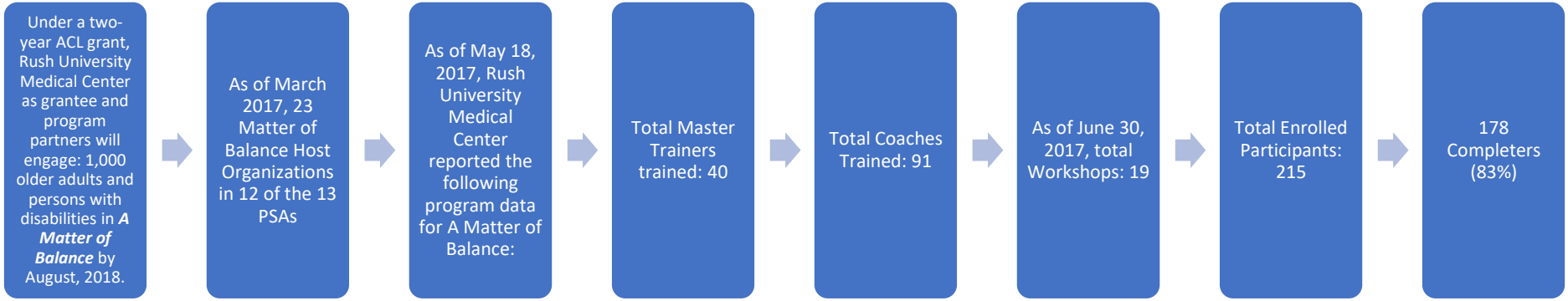
- “What I learned is that I know best how to help myself and it’s important to take action now. The things that have helped me the most to manage my chronic conditions are support from this workshop and from the other folks participating. I am not alone on this journey!” – Sharon from Suburban Cook County attended a workshop in the Spring of 2016.

- “I learned that I need to pay more attention to my diet and exercise. I didn’t know that my chronic condition was affected by not managing more carefully. I’m working on watching my carb intake. Portion control is more than a saying.” - Dan from Suburban Cook County attended a workshop in Fall of 2015.

A Matter of Balance – Falls Prevention



Progress Report: *A Matter of Balance*



Participants value *A Matter of Balance*

- "The exercises did more for me than going to the chiropractor has ever done…This class has changed my life…I have really noticed a difference all over my body, I can tell that I'm not as stiff in my back". - Gentleman, age 91, from Casey, IL, completed MOB Class in 2016

- "I am very glad I invested the time to take this class. I have told 2 friends in St. Louis and 3 friends locally – urging them to take it." - Rosemary, retired dental hygienist, from Millstadt, IL, completed MOB class in 2016

- "Interesting and educational. Introduced light exercises. Better balance when walking, and more confidence going up and down stairs. We met new friends and learned tips from one another. We go to the gym three times a week." Our advice to people at risk of falling: "You own it. It doesn't own you. Take care of it. Complete all the classes. You'll enjoy it." – Ed (age 95) and Karen (age 75) completed MOB class together in LaGrange Park, IL in 2016.

Return on Investment

- Research suggests that ***Take Charge of Your Health*** leads to a $714 per person savings in emergency department (ED) visits and hospitalization, which yields $364 per person net savings after considering national average program costs of $350 per participant

- Research has shown that ***A Matter of Balance*** participation was associated with a-$938 decrease in total medical costs per year. This finding was driven by a $517 reduction in unplanned hospitalization costs, a $234 reduction in skilled nursing facility costs, and an $81 reduction in home health costs.

Collaborative Partners in Illinois

- Health Care Providers
- Health Care Systems
- Health Insurance Companies
- Managed Care Organizations serving adults only eligible for Medicaid
- Managed Care Organizations serving adults dually eligible for Medicare and Medicaid
- Pharmacies
- College of Pharmacy, University of Illinois Chicago
- Fall Clinic at University of Illinois at Urbana-Champaign
- Illinois Fall Prevention Coalition
- Illinois Department on Aging
- Illinois Department of Public Health
- Retirement Research Foundation

Developing ICHAC as a *Network Hub*

- ICHAC participates in NCOA's Network Development Learning Collaborative.
- Team Illinois includes ICHAC as lead partner with AgeOptions and Rush University Medical Center as key partners
- Team Illinois identified the following areas for growth as a Network Hub:
- Align the needs of sustainability partners, such as health insurers, health care providers, etc., with evidence-based programs offered by our program partners through ***Illinois Pathways to Health;***
- Know our competitors;
- Create and implement non-disclosure agreements;
- Know which administrative functions of a network hub should be carried out directly by the Collaborative versus by sub-contractors, e.g., accounting, billing;
- Develop mutually agreed upon metrics to measure success of our partnerships.

