THE RETIREMENT RESEARCH FOUNDATION	**GRANT HIGHLIGHTS** FEBRUARY 2011

This information comes from GrantBriefs, RRF's bi-monthly internal newsletter. Much of the information is taken directly from grantees' reports and is presented in their own words. We thank grantees and others for their contribution to Grant Highlights.

CJE Field Tests Self-Neglect Assessment Instrument

In 2007, RRF made a two-year $213,111 grant to the Leonard Schanfield Research Institute of CJE Senior Life to refine and field test a Self-Neglect Assessment Instrument, which CJE began developing with a modest RRF grant awarded a couple of years earlier. Self-neglect is defined as behavior of an elderly person that threatens his/her own health or safety. It manifests itself as a refusal or failure of the person to provide him/herself with adequate food, water, clothing, shelter, personal hygiene, medication, and safety precautions. National studies confirm a fairly high incidence of self-neglect--upward of 100,000 elders annually. In 2006, the Illinois legislature passed a law making elder self-neglect a reportable issue. However, there previously was no validated assessment instrument for use with such cases.

The objectives of this grant were to: refine the Elder Self-Neglect (ESN) Assessment tool, validate it through field tests, and identify outcome measures for studying the impact of services on self-neglecting seniors. The project made considerable progress toward objectives but did not complete every aspect by the end of the grant period despite a no-cost extension.

The ESN Assessment tool has now been completed, and hierarchies for each conceptual domain were established, ranking indicators of elder self-neglect from mild to severe. An article on the ESN Assessment tool was published in an article in *The Gerontologist*.

The project created an advisory group, composed primarily of professionals from the Illinois aging services network. The group provided feedback about combining, revising, deleting, and adding various categories to the assessment tool. In the end, the assessment tool included 77 self-neglect items.

Eleven case management organizations from seven different service areas across Illinois were recruited to assist in field testing the assessment tool. It was tested on 215 older adults (exceeding the projected sample size of 200). At the conclusion of the grant, CJE had not fully completed psychometric analyses to establish cut-off points for determinations of elder self-neglect and to develop standardized protocols for administration and scoring. This will be completed over the next several months.

The project included a study to determine statewide outcomes indicators for an Elder Self-Neglect program. With input from 88 direct service providers, a final list of 82 treatment benefits was generated. They were aggregated into seven broad categories.

The categories include: environmental maintenance, health, community awareness, sustaining independence, development of psychological strengths, formal supports, and social Involvement.

A manuscript is currently under revision for a second submission to *The Gerontologist*. Four presentations on the project's results were made to professional audiences, including the Illinois Governor's Conference on Aging, the American Society on Aging Roundtable, ASA's annual meeting, and the Gerontological Society of America.

The project's team faced some challenges during the course of the grant. It was a challenge to recruit a sufficiently broad base of service providers from across the state to test the instrument. Also, given all the demands on case managers, there were problems in completing and returning assessments in a timely manner. These challenges caused delays in the project but were ultimately resolved. The self-neglect assessment tool is quite comprehensive and potentially quite useful. RRF will be interested in learning the extent to which it is used.

GALATA Serves Elders in Florida's Deep South

GALATA was established ten years ago to provide community-based services for disadvantaged Haitians, Hispanics, and African Americans living in the rural communities of Homestead and Florida City. This area is referred to as Florida's Deep South. In 2002, RRF awarded GALATA its first grant to begin providing services for the elderly in a program it has entitled "60+ Bridging the Gap." This program has grown each year and now attracts a variety of sources of support.

In 2008, RRF made a two-year $160,000 grant to GALATA to enable the organization to expand the 60+ Program by serving 100 new clients. GALATA planned to offer four services: case management, transportation, a hot lunch program, and social/educational activities. At the time of the grant, GALATA was serving 500 elders per year.

GALATA met and in some cases exceeded its projected numbers except in the area of transportation where service was about 20 percent lower than expected. The program assessed and provided services to 175 new clients. GALATA is now serving slightly over 600 elderly per year (accounting for attrition). This represents a 20 percent increase from the start of the grant. All new clients were screened and received an individual plan that identified needed services and referrals.

