THE RETIREMENT RESEARCH FOUNDATION

GRANT HIGHLIGHTS

NOVEMBER 2012

Florida Atlantic University Tests Internet Training on Nursing Home Quality Improvements

In 2010, RRF awarded a one-year, $124,985 grant to Florida Atlantic University to develop a web-based version of INTERACT II, a training program for nursing home professionals on quality improvement methods for reducing potentially avoidable hospitalizations among their residents. Hospitalizations are extremely risky for nursing home residents. Transfers are not only painful and stressful for patients, but also expose them to risks such as delirium, immobility, pressure ulcers, falls, and adverse medication reactions. While some hospitalizations are unavoidable, many may be averted if personnel recognize acute changes in resident well-being and act quickly and appropriately.

INTERACT II was created after the first version of INTERACT was initially piloted and refined. It is a teleconference training program with on-site follow-up and telephone consultation delivered by advanced practice geriatric nurses. INTERACT II has three components: 1) education for "high-touch" staff who perform most hands-on care to help them look for acute status changes and provide a method for rapidly reporting them to nursing supervisors; 2) tools for health professionals to assure systematic and thorough communication for rapid, clinically appropriate interventions; and 3) forms and procedures to ensure that correct information goes with the patient to and from the hospital when a transfer is needed. This can prevent adverse outcomes that might result from poor communication about patient status, history, and medications. In the initial pilot of INTERACT, significantly lower hospitalizations were found at six months after training.

The goal of this project was to convert INTERACT II into a new web-based version that would more easily be adopted, while remaining as effective as the more intensive intervention. Objectives were to develop and test a web-based version, implement it in at least 30 nursing homes, evaluate its use, and assess its impact on reducing hospitalizations. After testing, the PI planned to seek a federal grant for a more robust clinical trial of the program.

The project was successfully completed. The web-based version was developed. It consists of 12 modules--eight for online use and four with cases for self-study. The final report included a detailed description of the curriculum and the targeted users for each component.

Enrollment of nursing homes to test the INTERACT II web-based version far exceeded expectations. Because there was so much interest, the project team allowed staff from 127 nursing homes to participate--well above the objective of 30. In total, 1,428 staff participated in the training. However, training completion rates were not very

high, although no lower than rates for those that participated in the teleconference delivery version. The highest number of INTERACT II modules completed was nine, and only six percent of trainees got that far. Only 28 percent of participants finished half or more of the modules, thus demonstrating the difficulty of getting staff to complete such a lengthy curriculum.

The projectôs experience also underscored how difficult it is to effect change in nursing homes. Greatest use of the training tools occurred in nursing homes where there was a true ñchampion,ò i.e. a person selected to implement the practice changes and track their use facility-wide. Only 57 nursing homes (all with champions) truly implemented INTERACT II. Although this represented only 45 percent of the 127 participating nursing homes, it was almost double the 30 nursing homes that were originally expected to participate in the training program.

In the 57 facilities with a true ñchampion,ò the most widely adopted training tool was the ñEarly Warning Stop and Watch.ò Almost half reported facility-wide use of this tool. A similar percent reported facility-wide use of the SBAR Communication and Progress notes. This provides specific charting and content items to address as nursing shifts transfer patient care to one another. The third frequently used module related to monitoring quality. Nearly half of the ñchampionò homes reported using this tool in all units. Only two sites reported not using the quality indicators tool at all. Other tools frequently adopted facility-wide included the ñCare Paths;ò ñChange in Condition File Cardsòitems; and resident transfer form and checklist.

The PI, Dr. Joseph Ouslander, has begun making revisions to the program. He is making tools shorter, more engaging, and interactive. Believing that facilities would be more likely to implement changes if they were to pay for training, Dr. Ouslander has arranged for continuing education credits through Medline University.

Dr. Ouslander also met the projectôs final objective, which was to obtain federal funding for a more robust clinical trial. By the end of the grant period, he had received eight grant awards and subcontracts from sources such as the National Institutes of Health, the Veterans Administration, Commonwealth Fund, Medline, and others. With funding form PointClickCare, INTERACT II will be put into an Electronic Health Record.

