AGING
Innovations & Achievement
AWARDS

sponsored by CST Critical Signal Technologies

n4a

2014

Recognizing innovative programs and successful practices of Area Agencies on Aging and Title VI native American aging programs

About n4a

The National Association of Area Agencies on Aging (n4a) is the leading voice on aging issues for the 618 Area Agencies on Aging (AAAs) across the country and a champion in the nation's capital for the 246 Title VI Native American aging programs. n4a's primary mission is to build the capacity of our members to help older adults and people with disabilities live with dignity and choices in their homes and communities for as long as possible.

For more information about n4a, AAAs or Title VI programs, or to view more award-winning programs in our Clearinghouse of Best Practices, visit www.n4a.org.

n4a's Aging Innovations and Achievement Awards staff:

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About CST

Critical Signal Technologies is a Health Services Company committed to offering innovative, cost-effective patient monitoring strategies for homes, hospitals and senior independent facilities in the U.S. and abroad. CST-LTL programs dramatically reduce unnecessary hospital admissions and allow individuals to live independently longer without compromising their dignity by providing real patient centered care. www.criticalsignaltechnologies.com.

CST-LTL Leadership:

Jeffery S. Prough, President and CEO

Marguerite Linteau, Chief Clinical Officer

Heather Sellar, Executive Director, Business Development

Acknowledgments

Every year, n4a proudly recognizes the innovative programs and successful best practices of our members through the n4a Aging Innovations and Achievement Awards (AIA) program. This publication is a comprehensive listing of the 45 programs that have won the Awards in 2014.

It is thanks to our ongoing partnership with **Critical Signal Technologies your Link to Life** (CST-LTL)—long-time sponsors of the AIA awards program—that we have this opportunity to honor and showcase the program initiatives of Area Agencies on Aging (AAAs) and Title VI Native American aging programs across the country.

We salute all those who have contributed to the prestige of this awards program by sharing their initiatives with their peers in the Aging Network. This sharing of cutting-edge concepts, best practices and innovative ideas helps inspire others, seed replication and ultimately, boost the capacity and success of all agencies.

In fact, n4a recognizes all our members for their tireless efforts to creatively use limited resources to develop vital services and supports for older adults, their caregivers and people with disabilities in communities nationwide. We hope this book supports your agencies' program development efforts and builds connections with your colleagues.

And remember, nominations for the 2015 AIA awards will open in March 2015.

"CST is a long-time supporter of n4a and a company committed to this association. That can be measured not only by significant sponsorship investment we have made consistently for the past seven years, but by helping shape the n4a Aging Innovations and Achievement Awards program. In this program alone we have handed out checks totaling $35,000, hoping to inspire the many talented people who comprise n4a's membership. While doing all this we have encouraged the members of n4a to give us the opportunity to share the many innovative ways we can help you… especially as you travel into the teeth of reform. I cannot thank enough the members who have allowed us to share your ideas and serve you as partners. The entire CST team is here to help and we look forward to speaking to the all n4a members in the future."

Jeffery S. Prough
President and CEO
CST-LTL

Introduction

n4a annually recognizes the best practices of member Area Agencies on Aging (AAAs) and Title VI Native American aging programs through the n4a *Aging Innovations and Achievement Awards program.* The awards highlight leading-edge and successful programs that demonstrate sound management practices that are replicable by others in the Aging Network. They exemplify both traditional and new strategies in a range of categories including Advocacy, Care Transitions, Caregiving, Community Planning/Livable Communities, Economic Security/Financial Assistance, Elder Abuse/Financial Exploitation Prevention, Ethnic/Cultural Diversity, Health/Long-Term Services & Supports Integration, Healthy Aging/Nutrition, Home & Community-Based Care, Information & Referral, Technology, Transportation/Mobility Options, Volunteerism/Civic Engagement and "You Name It!"

- **Aging Innovations Awards** honor the most innovative and cutting-edge programs among all nominations received, and

- **Aging Achievement Awards** recognize programs that meet all of the award eligibility criteria as a contemporary, effective and replicable program.

Annually, the awards are presented at the n4a Conference & Tradeshow. This year at a luncheon at Dallas, Texas, 32 programs received Aging Achievement Awards with a certificate of recognition. Thirteen were honored with engraved Aging Innovations Awards. In addition, through the generous support of CST-LTL, the four top-ranking programs received monetary awards.

To qualify for an award, programs must be between one to five years in operation, receive minimal assistance from outside experts and demonstrate effective approaches in either offering new services or improving existing services. Award criteria include demonstration of measurable results, e.g., cost savings, improved client service and enhanced staff productivity. The AIA awards are open to n4a members only.

Highlights of all past *Aging Innovations Award* recipients are available in the n4a members-only Clearinghouse of Best Practices at www.n4a.org.

As you read, we hope that these awarding-winning programs will inspire your efforts as you address current challenges, seize opportunities and implement solutions in your community. And remember, plan to share your innovations with us next year!

Nick Beamer
n4a President, 2012–2014

Sandy Markwood
n4a CEO

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2014

Aging Innovations Awards

Senior & Disability Survival School and Senior & Disability University
San Francisco Department of Aging & Adult Services (DAAS)

To assist seniors and ensure local officials are considering their interests and concerns, DAAS hired a nonprofit agency called Senior and Disability Action (SDA) to develop an Empowerment Advocacy program that includes two components. Senior & Disability Survival School (SDSS) provides participants with information and contacts needed to gain access to health, housing and other support services. Senior & Disability University (SDU) offers formal training on influencing civic and political change.

Because seniors or adults with disabilities in San Francisco may come from immigrant, LGBT or disabled communities as well as a variety of different ethnic/racial backgrounds, classes are taught with a diverse audience in mind. One semester might target Russian immigrants living in the Sunset District; another may focus on homeless seniors living in the Central City. Having developed advocacy skills, graduates of SDSS and SDU participate in public hearings on a variety of issues such as free public transportation for seniors and adults with disabilities.

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Budget:
The current annual budget for SDA Empowerment Advocacy is $178,850, which includes salary and benefits for the directors of the schools, rent for office and meeting space, staff training and travel expenses.

Accomplishments:
In the last two years, 200 participants have been trained. According to a recent consumer satisfaction survey, 100 percent of participants are very satisfied with the training and approximately 55 percent have taken action to advocate for themselves or the aging and disability networks.

Replicability:
The curriculum developed for the two schools can be shared with other organizations via email. The cost of staffing can further be reduced with the assistance of committed volunteers.

Unseen Images, Untold Stories: Using Photovoice to Capture the Lives of LGBT Elders
ElderSource

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"Unseen Images, Untold Stories" is an exhibition by lesbian, gay, bisexual and transgender (LGBT) elders in Northeast Florida. LGBT elders confront a "double whammy" in facing challenges associated with aging while being vulnerable because of their sexual orientation and/or gender identities. The exhibition is based on PhotoVoice, a grassroots approach that uses photography to initiate community conversations on key issues.

The exhibit, supplemented by audio-recorded stories of six participants, is designed to increase community awareness; inform elected officials, policy makers and the general community; and encourage support of laws and services to help LGBT elders age with dignity and independence.

Budget:
The $10,994 budgets covers $1,600 for personnel; $1,500 for facilitator fees; $1,080 for exhibit materials; $1,500 for OnCell auditory components; $680 for installation; $1,825 for graphic design fees; $1,892 for brochures; $390 for advertising; and $527 for postage. Digital cameras and photography services were donated. Funding from a donor paid for the facilitator fees and production materials.