Contact Us

- Visit our website: https://www.ilpathwaystohealth.org/
- Please contact:

ILLINOIS COMMUNITY HEALTH AND AGING COLLABORATIVE

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Living well
Take Charge of your Health

MAC
MAINTAINING ACTIVE CITIZENS
Your area agency on aging

MAC, Inc. Living Well Center of Excellence Network Development Across Maryland

Leigh Ann Eagle, Executive Director
Sue Lachenmayr, State Program Coordinator

Discussion Topics

* Establishing Contracts with Hospitals to Drive EBP Expansion
* Challenges and Successes in Working with the Multiple AAAs
* Lessons Learned

Statewide Services for AAA and Health Care Partners

Statewide EBP Licenses	Statewide Calendar for Workshops	EBP Leader Trainings	Workforce Certification
Tracking of Referrals and Participant Engagement	Fidelity/Quality Assurance Monitoring	Data Entry and Reporting of Chronic Conditions and Disability Status	Reporting of Participant Self-Efficacy and Clinical Pre-/Post Measures
Ability to Add Additional Measures and Questions	On Site Technical Assistance	Annual Evidence-Based Training Academy	Quarterly Newsletters and Coordinator Webinars

Benefits to AAA Partners

- Partnerships with Hospital Systems
- Potential Funding Support for Workshop Implementation
- Reimbursement for QIO/QIN Additional Surveys
- Funding Support from State, National and Foundation Grants
- Regional Experts to Assist with Contracting
- Expertise and Resources to Attain DSMT Accreditation
- Expertise In Pricing Services and Contracts
- Training on Programs Reimbursable by Medicare
- Medicare Billing
- Diverse Health Care Partnership Models

Hospital Partners

* Peninsula Regional Medical Center (ACL CDSME, Falls, Pearls, H2H, Malnutrition Pilot)
* Johns Hopkins (CDSME, Falls, HRSA)
* Meritus Health (CDSME, Falls)
* University of Maryland Medical System (9 hospitals – CDSME, Falls)
* Medstar (10 hospitals - CDSME)
* Atlantic General (CDSME and Falls)
* Frederick Memorial Hospital (CDSME)
* Anne Arundel Medical Center (DSMP)

Contract Model: Regional Local Hospital

* Provide an array of cancer survivorship services (garden, cooking classes, gym and exercise boot camp, and an array of holistic programs), annual cancer retreat
* Cover cost of site/space for program and meeting implementation
* Provide an array of services to individuals in weight loss program (garden, cooking classes, gym, depression screening and programs)
* Provide targeted outreach to engage at risk minorities

Contract Model: Regional Local Hospital

* Train hospital-based CHWs and staff in evidence-based programs
* Provide depression screening and PEARLS to at risk individuals
* Host PRMC partner meetings and participate in hospital initiatives
* Pilot hospital to home services for Medicare/Medicaid individuals
* Pilot referral to nutritional services for individuals with diagnosis of malnutrition upon hospital discharge

Contract Model: Multiple Hospitals Across 2 States

* Empower individuals with chronic conditions to manage their health through Stanford Chronic Disease, Diabetes and Cancer Self-Management and a Hypertension Session O
* Identify high risk zip codes, identify partnering sites/organizations in those zip codes
* Recruit community individuals residing in high risk zip codes to be trained as workshop leaders
* Provide hospital-based liaisons to connect sites and leaders, set up workshops, and conduct pre-/post- BP, BMI, Body Fat and weight