GALATA provided 85 meals per day--45 at its center and 40 at the City of Homestead's Senior Center. During the grant period, GALATA was renovating its space so it could not accommodate the extra 40. GALATA also obtained important benefits that resulted in considerable savings to seniors and improved their access to services. Case workers enrolled 120 elders in Medicaid, 135 in SNAP (Supplemental Nutrition Assistance Program, formerly known as Food Stamps), and 105 in emergency energy assistance programs.

GALATA performed nutritional assessments and referred elders at highest risk of malnutrition to its meals program and to a nutritionist who provides *pro bono* counseling. Nutritional scores were reported to be improving. GALATA also provided 30 minutes of low-impact exercise and partnered with several health care providers to do screenings and health education. Partners included Barry University nursing students, the Miami-Dade Department of Health, Open Door Health Clinic, NOVA Southeastern University, and Care Plus Insurance. GALATA conducted two educational activities per month on health issues such as fall prevention, diabetes control, and glaucoma awareness. All classes were conducted in English, Spanish, and Creole. All services, including educational sessions, are ongoing.

While not within the scope of the grant, GALATA plans to open an adult day program. It had received licensing from the state for 30 slots per day. GALATA also received a grant from the City of Miami to obtain technical assistance to build its organizational capacity in areas such as financial management. Given GALATA's rapid growth, this will be quite valuable. GALATA continues to fill a unique niche in the Deep South by providing culturally appropriate services to three low-income minority and refugee populations that had been neglected by traditional providers.

Nursing Home Uses Wii to Improve Physical Fitness

A $5,535 RRF grant enabled the Bethesda Southgate Skilled Nursing Facility, a St. Louis area nursing home, to purchase two Nintendo Wii systems for its rehabilitation program. Bethesda Southgate wanted to provide its staff with a tool to address the lack of physical exercise, endurance, range of motion, and strength of its residents.

An electronic game system, Wii enabled the residents to enjoy and engage in games and exercises with staff, teenage volunteers, and family members. Residents, who would not otherwise have been able to participate, were able to play virtual games of golf, tennis, baseball, and bowling. All Wii activities were modified to each resident's unique physical level of activity.

Over a six-month period, Bethesda collected data on residents who participated in its "Wiihabilitation Program." This included long-term nursing home residents and short-stay Transitional Care Unit residents (averaging a 23-day length of stay). Bethesda tracked endurance/tolerance, range of motion, strength, posture, cognition, and level of participation. Compared to the short-stay residents, the long-term care residents using the Wiihabilitation Program had better participation and satisfaction with the program and increased activity tolerance and strength. However, even the short-stay residents showed benefits from the Wii program. Those who used it twice a week were found to be more social with the staff and other residents. Bethesda was not able to rate cognitive gains as originally intended due to the complexity of the various Wii games.

Information about the Wiihabilitation Program was shared throughout the Bethesda Health Group corporation and Southgate's sister facilities. It reached hundreds of individuals through corporate publications, its Community Council, family

and staff meetings, and facility tours. The program was featured in Bethesda's promotional DVD and the 2009 Report to the Community.

The Wii Program will continue to be used with both nursing home and transitional care residents. Bethesda also plans to expand its use in a new, furnished apartment facility and adult day care program. This modest grant will continue to contribute to improvements in the physical status and satisfaction of nursing home residents for years to come.

Nursing Homes Use IN2L Technology to Enhance Person-Centered Care

In 2009, a $10,000 RRF grant was awarded to Wisconsin Illinois Senior Housing (WISH) for the purchase of IN2L, specialized technology designed to improve the quality of life of older adults using computer and internet resources. The IN2L (It's Never Too Late) computer system is designed to make activities more meaningful and engage more residents with cognitive challenges; enrich family-resident visits; help residents stay connected in between face-to-face visits; enhance staff-resident interaction, resulting in improved job satisfaction for staff; and enrich participation of rehabilitation specialists working on physical, intellectual, and speech challenges of residents. The IN2L system is used by more than 350 long-term care organizations across the nation and credited with impressive results.