Accomplishments:
Five lesbians and one transgender female participated in the project. Prior to the exhibit, the participants were "out" in varying degrees. One almost quit during the project out of fear, but ultimately finished and is now fully out in her apartment building. Another created an LGBT Facebook page for her community. One reconnected with her mother. After the exhibit opened at the contemporary art museum in Jacksonville, one of the area's most rural counties began using the exhibit to jumpstart conversations.

Replicability:
A handbook developed by ElderSource is available to aid in replication. The program requires 1 to 2 percent of a staff person's time plus marketing and communications work. The greatest challenge involves attracting LGBT elder participants and finding venues willing to show the exhibit.

Healthy Seniors at Home
Region IV Area Agency on Aging (RIV AAA)

The Healthy Seniors at Home project provides frail seniors who cannot attend site-based classes offered by RIV AAA access to chronic disease self-management training through an in-home information-sharing model. Volunteers for RIV AAA's Senior Companion Program (SCP) who also have a chronic condition attend a six-week Personal Action Toward Health (PATH) class and then share what they have learned with homebound seniors through a peer-to-peer information-sharing model.

Quarterly in-service trainings and ongoing staff support ensure volunteers maximize program impact. This variation on the evidence-based PATH program developed by Stanford University brings critical support to frail elders each week by teaching them chronic disease self-management skills, while also providing much-needed respite for their caregivers.

Budget:
Total operating costs of $47,600—funded through a three year commitment from United Way—include personnel time of $29,880; fringe benefits of $3,182; staff travel costs of $1,600; supplies of $1,218; contractual costs (PATH trainer) of $2,000; volunteer travel costs of $5,000; and administrative costs of $3,720.

Accomplishments:
Participants in the Healthy Seniors at Home program report an increase in their ability to live independently, manage symptoms, increase exercise and activity levels, and communicate with physicians. Sixty-seven percent of participants report an increase in general health. Participants showed a decrease in fatigue, health distress, disability and activity limitations. One hundred percent of caregivers reported that the project helps them continue in their caregiving roles.

Replicability:
Program replication can be achieved by building on existing PATH and Senior Companion or other senior volunteer programs. If a pool of existing senior volunteers is not available, PATH class graduates can be recruited and trained to share their chronic disease self-management skills.

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Community Health Navigator Program
United Way's Area Agency on Aging of Tarrant County

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The Community Health Navigator (CHN) Program targets homebound individuals with multiple chronic conditions who are considered at high risk of hospitalization. The Agency initially developed the concept for this program to fulfill the need for a more cost-effective way to reduce hospitalizations. Community Health Navigators (CHNs)—including community volunteers, social work interns and retirees—use the Insignia Patient Activation Measure® (PAM®) software to develop behavioral action plans customized to patients' ability and environment.

CHNs work with participants to set goals and provide support to meet those goals during a six-month period. They call clients weekly and make monthly home visits—doing everything from organizing medications to helping create a list of questions for doctors. This is an innovative use of software that is normally utilized only in clinical settings.

Budget:
Total annual costs of $136,056 include salary and fringe benefits for the project lead and community health navigators (trained staff paid $10.50–$12 an hour); PAM® software licensing fees; monthly phone, mileage and office supply expenses; and durable medical equipment (such as scales) for clients. The program serves 250 homebound clients at a cost of $544 per person.

Accomplishments:
Participants report greater confidence in dealing with health issues, a decrease in hospital and emergency care, and a higher level of engagement in their health. On average, CHN participation results in an unprecedented 30 percent decrease in hospitalization.

Replicability:
Low startup costs (a one-time fee of $5,000 for up to 20 coaches and yearly software costs of $7,000 for up to 1,500 participants) make the CHN Program easy to implement. Utilizing volunteer CHNs reduces the annual cost to $51,281.Partnering with a home-delivered meal provider is recommended.

The Best of Both Worlds: Care Manager in the Home & Nurse in their Pocket
Elder Services of the Merrimack Valley, Inc.

When Elder Services was charged with reducing hospital readmission within its six partner hospitals through the Community-based Care Transitions Program (CCTP) funded by Centers for Medicare & Medicaid Services (CMS), the agency discovered that although coaches who visit recently discharged patients in their homes helped reduce readmission, oversight by clinical nurses could further improve the program.

To accomplish this, coaches who visit patients now use a special tablet equipped with Care at Hand (CAH) mobile technology, which provides coaches with questions tailored to the patient's diagnosis, treatment and risk factors. If patient responses indicate a decline in health status, the system sends real-time alerts to a nurse coordinator, who helps the patient and coach address issues within 24 hours.

Budget:
Deployment of CAH required investment in hardware and software and an increase in nursing care coordination activities. To serve 561 patients for six months, total operating costs were $205,243. The majority of the costs were absorbed by the CCTP. This resulted in net savings of $370,000, approximately $109 per patient per month.

Accomplishments:
The program is showing promising results in reducing readmissions. Prior to the introduction of the nurse care coordination and CAH technology, Elder Services had a 24 percent 30-day readmission rate. After introduction of the technology, the 30-day readmission rate dropped to 14 percent.

Replicability:
Sites interested in replicating these results should have non-clinical health coaches supervised by a central care manager who is a nurse. The Care at Hand management team provides technical assistance and shares best practices from partner organizations, which can serve as a guide for other programs looking to reconfigure or to initiate a care transition program.

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Intervention: Care at Hand real-time care coordination platform

Lay Caregiver Completes Survey (AAA/Home Care Agency)

Care Coordinator Receives Alerts (AAA/ASAP/MLTSS/Payer)

Emergency Dept/Admission — $$$$$ (Cost to Payer)

Primary Care Provider Visit — $$$ (Cost to Payer)

Home Visit by Nurse — $$ (Cost to Payer)

Call into Home by Care Coordinator — $ (Cost to Payer)

© Care at Hand

Good Health Good Living! eMagazine & Videos
Ventura County Area Agency on Aging (VCAAA)

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The 60-plus population in Ventura County is projected to increase 191 percent from 2010 to 2050. In order to promote citizen involvement in the planning and delivery of services for Ventura County's older population and their caregivers, VCAAA decided to create and distribute an eMagazine to celebrate the ways seniors are reinventing themselves and learning to use technology.

The eMagazine stories and accompanying videos serve as an example to other seniors in the community and also illustrate the ways in which the next group of 60-plus adults might embrace their own reinvention. In addition to distributing the magazine and videos online, VCAAA also plays the videos in the waiting area of the agency.

Budget:
The creation of the eMagazine and videos was factored into agency staff time. Startup costs included purchase of video and camera equipment. The eMagazine was posted on the agency's existing website, and videos were posted for free on YouTube.

Accomplishments:
This eMagazine and related videos are capturing "real" history and accounts of ordinary seniors accomplishing extraordinary things and effecting meaningful change. The publication is innovative in its online delivery and use of videos to cast a wider net of viewership than the traditional paper magazine.

Replicability:
The eMagazine and video format the agency created is available for replication. Resources required by interested agencies include video equipment, a camera for still photography and staff time to conduct interviews, take video and photos, and design and write articles. The total time involved in the preparation, creation and distribution of an eMagazine and related videos is approximately 15 hours.

Healthier Living Alumni Online Community
San Francisco Department of Aging & Adult Services (DAAS)

The Chronic Disease Self-Management Program (CDSMP) is a six-week, evidence-based health education program developed by Stanford University to assist adults with ongoing health conditions. DAAS worked with the National Council on Aging (NCOA) to provide an online community for CDSMP graduates, many of whom expressed interest in continuous support.