Contract Model: Multiple Hospitals Across 2 States

* Referral criteria embedded in Electronic Medical Record
* Started in late April to generate referrals for OUTPATIENT – Primary Care and Urgent Care facilities; inpatient referrals to follow
* Physician clicks on Community Health Programs tab in EMR
* E-mail to the Call Center Screening for unmet social needs at point of intake/enrollment and linkage to social services
* Call Center has patient information, uses motivational interviewing to enroll them in a class.
* Patient attends CDSME (30, 60, and 90-day post f/up)

Contract Model: Multiple Sites Across 2 States

* CDSMP/DSMP/CTS/Hypertension Leader Trainings February-March 2017 – 65 leaders; 3 Leader Trainings scheduled for September 2017 (45-60 new leaders)
* Training and technical assistance for hospital liaisons, regional coordinators on data collection and recruitment
* Onsite assistance at all workshop session 1, fidelity/quality assurance monitoring of workshop delivery/data collection
* Expansion of database to include clinical pre-/post-measures (BMI, Body Fat, Weight)

Challenges in working with our AAA Partners

* Transition from State 'Pay for Completer' Model
* 21 AAAs, 19 are local government
  * Limited flexibility, unable to partner with hospitals/health care providers
* Limited staff, due to fixed/reduced budgets

Despite these challenges, the number of AAAs offering EBPs now includes all counties and most AAAs have increased the number of workshops/participants in EBPs.

Opportunities to Engage AAA Partners

* Maryland State Office of Aging provided funding 10 AAAs to develop a referral path for home and community-based services for at least older adults upon hospital discharge.
* This was an initial interaction with a hospital, but it may open the door to further partnering/contracting with hospitals.
* Veterans are a new priority population for EBPs – we believe expanding reach across the aging network will increase the potential for funding via VA Choice.
* PEARLS expansion provides opportunities for Medicare reimbursement.

Lessons Learned in Engaging Health Care Partners

* Risk assessments to refer individuals to appropriate EBP
* Centralized referral, convenient community-based locations, HIPAA compliant and continuous quality assurance processes
* Tracking referrals and reporting of participant engagement and long-term goals
* Pre-/post clinical measures (BP, BMI, Body Fat, Weight, Handgrip strength)
* Matching of participant self-efficacy to required ACO/NCQA measures (ability to self-manage, set action plans, understand steps to take to improve condition)

Assessing Patient Risk and Referral to Evidence-Based Programs

Chronic Disease Assessment

* Do you have 2 or more chronic medical conditions?
* Are you taking more than 5 medications?
* Do you have difficulty managing your condition(s)?

Falls Risk Assessment for patients over 65

* Have you fallen in the past year?
* Do you feel unsteady when standing or walking?
* Do you worry about falling?

Depression Screen: Over the past two weeks, how often have you been bothered by any of the following problems?

* Little interest or pleasure in doing things
* Feeling down, depressed or hopeless

Malnutrition/Food Insecurity Screen: During the last 12 months

* Have you worried whether the food would run out before you got money to buy more
* Have you found that the food that you bought didn't last, and you didn't have money to get more.

Unique Services of Value to Health Care Partners

* Population health approach - EBPs are a key component within the continuum of care
* Targeted outreach to engage hard-to-reach individuals (minorities, non-English-speaking)
* Flexibility in program delivery venues (community sites, in-home)
* Opportunity to add tailored clinical measures and/or data elements
* Bundling of multiple EBPs (CDSME, PEARLS, EnhanceFitness)
* Linking of high risk individuals to wrap-around services

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Building a Collaborative Community Network: The Massachusetts Experience

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The Power to Redefine Aging.
Hebrew SeniorLife
HARVARD MEDICAL SCHOOL AFFILIATE

Overview of the HLCE

Vision: Transform the healthcare delivery system. Medical systems, community-based social services, and older adult will collaborate to achieve better health outcomes and better healthcare, both at sustainable costs.