RRF's grant enabled WISH to purchase IN2L technology for two of its long-term care facilities (one in Elkhorn, Wisconsin, and the other in Crystal Lake, Illinois). These facilities are home to 106 elders. Before installing IN2L, WISH staff made a site visit to Lutheran Homes and Services in Arlington Heights to see the system first-hand and gain insights on how to use it. Representatives from all WISH facilities, including six nursing homes and six assisted living facilities, attended. The site visit generated such enthusiasm that all facilities ended up fundraising to purchase their own IN2L units. RRF's modest $10,000 grant ended up generating $50,000 in local support for 10 more IN2L units.

WISH evaluated the success of IN2L through a survey and interviews with residents, their families, caregivers, other staff, and the Director of Nursing and nurse supervisors. The surveys were conducted at both sites at six and 12 months. A total of 135 interviews were completed. At least 25 percent of all residents either responded or had a family member respond on their behalf. At the six-month point, when awareness of IN2L was at its highest, 81.4 percent of respondents reported agreeing that positive outcomes were visible. Several quotes were provided in the report such as: "It makes therapy so much more fun;" "We have a difficult resident with Alzheimer's – she responds positively to IN2L;" and "It helps staff and residents come together."

Unfortunately, familiarity and usage of the IN2L system appeared to wane over time. However, WISH is instituting methods to teach new employees about IN2L and inform new residents and families about it. The Foundation made suggestions of additional ideas such as using IN2L to videotape interviews with new residents so that

staff will learn more about their background, history, and personal interests and see the immediate value of this technology.

RRF's grant helped WISH's long-term care facilities take an important step toward person-centered care. Perhaps other local providers located near WISH facilities will learn about IN2L, come to observe it first-hand, and become interested in purchasing it as well.

Universal Retirement Savings Account Legislation Fails to Gain State or Federal Traction

In 2009, RRF made a $75,000 grant to the Economic Opportunity Institute (EOI), a policy advocacy organization in the State of Washington, to continue working on establishing a Universal Retirement Savings Account program (URSA) in Washington and other states. RRF had supported this effort since 2006.

URSA provides a voluntary option of a low-cost portable defined contribution account for every worker. The idea behind URSA is to enable all workers, especially those with low or moderate incomes or employed by small businesses, to save for retirement by putting pre-tax dollars through payroll deductions into an investment portfolio vetted by the state. Features would include: auto-enrollment in a defined contribution plan with a pre-selected menu of investment options; state administration and oversight; payroll deductions; and optional employer contributions. The program would enable small businesses, which generally lack sufficient resources to research and create their own retirement savings plans, to provide an easy savings option for their workers.

The project had four objectives: continue to educate policymakers on the benefits of establishing the Washington Voluntary Retirement Account Program; develop and begin implementing a communications plan to raise awareness of the program in Washington State; work with advocacy groups and policymakers in several other states to develop and gain passage of URSA; and develop a multi-state coalition to gain federal support to cover administrative costs of URSA start-ups.

EOI made a valiant effort to get this savings program off the ground in Washington State. In 2007, EOI succeeded in getting a $450,000 appropriation from the state legislature to the Department of Retirement Systems to design a plan for Washington Voluntary Savings Accounts (the Washington version of URSA). EOI executed a communications plan and won support of the state's financial services industry, which had previously been a stumbling block. In 2009, the legislation to create Washington Voluntary Accounts was successfully voted out of three state senate committees and received a hearing. However, given state budget constraints, there was no appropriation committed for start-up, and the legislation died in committee.

EOI tailored a variety of strategies with advocates and policymakers in other states to get URSAs established elsewhere. It conducted a webinar in conjunction with the Sargent Shriver Center on Poverty Law, a strong advocate for URSA. All totaled,

EOI worked with advocates and policymakers in at least 20 different states. Legislation was introduced in six states, with West Virginia, California, and Rhode Island making the most progress. However, in the end, no state actually passed the legislation. Unfortunately, because many of these states have seen changes in both government and nonprofit leadership during the past year and experienced deteriorating fiscal conditions, much of the work on URSA has been put on hold.