Through the online community, graduates continue to have access to tools that support self-management, practice what they learned in the workshop, participate in forums, get support from others and share resources to better manage their chronic health conditions. They are also able to interact online with subject matter experts.

Budget:
The annual budget of $40,432 includes the cost for the online platform and a portion of the salaries of the Project Director, Community Services Manager and Community Monitors from NCOA. Creation of the online community was funded through a grant from the National Telecommunications and Information Administration (NTIA, U.S. Commerce Dept.) Broadband Technology Opportunities Program (BTOP).

Accomplishments:
As of April 2014, there are 510 active members. Both the membership and site visits have continued to increase since implementation. According to results of a consumer satisfaction survey, at least 65 percent of CDSMP participants reported that the online community has helped them maintain or improve their mental and/or physical wellbeing, that they want to continue the service and that they believe the online community helps reduce their sense of isolation and has increased their community or social engagement.

Replicability:
Although some older adults are still behind in their use of Internet resources, those who have gone through the online CDSMP training are already familiar with the social media application. The program is cost-effective, and outcomes are measurable. The experiences of the DAAS staff can be shared via Prezi, an online presentation, by request.

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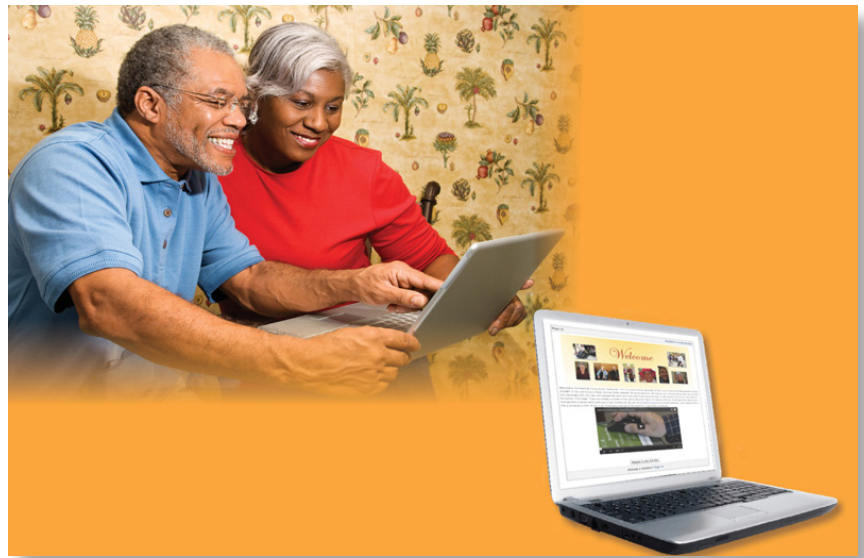
Saturday Service 4 All
Mountain Empire Older Citizens, Inc. (MEOC)

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In 2011, when the Mountain Empire Regional Transportation Advisory Committee (MERTAC) conducted a survey as part of the creation of a transportation development plan, 55 percent of respondents identified Saturday transportation as an unmet need in the area. At the time, individuals who were transportation-dependent had no option for recreational, social or employment transportation on the weekends.

In response to this need, MEOC began Saturday transportation for individuals with disabilities and seniors through the assistance of a variety of community partners including the local community services board, behavioral health providers, and the Department of Veterans Affairs. This service, provided by MEOC's transit department, offers a coordinated system of public and human service transportation with additional support services including passenger attendants, shopping assistance and mobility management.

Budget:
MEOC received a total of $100,000 from the Virginia Board for People with Disabilities and the Virginia Department for Aging and Rehabilitative Services, which accounts for driver, dispatcher and supervisory staff wages and fringe. Administrative services are provided by the Mobility Manager through existing funding from the Department of Rail and Public Transportation. Fares are collected to assist the program.

Accomplishments:
Within the first year, MEOC provided 1,627 one-way trips. Halfway through the second year, MEOC has provided 1,131 one-way trips.

Replicability:
A cooperative relationship between the aging and disability communities as well as support from state transportation organizations is key for successful replication. Having a collaborative transportation council with inclusive representation allows members to discuss new ideas and/or concerns openly.

Legacy Corps – Support for Veterans & Military Families
County of San Diego, Aging & Independence Services (AIS)

The high concentration of veterans and active-duty military in San Diego—and the related high occurrence of problems stemming from traumatic brain injury, post-traumatic stress disorder and associated dementias—prompted AIS to apply for funding for veteran caregiver support through the Corporation for National and Community Service's Legacy Corps program. AIS was approved for 30 Corps volunteers dedicated to supporting the needs of military and former military personnel. Volunteers—who range from younger students and active-duty military to retirees—commit to 450 hours of service in a 12-month period in exchange for a monthly living allowance and college tuition assistance.

Legacy Corps provides one-on-one support and respite, as well as connections to a variety of available community services, to family caregivers of military personnel. Forming alliances with the Veterans Coalition of San Diego and the Caregiver Coalition, AIS also spearheaded a Benefits Expo that included veterans and senior services organizations, nonprofits and businesses that provide services for caregivers and veterans. New partnerships also have resulted in additional services for caregivers onsite at Balboa Navy Medical Center, Glenner Memory Centers and Vista Jail.

Budget:
The initial contract with the University of Maryland, which subcontracts to run the Legacy Corps program, included $82,500, funding 30 volunteers. With the addition of a 58 percent match, the budget totaled $196,821. For the second year, slots were increased to 33, resulting in funding of $90,750 and a total budget of $233,971.

Accomplishments:
During its first year, Legacy Corps provided 5,314 hours of service to more than 55 families. To date, program year two is on track to provide an estimated 6,700 hours, engaging an additional 25 families.

Replicability:
Additional AmeriCorps/Legacy Corps volunteer slots are available nationwide through the University of Maryland at www.sph.umd.edu/hlsa/aging/legacy_corps/index.html.

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Moodle Volunteer Development System
Ventura County Area Agency on Aging (VCAAA)

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State Health Insurance and Assistance Program (SHIP) counselors volunteering with VCAAA often faced a wait time and had to undergo a complex, time-consuming training process before going out into the community to help people with Medicare and Medicaid problems. To remedy this situation, VCAAA set a goal to reduce the volunteer dropout rate by 50 percent.

To meet this goal, VCAAA sponsored the development of an online, web-based program that provides volunteer training as well as access to necessary documentation and videos. Volunteers can communicate privately online with their mentors during the training and can track their time. The system provides counselors a secure learning environment that is available at any time or from any place.

Budget:
Moodle is a free, open-source web application. The cost of creating the site is very low. First-year startup costs are approximately $600. The critical component involves finding volunteers with the willingness and technical skill to complete the training and take on the challenging work.

Accomplishments:
Beginning training when volunteers walk in the door helps them feel more plugged into the group and increases the odds that they will stay with the program. Additional positive outcomes include cost savings and improved quality of SHIP counseling.

Replicability:
This program has high potential for replication. Through a joint venture with Ventura County and the State of Colorado, the program has already been replicated in Colorado. The Ventura County AAA freely shares course materials.

2900 Lakeview – Service Expansion & Coordination
Region IV Area Agency on Aging (RIV AAA)

2900 Lakeview is a hospital, hospice, Center for Independent Living (CIL) and RIV AAA partnership that resulted in a one-stop access point for aging and disability services, including a Program of All-Inclusive Care for the Elderly (PACE). Co-location of staff, co-branding across agencies and integrated intake creates seamless access to information and services across the age and disability spectrum.