Key Features:

* Statewide Provider network of diverse community based organizations
* Seven (7) regional collaboratives
* Centralized referral, technical assistance, fidelity, & quality assurance
* Multi-program, multi-venue, multicultural across the lifespan approach
* Centralized entity for contracting with statewide payors
* Diversification of funding for sustainability
* EBP integration in medical home, ACO and other shared settings

Our Partnership Path

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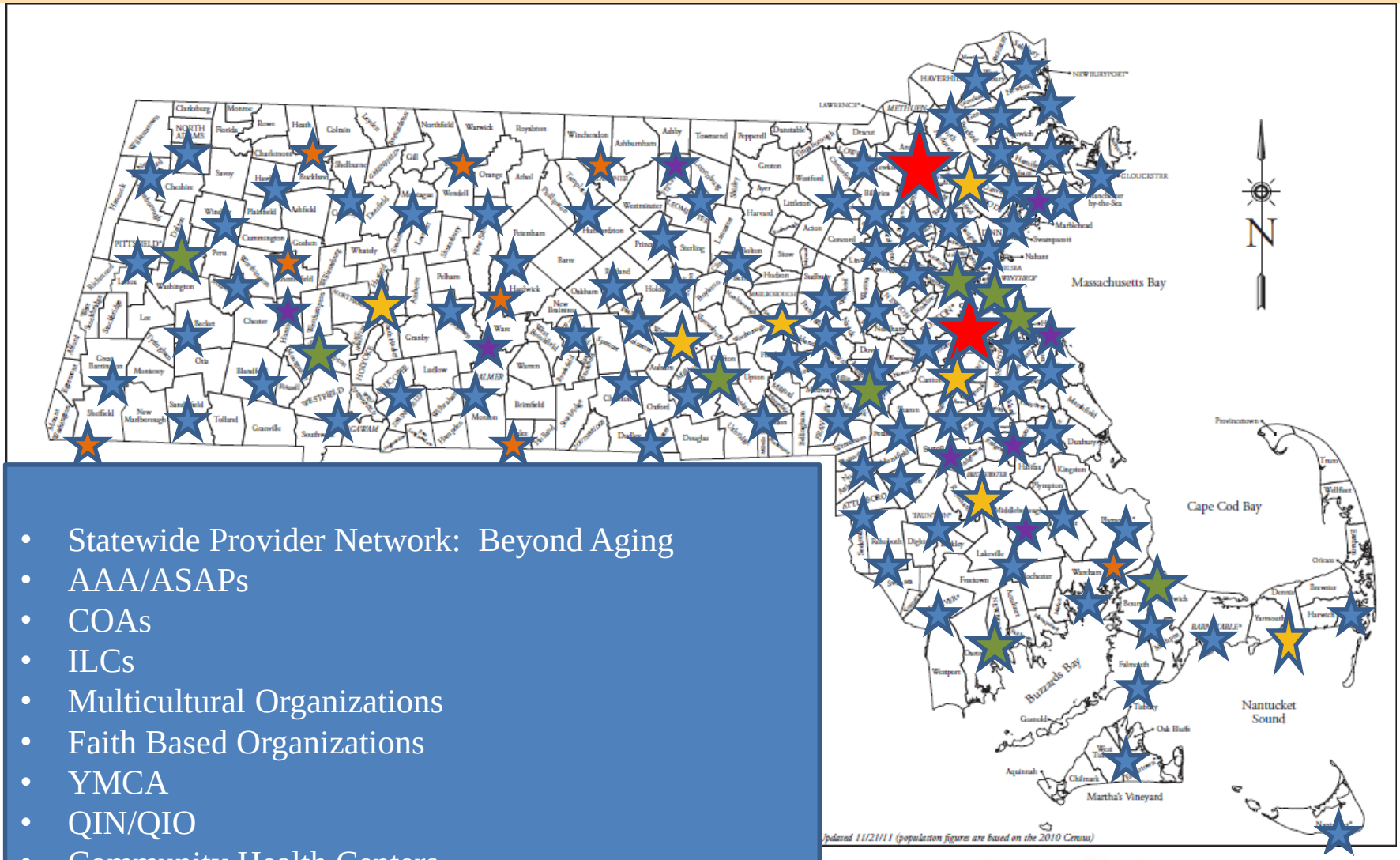
HLCE Provider Network



- Statewide Provider Network: Beyond Aging
- AAA/ASAPs
- COAs
- ILCs
- Multicultural Organizations
- Faith Based Organizations
- YMCA
- QIN/QIO
- Community Health Centers