The hope in 2009 was that EOI would be able to gain a $15 million federal appropriation to seed the start-up of URSA in several states. Unfortunately, the attempt to get a federal appropriation was unsuccessful. In the end, this project was thwarted by the economic downturn, huge financial constraints that states were facing, and challenges by the financial services industry. By the end of the grant period, EOI had not been able to gain traction within the State of Washington, nor were other states' efforts successful in URSA implementation.

Although the project did not succeed in the short-term, the URSA model has been soundly developed and EOI's products such as policy briefs, a dedicated portion of its website, URSA templates, and others are excellent. The identification of necessary stakeholders and the relations among collaborating groups are well established. If the financial and political environment were to improve, the project's tools and relationships would become quite useful.

St. John de la Salle Church Improves Accessibility

St. John de la Salle Church is a 467-member Roman Catholic Church located on Chicago's far southside. Almost all the members are Black and low income. Seniors comprise half of the parish membership. In 2009, St. John de la Salle Church was awarded a $7,766 Accessible Faith Grant to install a platform lift between the upper and lower levels of the facility. Prior to the grant, the upper and lower levels of the church could be reached only by stairs and prohibited many who could not access either the sanctuary or the activity space and auditorium.

St. John de la Salle Church completed the project early, with no significant problems and on budget. Due to their increased awareness of accessibility issues, the church leaders decided to remove a few rows of pews to make room for wheelchairs.

The Pastor reported that parishioners and members of the community have welcomed the availability of the lift. Many more can now participate in activities such as weekly prayer groups, exercise programs, and the bi-monthly pantry. The pastor also reported that the accessibility changes have improved fundraising and led to additional civic activities. For a congregation that is financially challenged, the ability to raise approximately $8,500 as its portion of the accessibility project was significant. This project demonstrates how the Accessible Faith Grant Program can galvanize congregations and increase their awareness of the needs of elderly and persons with disabilities.

Ethnic Agencies Receive Training on Geriatric Depression Screening

In 2009, RRF made a one-year grant of $40,000 to the Coalition of Limited English Speaking Elderly (CLESE) to continue to strengthen the capacity of its member agencies in identifying and serving elder immigrants and refugees with mental health issues. CLESE contracts with White Crane Wellness Center to educate the staff members of ethnic agencies about mental health issues among seniors, to be able to identify those in need, and to know when to refer them for assistance. In turn, the staff of these agencies screen seniors for depression and engage those who are at risk in small group discussions, providing them with coping skills to manage negative mood. The groups meet weekly for two hours over an eight-week period. Seniors with greater mental health needs are referred for professional counseling. The six agencies that have been participating in the program include: Arab-American Family Services, Chinese American Service League, Hanul Family Alliance, Korean American Community Services, Metropolitan Asian Family Services, and Polish American Association.

This past year CLESE strengthened the project by having White Crane Wellness Center train the lead social worker at each of the six agencies to use the Geriatric Depression Scale. This scale was recently documented as reliable and valid for use with ethnic populations. It represents a considerable improvement over the previous simple two-question screen used by CLESE agencies to suggest to seniors they might wish to participate in the support groups.

All six agencies completed the training and, in turn, trained staff members within their agencies. In total, 78 staff members were trained to use the Geriatric Depression Scale. In responding to questions about the impact of the training, the staff reflected growing confidence in understanding, engaging, and assisting persons with depression. The issue of depression has been destigmatized among staff; they find it no longer unusual or hard to approach the subject.

The goal was to use the Geriatric Depression Scale to screen at least 250 to 300 seniors who might be at risk for depression. The agencies screened a total of 472 seniors. Some 42 percent (200) scored five or higher, which indicates at least moderate risk of depression. Each of the agencies brought together at least one small group of older adults for a series of eight sessions. These groups, facilitated by trained ethnic agency staff, help seniors learn resiliency skills, socialize, articulate and validate their feelings, and improve their ability to cope with the stresses of daily life in later years. During the grant period, 217 older adults attended at least one session. This far exceeded the projection of 100 participants.