Open in 2012, 2900 Lakeview expanded from an 11,000-square-foot RIV AAA office to a 34,000-square-foot shared venue for RIV AAA, PACE, a public resource center, a call center for aging and disability, Foster Grandparents, Senior Companions, the local State Health Insurance and Assistance Program (SHIP), a peer-run SeniorNet computer classroom and multiple meeting rooms. RIV AAA spearheaded finding investors, championing a capital campaign, overseeing legal issues, creating the PACE organization, hiring staff and redesigning 2900 Lakeview.

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Budget:
RIV AAA secured $2.5 million in low-cost cash loans from three entities to fund the PACE startup. Capital campaign donations of $1 million, direct infusion of $500,000 from RIV AAA, and commercial loans of $2 million secured by RIV AAA provided renovation and expansion funds. PACE has a five-year business plan and will pay back all loans. Annual operations are $14 million.

Accomplishments:
PACE has created 53 jobs and $12 million in annual revenue. Currently, 85 PACE participants are enrolled, with a target of 225. Program business, referrals among agencies and attendance at classes have all increased.

Replicability:
AAA's can replicate this effort by spearheading or joining PACE development. Common examples of investors are hospitals, housing corporations, hospices and local foundations. It takes about a year and a half to secure investors and conduct and obtain approval for a PACE feasibility study; one year for renovation; five years for self-sufficiency and loan paybacks; and one year for coordinated planning of services.

Grandparents Raising Grandchildren
County of San Diego, Aging & Independence Services (AIS)

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In San Diego County, approximately 24,000 grandparents have primary responsibility for the welfare of their grandchildren. Many of these older adults face challenges in navigating the complex maze of available health, education and social service programs. To help address this situation, AIS joined with community members to create the Grandparents Raising Grandchildren initiative, which provides education, support and resources for grandparents and kinship caregivers who are raising children; advocates for grandparents; and creates awareness about the unique needs of grandparents.

The committee hosts an annual Grandparents Raising Grandchildren Symposium and created a handbook that includes information on determining legal status of grandparents, navigating the child welfare system, and finding resources for child care, housing and mental health services.

Budget:
Initial funding of $83,000 was provided through OAA Title III E National Family Caregiver Support Program funding and various community partners. The majority of expenses (75 percent) related to the Symposium. The remaining 25 percent of funds were spent on printing the handbook, which is also posted online. Committee members have incorporated work on this initiative into their regular workload.

Accomplishments:
More than 700 grandparents and others have attended the Symposium, and evaluations have been overwhelmingly positive. In addition, thousands of resource handbooks have been distributed. Further, the committee has forged relationships with entities like the Children's Initiative to identify and implement legislative efforts to improve the lives of grandparents raising grandchildren.

Replicability:
The initiative may be replicated by organizations that have strong relationships with community agencies that serve this population. Once key stakeholders have committed to participating, subcommittees can be formed for outreach and education, data and resource collection, and advocacy and policy change. The symposium could be replicated in a cost-effective fashion by seeking sponsorships from partner agencies, utilizing local speakers and limiting food purchases.

Wills for Seniors
Jefferson Area Board for Aging (JABA)

JABA hosts Wills for Seniors in conjunction with four teams of lawyers, law students and notary republics who volunteer their time to meet privately with seniors to prepare customized legal documents, including a will, a power of attorney and an advance medical directive. The event was created in 2010 when Andrew Nae, Jr., a local attorney, approached JABA with a partnership idea aimed at meeting the unmet need for legal assistance among low-income seniors.

JABA promotes the event to seniors and serves as host. University of Virginia law students, under the watchful eye of seasoned attorneys, handle the legal paperwork. The event, which is held in the JABA offices, is now so popular that there is a waiting list for appointments with the legal teams.

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Budget:
Wills for Seniors costs of about $200 include lunches, utilities and printing. All attorneys, notary republics and law students donate 100 percent of their time, so no additional financial support is needed.

Accomplishments:
Since 2010, the event has provided basic estate planning and legal services valued at $300,000 for more than 300 local, low-income seniors. Wills for Seniors provides elders with peace of mind, as they are able to express and have control over their final wishes in a way that they might not otherwise be able to afford to do.

Replicability:
JABA is willing to offer step-by-step training and hands-on assistance for any agency wishing to implement this easily replicable program. Materials on the process, schedule, documents used and more are ready and available for use by other agencies.

2014
Aging Achievement Awards

ADVOCACY
Senior Bullying
Pennyrile Area Agency on Aging & Independent Living (AAAIL)

When participants and staff at a local senior center reported that they were victims of disturbances, threats and physical violence caused by a participant/volunteer, Pennyrile AAIL collaborated with local police, agencies and officials to resolve the problem and create "Senior Bullying," an awareness training for senior citizens, service providers, social workers and others who work with senior citizens. The training defines bullying, identifies where it occurs and types of bullying, and provides information on how to handle it.

Budget: Costs to offer the training are minimal and include staff time, travel and printing of training materials.

Accomplishments: Approximately 135 individuals have been trained. The existing problem has been addressed. Greater awareness has resulted in more proactive, preventive measures being implemented in places where seniors are located.

Replicability: This training can be replicated by utilizing existing staff and collaborating with local agencies, facilities and organizations. Pennyrile AAAIL has provided the training to other areas of the state and is presenting on it at national conferences.

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ADVOCACY
Wisconsin Aging Advocacy Network
Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR)

GWAAR convened a meeting of older adults, Aging Network leaders and aging program professionals committed to advancing public policy to improve the lives of older adults. The meeting led to the creation of Wisconsin Aging Advocacy Network (WAAN), an alliance that identifies key issues, engages members in advocacy campaigns and increases the capacity for grassroots leadership in the state.

Budget: The 2013 budget totaled $21,763, including room fees, a conference phone line, refreshments and 10 percent staff costs for leadership and staff support supplied by GWAAR. WAAN's core members contribute toward operating expenses.

Accomplishments: WAAN has succeeded in influencing policy related to Medicaid waivers, the senior prescription drug assistance program, transportation funding, state nutrition program funding and more. GWAAR recently registered as a lobbying principal with two authorized staff lobbyists to help advance GWAAR and WAAN priorities.

Replicability: Replication could occur in every state. A commitment of staff time and resources is necessary to handle meeting logistics and develop and disseminate information.

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CAREGIVING
Alamo Caregiver Empowerment Hands-On Care Training for Family Caregivers
Bexar Area Agency on Aging (Bexar AAA)

Bexar AAA collaborated with six partners to develop Alamo Caregiver Empowerment (ACE) Wings, an 11-module hands-on program based on best practices of home health care. The curriculum provides caregivers with foundational information, demonstrates relevant skills and walks caregivers through delivery of each skill. Brief online videos help participants review skills and provide information for those who cannot attend the onsite training.

Budget: Startup costs of $17,210 include personnel, fringe benefits, travel, equipment and supplies ($5,000), curriculum consultation/development, website development and the Elder Skills online video subscription ($3,960). Ongoing costs include a percentage of a staff member's time and benefits, nurse instructors/consultants ($35/hour) and the Elder Skills renewal fee ($1,140).

Accomplishments: Since ACE Wings began in October 2012, more than 1,000 family caregivers, 24 promotoras and 20 elder friends have participated. Lickert assessments completed by caregivers document a 99 percent satisfaction rate.