The web-based version of INTERACT II has the potential to reach large numbers of nursing home personnel who are interested in avoiding unnecessary hospitalization among their patients and improving quality of care. Because the modules can be used selectively, improvements in care can be made incrementally and eventually lead to system-wide implementation. With the impetus under healthcare reform to reduce hospitalizations, nursing homes will become increasingly more interested in tools such as INTERACT II in the future.

Shawnee Alliance Implements Care Transitions Program

RRF awarded a one-year $48,018 grant to Shawnee Health Service and Development Corporation in Southern Illinois in partial support of the launch of the Bridge Program. The goal of the Bridge Program was to break the ñhospital to nursing

homeò transfer cycle by improving upon care transition. The program was operated by Shawnee Alliance for Seniors, the senior service division of Shawnee Health Service. It was one of four programs that were part of the Illinois Transitional Care Consortium, supported by The Weinberg Foundation.

Originally created by Rush University Medical Center, the Bridge Program involves placing a ñcare transitionò social worker with experience serving seniors in two Southern Illinois hospitals (Herrin and Memorial). Nursing and discharge staff at the two hospitals notify Bridge Program Coordinators when a high-risk patient is admitted. The Coordinators interview patients and families to assess their interest in getting help. Those interested are assessed for eligibility to receive state- and federally-funded in-home care. Coordinators monitor patient status and work with discharge planners to ensure needed services are in place. Bridge Coordinators help seniors access services such as home-delivered meals, home-nursing, transportation, medical equipment installation and training, primary care follow-up, and medication management. Once patients are discharged, the Bridge Coordinators contact them within 48 hours and as needed for up to 30 days. Clients are then referred back to Shawnee Alliance social workers for ongoing case management.

Shawneeôs launch of the Bridge Program was very successful. During the grant period, the program served 429 older patients. The program got services into seniorsô homes within 1.1 days of hospital discharge. All seniors served had doctor visits within 30 days. This is twice the national rate of only 50 percent. Among the most needed services were durable medical equipment and health supplies, home health and personal care, home physical therapy, and emergency home response systems. Patients frequently required home delivered meals. The program continues, and Shawnee Alliance is receiving more frequent referrals. This includes patients with higher incomes who can pay for services the agency offers.

Shawnee conducted interviews with family members at the conclusion of their service. A significant percent indicated that the program reduced stress associated with the discharge transition. Shawnee also surveyed staff at the two hospitals. The program received very high ratings for assisting families to understand their post-discharge options, arranging for community services, and providing home visits within one day of discharge.

The program had a number of positive ripple effects. A third area hospital in Southern Illinois began providing enhanced discharge services with help from Shawnee, and relationships between Shawnee Alliance and Southern Illinois Healthcare were strengthened. In addition, the U.S. Administration on Aging learned about Shawneeôs Bridge Program and asked the staff to participate in a national webinar to assist rural communities interested in transitional care. AoA also asked Shawnee to produce a case study for distribution to rural sites. Finally, the program led to Shawneeôs participation in the creation of a Southern Illinois Primary Care Medical Home in partnership with other healthcare providers in the area.

Study Finds Broader Adoption of Culture Change

In 2008, Brown University received a three-year, $289,435 RRF grant to study the level of adoption of long-term care culture change nationally and assess outcomes related to quality of life and quality of care. For several years, RRF and other funders have invested in organizational changes in nursing homes leading to more home-like settings and delivery of resident-centered, personalized care. Brownôs study aimed to determine how successful these efforts have been and the conditions under which culture change is more or less likely to occur.

Brown has a large dataset, combining all the data about long-term care that nursing homes and states are required to report to the federal government. This includes patient and provider characteristics, healthcare services use, quality outcomes, and surveyor ratings. RRF funding enabled Brown to add new information to its existing data about culture change.

The project team mailed a survey to a random sample of 4,149 U.S. nursing homes. Interviews were conducted with administrators at 64 facilities of varying quality as measured by survey deficiency reports. The response rate was 58 percent for Directors of Nursing and 59 percent for Administrators. For 45 percent of the surveyed facilities, both respondents returned their questionnaires. This was below the anticipated 60 percent response rate.