Improvement was measured by re-administering the Geriatric Depression Scale after the sessions ended. There was some remarkable improvement in many individuals. The most dramatic improvement was seen among the Chinese participants. CLESE has posted the eight-week depression curriculum on its website.

Another objective of the project was to educate primary care physicians about the mental health services offered by ethnic agencies participating in the program. The agencies identified 37 primary care doctors who serve their elders. These doctors received mail and telephone contact from a White Crane social worker to discuss the project and depression among their patients.

Service Providers and Elders Trained to Address Sexual and Domestic Violence

In 2007, RRF made a third-year grant of $62,548 to the Women's Center of Jacksonville (Florida) to continue its "Stop Violence Against Elders" (SVAE) Program. This grant followed two-year support to launch the program. SVAE is a training program, initially for law enforcement prosecutors and adult protective service investigators, to improve the recognition, investigation, and prosecution of instances of elder abuse. The third year grant enabled the Center to continue training broader audiences and create a community-wide collaboration to develop a coordinated response to such violence. The Center expanded training to four groups: law enforcement personnel, nonprofit elder-service providers, health care personnel, and elders themselves. The Center used a "train-the-trainer" model, involving volunteers and staff from several agencies to deliver the training.

All training objectives were met and, in most cases, the numbers of trainings and trainees exceeded expectations. During the grant period, the Center conducted 563 SVAE trainings. They included: 65 law enforcers from Sheriff's and Attorney General's Offices; 432 health care professionals such as nurses, family practice residents, and county health department personnel; 463 employees of elder-serving agencies such as city and county supervisors and social workers, and domestic violence and shelter workers; and 931 elders reached through churches, libraries, and caregiver groups. As a result of presentations to elders, 91 cases of elder abuse were disclosed.

The Center held four train-the-trainer workshops--twice the projected number. It trained 152 volunteers and staff members to make presentations. All training sessions included a feedback form. Respondents rated the training sessions high for expectations met, knowledge gained, and community resources identified.

The Center convened a task force of service providers, government officials, and criminal justice personnel to study the problem of elder domestic violence. As a result, improvements were made in agency collaboration on elder abuse cases and a streamlined referral system was created. Midway into the grant period, the Attorney General's Office created its own Elder Abuse Task Force. Therefore, the Center disbanded its task force and most of its members joined the one created by the Attorney General's Office. However, about a year later, the Attorney General's Office terminated its Task Force due to budget constraints.

One of the project's objectives was to investigate the feasibility of creating an emergency shelter specifically for elder victims of domestic violence. A questionnaire was sent to several organizations to determine their level of interest and need for a

dedicated shelter. The Center's staff made a site visit to such a shelter in New York City as part of its feasibility study. Ultimately, the Center abandoned the idea of a shelter because it did not think it could raise sufficient funds.

Unfortunately, during the third year of the project, the Center realized it would not be able to attract additional funding to continue. Although the Center raised modest funds from its local community foundation, it ended up folding the program about a year after RRF's funding ended. Although the Center formally closed the project, the training program is still offered and the excellent materials (a CD, PowerPoint, and other information hand-outs) are still available. Elements of the project have been incorporated into the responsibilities of the Center's Rape Recovery Team. All of the Center's five advocates and mental health counselors have received specialized training to work with elder victims. The advocates know how to connect these victims to services and work with law officials on behalf of elder abuse cases.

Aging Care Connections Expands Transitional Care Program

In 2009, RRF made a second-year, $35,000 grant to Aging Care Connections (ACC), to continue the Bridging Care Program, which transitions elders from a hospital or sub-acute facility back to their homes. The goal of Bridging Care is to deliver a full spectrum of coordinated services to support a safe transition of people age 60 or over throughout the continuum of care and to allow for successful reintegration into the community. The program aims to create effective communication among existing "silos" of care.