Replicability: To implement the training, organizations can purchase the 11 module presentations at $250 through Bexar AAA. Costs are reduced if nurses donate their time to teach modules and local health care providers donate equipment and supplies.

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CAREGIVING
Caregiver Project
Alliance for Aging, Inc.

The Caregiver Project integrates state and federal funding for caregiver services, education and training together with the services of the Alliance's Aging & Disability Resource Center (ADRC) Family Caregiver Specialist. The specialist offers direct assistance to caregivers and families by providing information and counseling about services available through the Alliance and in the community.

Budget: The Caregiver Project, based entirely on available Older Americans Act and state general revenue funding, totals approximately $3 million.

Accomplishments: The Caregiver Specialist annually counsels 2,300 clients and educates an additional 2,500 people through outreach about caregiver services. Funded programs in the community serve 1,230 individual clients and their families. The project has enabled the Alliance to more strategically address caregiver needs.

Replicability: The Caregiver Project can be replicated by strategically integrating federal and state funding sources with a designated, highly-trained specialist specifically devoted to addressing caregiver and family issues.

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CAREGIVING
Care Pathways
Riverside County Office on Aging (OoA)/Aging & Disability Resource Connection

To expand caregiver education and support, in 2010 the Riverside County OoA implemented Care Pathways, 12 weekly, two-hour workshops delivered at sites in targeted communities around the county. Topics include issues caregivers face, with the goal of providing support for and decreasing risk of depression among caregivers. Since 2013, an Aftercare program offers ongoing monthly group meetings, additional workshops, follow-up phone calls and a two-day caregiver symposium for all Care Pathways graduates.

Budget: The FY 2012–2013 operating budget of $430,000 included salaries, fringe, benefits and mileage for 4.5 facilitators; mailings; educational event costs; and overhead.

Accomplishments: To date, more than 500 participants have graduated from Care Pathways. According to 2011–2012 survey data, 97.5 percent of surveyed participants said the support groups helped them reduce stress associated with being a caregiver.

Replicability: Agencies could identify local partners to assist in implementation and donate workshop space. A sliding fee or suggested donation could help offset costs.

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CAREGIVING
Caring Together, Living Better
AgeOptions

In 2011, AgeOptions developed the Caring Together, Living Better (CTLB) project to design, test and refine a faith-based, train-the-trainer caregiver curriculum to meet the spiritual and supportive needs of African American caregivers in the community who rely heavily on their faith to overcome caregiving challenges. The Paths to Faithful Caregiving curriculum under CTLB, adapted from the University of Illinois Extension's evidence-informed Caregiving Relationships curriculum, includes faith exercises with topics that fit caregiver needs.

Budget: Costs associated with the Paths to Faithful Caregiving curriculum include facilitator training and curriculum usage fees. AgeOptions and the University of Illinois Extension are working on developing a licensing process for the program.

Accomplishments: According to results from pilot tests, 97 percent of the caregivers' ratings of the faith exercises described them as either extremely helpful or very helpful.

Replicability: Volunteers or staff can lead workshops after they have been trained. With minor changes, the program can be adapted to spiritual backgrounds other than Christianity.

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CAREGIVING
Community Care Transitions Program
Salt Lake County Aging & Adult Services

Caregiver Academy is a monthly training that enables caregivers to develop skills, receive peer support, and learn about new resource service options within the Salt Lake area. "A Caregiver's Guide" is given to each participant for use as an in-home care guide.

Budget: The initial 132 hours to design, measure and create the program cost approximately $3,280. Once the program was developed, monthly staff costs were $99.40. "A Caregiver's Guide" costs $7.50 to print but is also available for free online.

Accomplishments: The Caregiver Academy was held 16 times from July 2012 to November 2013. More than 115 caregivers attended. Ninety-five percent of survey respondents would recommend the Academy to another caregiver, and 91 percent found the handouts and activities extremely to very helpful.

Replicability: This program is easily replicable with a minimal budget if sponsorships are solicited and local providers, subject-matter experts or caregivers donate their time for the one-hour skill-building presentations.

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CARE TRANSITIONS
Appalachian Community Transitions
Appalachian Agency for Senior Citizens (AASC)

Appalachian Community Transitions (ACTion) is a Community-Based Care Transitions collaborative that seeks to improve transitions from inpatient hospitals to other care settings in rural southwest Virginia. Highly trained professionals work closely with hospital staff from four local acute care hospitals to coach patients and their caregivers to pinpoint issues that lead to readmission. AASC has also developed an electronic referral system with local hospitals and departments of social services to further increase care.

Budget: The annual budget includes $7,000 for training and travel, $104,888 for personnel and administrative wages, and $15,000 for overhead including equipment, supplies, insurance, gasoline and support costs.

Accomplishments: Currently, 89 percent of patients have avoided hospital readmission.

Replicability: The Care Transitions Intervention is easily replicated within any system that is ready to accept a new concept of providing quality health care. AASC is working with various agencies and hospital associations on statewide replication.

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CARE TRANSITIONS
Care Transitions Intervention
Riverside County Office on Aging/Aging & Disability Resource Connection

Care Transitions Intervention (CTI) is an evidence-based, four-week, low-intensity program that teaches patients to take a more active role in their health care. Seniors with chronic diseases who are being discharged from the hospital learn to use specific tools and skills. This is done with assistance from a Transitions Coach who follows patients' hospital stays, conducts home visits for 24 to 72 hours after discharge and tracks patients for the first four weeks after they leave the hospital.

Budget: The program costs $96,000, which includes the salary, fringe benefits, mileage and overhead cost for one Transitions Coach.

Accomplishments: In 2013, 30-day readmission rates for patients who completed CTI were cut in half from participating hospitals' overall readmission rates. Pre- and post-patient satisfaction scores increased for patients who completed CTI.

Replicability: Local agencies can partner with area hospitals and foundations to fund a Transitions Coach position. CTI has tools to assist with presenting benefits and a business case to stakeholders.

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CARE TRANSITIONS
The San Diego Care Transitions Partnership
County of San Diego, Aging & Independence Services (AIS)

The San Diego Care Transitions Partnership (SDCTP), a partnership between AIS and four large health systems, provides comprehensive hospital and Community-based Care Transitions Program (CCTP) support to medically and socially complex patients through Care Transitions Intervention (CTI). CTI offers coaching by trained nurses; medication support by pharmacists; and the Care Enhancement program, through which AIS social workers provide short-term, intense, post-discharge care coordination.

Budget: The CCTP Program Agreement with CMS prohibits the release of any rate information; however, fiscal year indirect costs of $501,116 were not reimbursed in the rate. To serve other payors, AIS established an annual rate that includes salaries and benefits and all indirect costs for CTI ($174,297) and Care Enhancement ($139,999).

Accomplishments: From May 2013 through February 2014, 8,681 patients completed comprehensive, patient-centered care transition services in 13 hospitals. Only 848 were readmitted to the same health system within 30 days. In that timeframe, the SDCTP achieved a readmission rate of 9.8 percent, compared to the baseline readmission rate of 18.6 percent.

Replicability: Both CTI and Care Enhancement require training and staff flexibility to make daily hospital and home visits.