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Value to Community Partner

- Multi-site license for CDSME (no cost, but …)
- Discounted or no-cost trainings in diverse programs
- Bi-monthly Fidelity / Best Practice Webinars
- Fidelity Committee
- Connections with Health Care
- Program reimbursement
- No membership fee
- Website with calendar and leader portal
- Annual Sharpening Your Skills Conference

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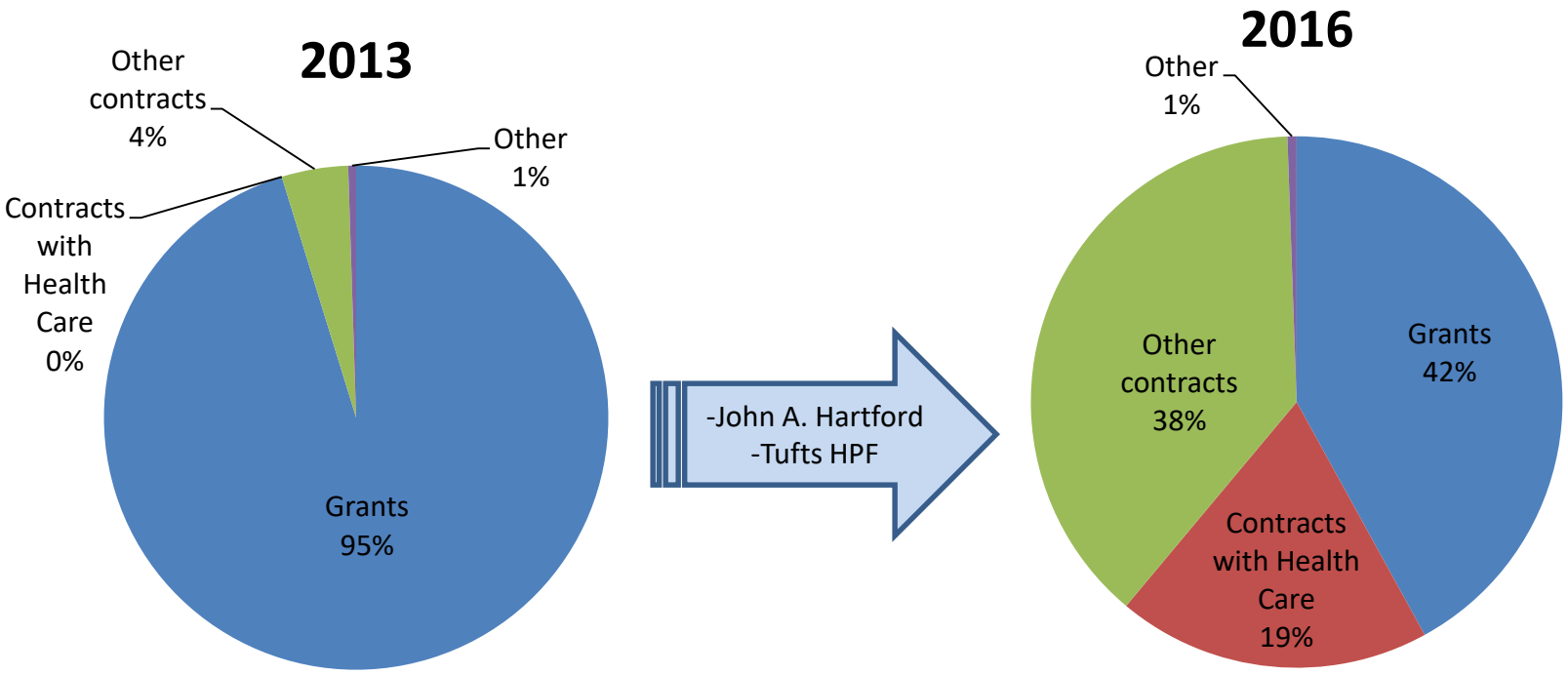
Outcomes: Towards a More Sustainable Model



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Key Learnings

- Start TODAY (or someone else will)
- Develop a shared mission and vision
- Look beyond usual suspects / aging network
- Consider including your competitors
- Provide Value to partners beyond $$$
- Be collaborative… until you can't
- If you know 1 network ….
- Communicate, Communicate, Communicate
- Celebrate Successes

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Celebrate Your Successes

Elder

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