In 2007, in partnership with Adventist LaGrange Memorial Hospital, ACC created the Aging Resource Center through which it operates the Bridging Care Program. Located on the first floor of the hospital, the Center has an MSW social worker who helps hospitalized older patients and families arrange for services they will need upon returning home. The social worker partners with Adventist's discharge planners, who continue to be responsible for arranging in-home health or therapy services. In 2008, with its first grant from RRF, the Aging Resource Center expanded to add a second, part-time social worker who coordinates transitional care for patients moved to rehab or sub-acute care before returning home. This social worker visits patients at the sub-acute facilities and works collaboratively with the discharge partners at these sites.

ACC's objectives were to serve 420 new clients (300 referred by the hospital and 120 from sub-acute sites) and evaluate the program's impact and cost-benefit. Over the one-year period, the program served 363 elders (251 from the hospital and 112 from four sub-acute sites), or 86 percent of the projection. Overall, the Center logged 540 contacts with patients, clinicians, and family members.

Categories of service referrals showed that the project addressed elders' needs that are critical for a safe transition to home. They included: home care, care coordination, home delivered meals or other food-related needs, transportation, obtaining benefits, adaptive equipment, caregiver respite, community-based long-term care services, housekeeping, housing, mental health services, medication management, and referrals to geriatricians, home health, and hospice.

Of those served by the program, 93 percent met minimum nursing home admission criteria. This suggests the program intentionally served the frailest and most complex patients. In collaboration with Adventist, readmission data were analyzed. A sample of 149 patients served by the program was evaluated for readmission within 30 days of discharge. The sample was compared to the total population of Adventist patients 60+ over the same one-year period. Of the 149 patients served by the program, only 16.8 percent were readmitted within 30 days of discharge. This compares to a national readmit rate of 19.8 percent. The report indicates this percentage was much lower than the readmission rate for the total population of Adventist patients age 60+ although more complete analysis is needed.

The program was effective at improving access to community-based services from within the healthcare system. By completing on-site assessments at the hospital and sub-acute facilities prior to discharge, the program was able to eliminate the previous average 14 calendar-day delay between discharge and start of services. This expedited important services such as home delivered meals, respite care, and flexible senior service funds. ACC reports that the program has resulted in improved communication between the sub-acute and acute hospital settings with discharge planners increasingly offering more referrals for community-based resources. This is a subtle but very important culture shift toward community services.

There is great interest in the development of transitional care models. A consortium of agencies throughout the state has created the Illinois Transitional Care Consortium. While this program cannot yet be considered an evidence-based care coordination model due in large part to evaluation constraints, it is making a promising contribution to the development of these very important services and to the work of the Illinois Transitional Care Consortium.

Buckwalter Receives Gerontological Nursing Award

At its annual meeting last fall, the Gerontological Society of America (GSA) announced Kathleen Buckwalter, PhD, RN, of the University of Iowa as the 2010 recipient of the Doris Schwartz Gerontological Nursing Research Award. The award, presented by GSA's Health Sciences Section in collaboration with the John A. Hartford Foundation's Institute for Geriatric Nursing, was made in recognition of outstanding and sustained contribution to geriatric nursing research.

Dr. Buckwalter is the director of the John A. Hartford Center of Geriatric Nursing Excellence at the University of Iowa. She is also associate director of the University's Gerontological Nursing Interventions Research Center and co-director of its Center on Aging. A prolific researcher and publisher on issues affecting the elderly, Dr. Buckwalter particularly focuses on improving mental health services and community-based care for chronically ill older persons. She is the Senior Editor of the *Journal of Gerontological Nursing* and *Research in Gerontological Nursing*.

Dr. Buckwalter is a highly respected mentor. She has mentored over 85 student theses and almost 50 doctoral dissertations in nursing and related disciplines. She has also mentored 26 postdoctoral fellows.

RRF has had the privilege of working with Dr. Buckwalter. She was the Principal Investigator on a successful project funded by RRF in 2007 ($173,346 over 2-1/2 years) that developed and tested the first-ever dementia training program to promote involvement in meaningful activity. The project's excellent training materials are available at nominal cost and posted on the University of Iowa's website. Our congratulations to Dr. Buckwalter!