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COMMUNITY PLANNING / LIVABLE COMMUNITIES
Community Streets as "Play Areas"
Bexar Area Agency on Aging (Bexar AAA)

Bexar AAA created a collaborative of more than 60 community partners called Age Well Live Well Alamo Area (AWLW) to address health and wellness, volunteerism and resource sharing. AWLW sponsored an Activity Zone as part of the YMCA of Greater San Antonio and the City of San Antonio's Síclovía, a free event that turns city streets into a safe place for people to exercise and play. In the Síclovía AWLW Activity Zone, partners demonstrate exercises on the Solar Stage and attendees participate in the "Passport to Fitness" challenge.

Budget: The AWLW program was implemented over two years with $25,000 in state grant funding and $12,000 in donations rom AWLW collaborative partners for Siclovia.

Accomplishments: In a survey conducted by the University of Texas Health Science Center's Institute for Health Promotion Research, 42.5 percent of the 65,000 attendees stated they would not have been active had it not been for the event.

Replicability: This "Play in the Street" program can be performed on any street with city approval, permits and planning from local officials, organizations and businesses.

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ELDER ABUSE / FINANCIAL EXPLOITATION PREVENTION
Older Adults Financial Protection Consortium of Miami-Dade & Monroe Counties
Alliance for Aging, Inc.

The Alliance, in collaboration with community partners, created the Older Adults Financial Protection Consortium of Miami-Dade and Monroe Counties to address the growing problem of financial exploitation of older adults. Initiatives included an Elder Financial Abuse Symposium, at which a panel of experts discussed legal and ethical issues related to financial abuse, and a financial literacy program—Money Smart for Older Adults—launched by the Alliance and the Consumer Financial Protection Bureau (CFPB, a new federal agency).

Budget: Total operating costs of $26,040 include 20 percent of the OAA Title VII Elder Abuse Prevention Coordinator's time ($4,200) and the salary for the Consortium Manager ($21,840). Funding for other operations is in-kind.

Accomplishments: Training and presentations served more than 200 older adults and professionals. More than 100 elders, caregivers and professionals attended the Elder Financial Abuse Symposium.

Replicability: The Alliance modeled its program after a financial protection network in California. Programs are available to others at no cost.

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ETHNIC / CULTURAL DIVERSITY
LGBT Alliance
Multnomah County Aging & Disability Services

Multnomah County Aging & Disability Services spearheaded an education and outreach campaign to provide LGBT sensitivity training to its staff and provider network. The initiative included forming an LGBT Alliance work group, holding listening sessions with LGBT older adults, developing a "welcoming designation" for adult care homes, producing safe space posters for office lobbies, and hosting "cozy conversations" of interest to LGBT consumers. Three-hour, mandatory staff trainings, developed with local content experts, included showings of the film Gen Silent.

Budget: The only cost to date is the $2,500 Gen Silent rental fee. The agency partnered with AARP and local health systems to attract larger audiences and leveraged their support to underwrite training costs.

Accomplishments: The 117 training participants experienced a 46 percent improvement over baseline knowledge as a result of the training.

Replicability: Collaboration with LGBT consumers and agencies serving LGBT older adults is crucial. Multnomah County Aging & Disability Services provides technical assistance to other agencies interested in the initiative.

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ETHNIC / CULTURAL DIVERSITY
Great Lakes Inter-Tribal Council's Tribal Technical Assistance Center
Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR)

To provide culturally appropriate and tribal-specific technical assistance to tribal aging units, GWAAR contracted with Great Lakes Inter-Tribal Council (GLITC) to create the Tribal Technical Assistance Center (TTAC). The TTAC serves tribal aging units by providing technical assistance and support for aging and disability resource services and sharing information with, and about, tribal communities.

Budget: GWAAR contracts with GLITC to staff two full-time employees. In 2013, the operating cost for the GLITC contract was $170,799.

Accomplishments: The TTAC supervises and/or assesses a variety of nutrition, health, OAA Title VI and Title III programming; trains tribal advisory boards; facilitates six annual meetings of the Wisconsin Tribal Aging Directors Association; and serves as liaison to GWAAR, the State Office on Aging and the U.S. Administration on Aging (AoA) Title VI programs.

Replicability: A tribal-specific technical assistance center can be easily replicated in state Older Americans Act programming with identification of a multi-tribal organization with cultural competency. Tribal self-determination and sovereignty must be honored and recognized.

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HEALTH-LTSS INTEGRATION
Best Practices of Northern Michigan
Region 9 Area Agency on Aging and Area Agency on Aging of Northwest Michigan

Educating staff of 41 Skilled Nursing Facilities (SNF) to move from the acute care medical model to person-directed care is particularly challenging in vast rural regions. To achieve this goal, Long-Term Care Ombudsman (LTCO) from the Region 9 AAA and the AAA of Northwest Michigan developed the Best Practices of Northern Michigan (BPNM) Annual Conference, quarterly trainings and 12 webinars using the MDS 3.0 Learning Collaborative.

Budget: Costs incurred include staff time and mileage. For Region 9 AAA, approximately 25 percent of the LTCO hours are committed to the BPNM effort. All conferences and quarterly training expenses are funded through registration fees.

Accomplishments: LTCO increased conference attendance from 115 to nearly 300 in three years by building a database of SNF staff email addresses. BPNM has helped SNFs achieve improvements in clinical, human resources and business outcomes. SNFs are now in closer compliance with Centers for Medicare & Medicaid (CMS) Nursing Home Guidelines.

Replicability: Replication is accomplished by building relationships and engaging SNF staff and residents in evaluating educational needs, securing resources and building the program.

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HEALTHY AGING / NUTRITION
Senior Garden
Ventura County Area Agency on Aging (VCAAA)

To reduce overhead and support local farmers and seniors, VCAAA employees began growing fresh produce on land supplied by the Ventura Probation Agency. In addition to providing seniors with produce, the garden provides opportunities for seniors to mentor young volunteers and at-risk youth and show them how to work the land.

Budget: Most of the $23,000 annual budget is for the cost of a part-time Garden Manager. Expenses can be mitigated by forming partnerships with local agricultural businesses, city and county governments, food banks, nurseries and farmers for use of land and supplies.

Accomplishments: In 2013, the Senior Garden grew nearly 8,000 pounds of fresh produce to supplement the Senior Meals Program that serves approximately 175,000 seniors annually.

Replicability: The program can be easily replicated by following the model and business plan in place in Ventura County. Upfront planning includes locating fertile land, soliciting donations of equipment and supplies, finding volunteers and developing a distribution plan.

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HOME / COMMUNITY-BASED SERVICES
ElderHelp Program
Ventura County Area Agency on Aging (VCAAA)

The ElderHelp Program (EHP) helps low-income, frail seniors maintain their independence at home by providing free, short-term assistance with activities of daily living. Key program services include emergency aid vouchers for one-time-only food, shelter or warmth assistance; minor home repair/modification or security devices assistance; and transportation assistance, which provides bus tickets and rides to medical appointments.

Budget: VCAAA received $100,000 a year in transportation funds that, coupled with another $250,000 in Older Americans Act funding, grant funding and donations, covers the annual cost of the EHP. Referrals come through local social service agencies, so assessment costs are borne by the referring agency.

Accomplishments: For FY 2012–2013, 583 clients were provided assistance. On average, 37 percent of clients are new to OAA-funded aging services. Eighty percent of these individuals ultimately receive other OAA services.

Replicability: VCAAA is willing to share the model, guidelines and documents used in the operation of the program. The timeline for replicating and rolling out the EHP is less than three months.