Eighty-five percent of facilities reported that they incorporated at least some level of culture change, but only 12 percent reported complete adoption. Compared to a 2005 survey, this represented a seven percent increase in complete adoption of culture change. Nineteen percent of facilities reported full adoption for at least some residents, usually in a subset of units. Another 51 percent reported adoption of at least some elements of culture change. Only 14 percent reported they have not engaged in any culture change and have no plans to do so.

The rate of culture change adoption was found to be higher for nursing homes in states that had pay-for-performance policies emphasizing it. Qualitative data found that culture change is fueled by a desire to attract financially desirable residents, not by an underlying philosophy of care. As evidence, facilities that have adopted culture change had fewer Medicaid patients. Administrators of facilities that fully adopted culture change were more likely to report that they were fulfilling regulations of the Centers for Medicare and Medicaid Services. They also reported increased market share, especially by Medicare eligible patients. These same nursing homes had lower hospital readmission rates, used significantly fewer antipsychotic medications, and were less likely to use physical restraints.

Most frequently mentioned barriers to adopting culture change included staff resistance to altering work routines; residents and familiesô wariness of change; increased costs for physical plant changes; physical plant limitations; and a resident mix that did not lend itself to culture change (e.g., too many residents with dementia or too many short-stays).

Although not surprising, the data showed a steady increase in adoption of culture change. Given the large dataset, Brownôs findings are likely to be taken very seriously. The finding about underlying motives for adoption of culture change may be particularly useful to leaders as they promote such practices to new facilities. The project team has drafted five manuscripts for publication. The team also presented the findings at an award-winning seminar at the Gerontological Society of Americaôs meeting.

UIC Studies Illinois' Experience with Replication of Chronic Disease Self-Management Program

In 2008, RRF awarded the University of Illinois at Chicago School of Public Health a two-year, $195,651 grant for systematic evaluation of a federally-funded effort in Illinois to widely replicate the Chronic Disease Self-Management Program (CDSMP). The CDSMP uses weekly group sessions to teach patients about chronic disease management skills, while offering emotional support to discuss the challenges they face with other patients.

Developed at Stanford, the program was tested and found to improve health behaviors, attitudes and outcomes for patients with congestive heart failure, chronic obstructive pulmonary disease, depression, and diabetes. Given these results, the U.S. Administration on Aging (AoA) awarded grants to several states, including Illinois, to broadly replicate the program.

Although AoA provided funds for evaluation, these dollars were inadequate to study whether replication sites were adhering fully to the original model and deriving the same benefit as in the controlled CDSMP trials. These implementation questions are important to identify barriers and facilitators of high-quality replications, and to help funders learn the conditions under which supporting further program adoptions make sense.

RRFôs grant enabled the projectôs investigator Tom Prohaska, Ph.D. to take advantage of the opportunity created by the multi-site replication project to evaluate these implementation issues in a systematic fashion. Baseline data were gathered on 891 participants from seven sites. Thirty-nine percent of the participants were minority. Arthritis, diabetes, and hypertension were the most common conditions reported. Four-month follow-up data were gathered on 260 of the 615 participants who completed the course and the post-test. This represents a 47 percent response rate for the four-month follow-up, which RRF staff considers to be very good, given the chronic health problems of participants and the timeline from baseline to follow-up.

The study found no benefits for CDSMP participants in terms of health outcomes or behaviors, emotional well-being, or medical care. However, at four months, subjects did report higher levels of confidence than they had at baseline about managing symptoms of their illnesses without use of medication.

The project studied 116 lay leaders, although only 25 percent completed the follow-up surveys. Fifty-six percent of the leaders who did respond reported that they

had not actually led a CDSMP group within two months of being trained, as had been expected of them. This suggests a large hidden cost in CDSMP replications. Most of the lay leaders who delivered the program reported good fidelity to the program model. However, there were fidelity issues with how they were trained. The lack of adherence to the program manual is another area of concern of relevance to replications of evidence-based practices.