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HOME / COMMUNITY-BASED SERVICES
Ohio Veteran Directed Program
Area Agency on Aging District 7, Inc. (AAA7)

In June 2012, the Ohio Veteran Directed Program began serving veterans who are at risk of nursing home placement in southern Ohio. The partnership between AAA7 and the Chillicothe Veterans Affairs Medical Center allows veterans to manage their own budgets to hire and direct workers and purchase other necessary goods and services. AAA7 also provides care management and financial management services to the veterans.

Budget: Startup funds of at least $10,000–$15,000 cover services and administrative fees. The total annual operating cost with 70 veterans and two care managers is approximately $233,000, generating about $300,0000 in annual income.

Accomplishments: Forty veterans have transitioned from institutional care back to their homes. In AAA7 surveys, 90 percent of veterans enrolled report the program is allowing them to remain at home and 74 percent report improved health and quality of life.

Replicability: All documented procedures, policies and participant guides are available. Assistance from the National Resource Center for Participant Direction is available to agencies nationwide.

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HOME / COMMUNITY-BASED SERVICES
Options for Long Term Care
Senior Resources of West Michigan

Senior Resources developed a 28-page booklet called "Options for Long Term Care" with the assistance of the local Aging & Disability Resource Collaborative. The booklet was published in direct response to older adults and family caregivers who requested printed information on available services and aging and disability resources. Senior Resources counselors use the information to educate people on in-home care services, out-of-home care options, payment choices and eligibility requirements for government assistance programs such as Medicaid Waiver and PACE.

Budget: The color booklets cost $5 each to print and are given to the public for free. Advertising income of $200 per sponsorship helps offset printing costs. Sponsors receive a listing on the back cover of the booklet.

Accomplishments: Feedback about the booklets received at workshops and presentations has been positive.

Replicability: Organizations can replicate this booklet by editing it to reflect the aging and disability resources available in their service region.

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INFORMATION & REFERRAL
Making the Link
Anne Arundel County Department of Aging & Disabilities (DOAD)

The Making the Link (MTL) program was developed to expand awareness of DOAD services among physicians, patients and caregivers as well as local organizations, businesses and government agencies. This is accomplished through distribution of a yellow resource pad that lists programs, resources and contact information; creation of a PSA that airs in local hospitals and on government cable access channels; and use of Facebook and Twitter.

Budget: The total FY 2013 budget of $34,986 includes $3,586 for program materials, $7,000 for advertising, $1,844 for travel and $15,625 for the project coordinator's salary.

Accomplishments: Since 2012, MTL has distributed 892 pads to 67 businesses, government agencies and health care providers. The number of caregivers attending support groups and education programs and the number of calls to the DOAD Information and Assistance Department has increased since the program began.

Replicability: The success of this project hinges on creating relationships with providers, organizations and businesses that work with elderly and caregiver populations.

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INFORMATION & REFERRAL
Senior Resource Directory
Southern Alabama Regional Council on Aging (SARCOA)

To fulfill the need for a printed publication listing resources, programs and services available to seniors and disabled individuals, SARCOA created the "Wiregrass Senior Resource Directory" in 2009. The project was implemented through SARCOA's volunteer group, the Senior Advocates. The directory, which is updated every two years, is intended to provide an overview of resources in the Wiregrass area.

Budget: The Senior Advocates sell advertisements for publication in the directory, which cover printing costs so the directories can be distributed for free.

Accomplishments: The Senior Resource Directory has reached 20,000 individuals. The directory has also served as a reference book for SARCOA's new staff and volunteers as well as partner agencies.

Replicability: The resource book can be easily replicated to provide local information to an organization's target population. Necessary items include a database of information, a design program such as Adobe Creative suite, volunteers and a printing company.

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TRANSPORTATION / MOBILITY OPTIONS
CARS: Call a Ride for Seniors
Bexar Area Agency on Aging (Bexar AAA)

Call a Ride for Seniors (CARS) is a collaborative group established by Bexar AAA that includes four volunteer driver operators that provide senior transportation to those in need. As a result of this initiative, seniors in all four quadrants of San Antonio are covered by free, high-quality, door-to-door volunteer driver transportation services. Operators benefit from greater efficiencies in ride coordination, greater opportunities for grant funding, increased social media/public outreach, and more efficient trip and records management. Learn more: www.CallaRideforSeniors.org

Budget: Federal Transit Administration (FTA) grant funding covers a Mobility Manager and Specialist, website development, ride software, guidebooks and ride reimbursements. The CARS collaborative requires approximately 25 percent of the two-person Mobility Management team's time, or approximately $37,000 annually.

Accomplishments: The CARS collaborative has provided 57,085 one-way rides.

Replicability: Replication requires applying for annual FTA grant funding and working with volunteer driver operators. A number of groups serving veterans and rural areas are working to replicate CARS.

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TRANSPORTATION / MOBILITY OPTIONS
myride2
Area Agency on Aging 1-B (AAA 1-B)

myride2 provides seniors and adults with disabilities access to transportation and driver safety information via a toll-free, multilingual phone line. Mobility specialists work with individuals and transportation providers to determine which transportation options best fit individuals' needs and directly connect callers or schedule rides. Individuals can also search for a provider, request a ride or find other mobility information through the website (www.myride2.com).

Budget: FY 2013 operating costs totaling $95,418 support the Mobility Specialists/Project Manager at AAA 1-B and the Disability Network Oakland/Macomb as well as costs for evaluation, technical equipment/support, travel expenses, fiduciary services, telephone lines and marketing.

Accomplishments: In FY 2013, myride2 received more than 1,600 requests and had more than 1,000 visits to the website. Ninety percent of callers said that myride2 provided at least one new option for transportation providers.

Replicability: Organizations can begin by developing and maintaining an inventory of available transportation and mobility services. Next steps include dedicating staff to the project and creating a website or phone line.

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TRANSPORTATION / MOBILITY OPTIONS
Rappahannock Area Agency on Aging Mobility Options Travel Training Program
Rappahannock Area Agency on Aging, Inc.

To help seniors age in place and stay active in the community, the Rappahannock AAA Mobility Options Travel Training Program provides free bus passes and personalized, hands-on education on safely navigating local public transportation. A travel trainer provides one-on-one assistance to individuals, including assisted travel on bus routes.

Budget: The FY 2013 budget of $13,359 included the travel trainer's salary of $11,250 for 15 hours per week for 50 weeks, single bus tickets and monthly passes for $1,692 and mileage reimbursement for $416.

Accomplishments: In FY 2013, 94 individuals received hands-on travel training. In addition, 10 professionals were trained to become travel trainers. Ten community presentations attracted 89 total attendees.

Replicability: Replication requires a strong working relationship with the local transit system and partners whose clients have transportation needs. Sharing resources and discretionary funds can stretch a new program and serve more clients.

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TRANSPORTATION / MOBILITY OPTIONS
Veterans Enhanced Transportation Services (V.E.T.S.)
Prince William Area Agency on Aging

V.E.T.S. provides transportation assistance to help veterans and their spouses reach medical appointments. The program, administered through a partnership between the Prince William AAA and Prince William's Retired Senior Volunteer Program (RSVP), also gives veterans age 55 or older the opportunity to volunteer in their community as drivers. The Agency is located about 25 miles from the nation's capital and, because the area has a large concentration of retired veterans, the service is heavily used.

Budget: The only cost involved is the built-in staff time provided by the Agency, RSVP and other community partners.

Accomplishments: Since April 2013, the V.E.T.S. program has served more than 25 veterans and/or their spouses and has logged 221 trips. As veteran referrals have increased, the number of volunteer drivers has increased to 15.

Replicability: The model used for this program is available for replication. Key resources include community partners and qualified volunteer drivers.

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VOLUNTEERISM / CIVIC ENGAGEMENT
Senior Medicare Patrol Resource Center
Northeast Iowa Agency on Aging (NEI3A)

The Senior Medicare Patrol (SMP) is a group of highly-trained volunteers who teach seniors about health care fraud. In 2011, the SMP Resource Center began providing web-based training and written tools to enhance the safety and quality of SMP volunteer programs. Competitive federal funding was made available to establish and run the national SMP Resource Center.

Budget: Annual operating costs of $122,274 include salaries for involved Resource Center personnel and fees for consultants. Additional costs include printing SMP Volunteer Program Management manuals ($16 each).

Accomplishments: Webinars were held on 16 Volunteer Risk and Program Management (VPRM) topics, with more than 90 percent of participants giving them the highest available quality score. Online VRPM information and materials were accessed more than 36,000 times from March 2011 through April 2014.

Replicability: Agencies can use the implementation tools available for download at www.smpresource.org. An individual agency would require a full-time equivalent position, such as a volunteer coordinator, dedicated to local customization and implementation.

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YOU NAME IT (Community Organization)
A Community-Wide Approach to Solutions to Senior Hunger
Area Office on Aging of Northwestern Ohio, Inc.

The Area Office on Aging of Northwestern Ohio, Inc. created a film for its annual legislative breakfast to show the faces of senior hunger and allow individuals to tell their stories in their own words. As a result of the response to the video, the agency was able to partner with a local public television station to create 15 public service announcements (PSAs) and a series of televised town hall forums.

Budget: The expenses for the town hall and PSAs were covered by $60,000 in sponsorships.

Accomplishments: The professionally produced video, viewed by hundreds of elected officials and community leaders, was key to stimulating community awareness. As a result of its efforts, the agency garnered support for increasing the amount of local senior services tax levy funds used to provide meals to older adults.

Replicability: This program can be replicated by building a strong relationship with a local public television station and gathering corporate and nonprofit sponsorships.

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YOU NAME IT (Social Club)
Kindred Spirits Social Club
Howard County Office on Aging

Kindred Spirits is a fee-for-service social club for individuals aged 50-plus with a recent diagnosis of a memory-related disorder. The club provides a place for people with similar diagnoses to come together for socialization, companionship, support and education. Kindred Spirits offers speakers, field trips and classes to help participants maintain their current cognitive and physical functioning.

Budget: Total FY 2013 costs of $119,385 included salary and benefits for a director and assistant at $109,607, contractual services for instructors at $8,971, and snacks and household costs of $808.

Accomplishments: Since 2011, Kindred Spirits has served 29 individuals who spend an average of 15 months in the program. Five members successfully transitioned to the Senior Center Plus Program and remain active there. One attends an adult medical day center. All remain living in the community.

Replicability: Replication is easiest if the program is located in a senior, community or retirement center that provides programs and services for older adults and in-kind support of staff, building use and programming. Volunteers may be enlisted but must be carefully selected and trained.

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YOU NAME IT (LGBT Support & Advocacy)
LGBT Supper Club
Coastline Elderly Services, Inc.

Social isolation affects many LGBT older adults who must deal with stigma and discrimination. To help LGBT individuals increase their socialization in a safe place, Coastline teamed up with local aging agencies to provide a Supper Club for LGBT people 55 years of age or older. The program provides a monthly evening meal, social networking among peers, special events such as daylong trips and the showing of the film Gen Silent, intergenerational involvement with LGBT youth and educational programs.

Budget: Costs of monthly meals and some entertainment and social events, including viewing of Gen Silent, were $4,200 and were covered by the Lipsky-Whittaker Foundation. Space, staff, communications and other expenses were provided as in-kind donations.

Accomplishments: As a result of the Supper Club and related activities, LGBT elders have a safe place to gather. The showing of Gen Silent was attended by 150 people.

Replicability: The program can be replicated in places where LGBT elders wish to socialize with one another. Funding is not necessary if a location is available for free and if small donations are provided.

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YOU NAME IT (Senior Center Standards)
Moving Senior Centers Forward in a New Environment
Central Plains Area Agency on Aging (CPAAA)

CPAAA works with local Senior Centers to help them meet the changing interests and needs of their target population. Recently, CPAAA developed four requirements to complement current Senior Center standards. These standards include identifying staff or volunteers to undergo Statewide Health Improvement Program (SHIP) training; developing standardized programming that addresses pertinent topics; developing a volunteer base and recruiting two percent of membership to serve as volunteers; and providing evidence-based programs to attract members and establish the center as a resource for quality, cutting-edge programming.

Budget: Costs include about 20 hours of the CPAAA program manager's time each year for planning, educating senior centers and providing technical assistance.

Accomplishments: These standards have resulted in a 60 percent increase in Medicare counseling sessions and a 50 percent increase in active volunteers. In addition, 85 percent of senior centers increased the number of evidence-based programs they provided.

Replicability: Senior Center funders can establish standards to improve consistency and program quality. Center funding should be based on adherence to the standards.

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YOU NAME IT (Connecting Health Care Providers to Community Resources)
Physician Resource & Education Toolkit
Kentuckiana Regional Planning & Development Agency (KIPDA)

The KIPDA Rural Diabetes Coalition (KRDC) seeks to eliminate diabetes disparities among older adults in rural Kentucky. The Physician Resource & Education Toolkit includes patient education packets with information on diabetes, self-management and local resources. The packets are distributed to the offices of medical professionals and to public health departments. Health care professionals use Resource "Prescription" Pads to refer patients to services, classes or a contact person for more information. Continuing education events for health professionals are also offered at low or no cost.

Budget: Costs include patient packets ($1.07 each), prescription pads ($1.70 each) and printing and postage ($150). For continuing education events, costs include food, venue rental and speaker fees.

Accomplishments: The pads and prescription packets are regularly used by 21 physicians, 10 pharmacies, EMS in two counties and one senior center. One hundred percent of continuing education participants who completed an evaluation agreed or strongly agreed that the program content was satisfactory.

Replicability: Having outreach partners or staff meet with office managers or doctors to encourage use of the toolkit is crucial. Local hospitals, medical associations, provider networks and health coalitions can help distribute information and promote events.

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YOU NAME IT (Innovation in Coordinated Care)
The San Diego Beacon Care Transitions Pilot
County of San Diego, Aging & Independence Services (AIS)

AIS teamed with three hospitals to provide care transitions support and coordinated post-discharge care for 298 indigent, socially complex patients with multiple unmanaged chronic health conditions and a high risk of readmission. A team comprised of an AIS transition coach—who is a registered nurse and a social worker—strives to meet the complex health and social support needs of patients by providing intense care coordination, in-home care, transportation and home-delivered meals.

Budget: FY 2012–2013 costs for the Beacon Pilot were $310,003 and included personnel, overhead and purchased services.

Accomplishments: The partnership achieved a 12.4 percent, 30-day, all-cause readmission rate for participating patients, compared to the estimated 21.2 percent readmission rate for an equivalent sample of patients used for comparison. Estimated savings are $303,342.

Replicability: The Beacon Pilot utilizes Care Transitions Intervention, a four-week care transitions model, and the Care Enhancement Program, which ensures immediate access to social supports upon discharge and for up to 30 days after discharge. Both programs require staff flexibility to make daily hospital and home visits.

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