The study also provided good feedback from lay leaders as to how CDSMP trainings could be strengthened. The volunteers reported the need for better guidance to focus discussions and strategies for problem-solving with participants. The research revealed greater difficulty in recruiting leaders in rural areas, a finding in an implementation evaluation of CDSMP replications in Texas as well.

Finally, the study addressed the question of sustainability, another issue that is important for replications of evidence-based best practices. Staff at agencies running the CDSMP replications were uniformly concerned about sustaining the program after AoA funding ended. While Area Agencies on Aging that sponsored some of the programs felt they might have access to Older Americans Act dollars for this purpose, providers in health care settings and other agencies reported they would need new external sources of support for sustainability.

Dr. Prohaskaôs study is very important because it is the first to provide a systematic review of problems inherent with large-scale replication, including the recruitment of volunteer leaders, their commitment to teach courses once trained, training fidelity, and sustainability. The study is also the first to question the health benefits of CDSMP. This information is important to funders like RRF who are interested in supporting replication of evidence-based practices. It underscores the importance of weighing the conditions under which replication is likely to succeed.

Alivio Medical Center Successfully Replicates Chronic Disease Self-Management Program

In 2008, RRF awarded a three-year, $255,000 grant to Alivio Medical Center to implement *Tomando Control de Su Salud* (Taking Control of Your Health) in Chicagoôs Latino neighborhoods. This is the Latino version of the Chronic Disease Self-Management Program described in the previous article on the UIC study.

The Latino version of CDSMP goes beyond simply translating the materials into Spanish. The programôs educational components and outreach strategies have been modified to reflect cultural factors shaping Latinoôs health beliefs and behaviors. For example, recognizing the close relations of Latino families, the curriculum has added strategies for engaging family members in helping patients with disease management.

This was the first chronic disease self-management program offered to older adults by Alivio. In part, Alivio selected *Tomando* because it is not limited to one chronic disease or condition. Therefore, it allows for inclusion of many more

participants and their families. More than 45 percent of *Tomando* participants reported more than one chronic condition.

Overall, Alivio met more than 90 percent of its objectives in program participation, leadership recruitment and training, and development of community partnerships. Alivioôs first objective was to serve 2,520 seniors, age 55 and over, over the three-year period. Alivio served 2,061 participants -- 82 percent of its goal. Alivio found that it took more time than expected to build the seniorsôtrust. Many seniors did not understand the nature of the program or its potential value. To help overcome seniorsôreluctance to participate, Alivio conducted demonstrations at churches and other familiar places.

Alivioôs second objective was to recruit 100 class leaders, preferably from community residents, to provide instruction and model behavior for the program. Alivio successfully recruited, trained, and deployed 97 class leaders who offered at least one series, thus almost hitting its goal. Ninety-one of the leaders came from Alivioôs service area; nearly 60 percent were age 55 and over, and all were Latino. Women comprised 80 percent of the group. Thirty percent had started out as class participants and upon completing the program, they came back to become leaders.

The program retained 66 leaders. This is a fairly high number, compared to the experience of other volunteer-led chronic disease self-management programs and the findings of Dr. Prohaskaôs study described in the previous article. Leaders left the program because they returned to work, moved out of the area, or simply lost touch. Recruitment and participation were enhanced by provision of a small travel stipend and hands-on support. Ironically, in some ways Alivio was aided by the economic downturn. Some leaders and class participants had lost their jobs and thus had time to get involved with the program. Others who cared for grandchildren were able to participate when their children lost their jobs and resumed primary child care responsibility.

Alivioôs third objective was to build a linkage between its clinical services and *Tomando de Su Salud*. As a result of the project, clinical providers began to appreciate chronic disease self-management programs as an integral part of the continuum of patient care. Clinicians began making regular referrals to *Tomando* as well as to Alivioôs benefits counseling services and the Senior Center.

Alivio exceeded its fourth objective--to partner with 100 community organizations for outreach, participant recruitment, and site sponsorship. Over the three-year period, Alivio reached out to, and worked with, 114 organizations. The partnerships were quite diverse, including a community organization dedicated to working with people with developmental disabilities, an adult education institution, a charter school network, and many churches. The partnerships enabled Alivio to serve older adults in their own neighborhood or at a venue where they were more comfortable.

The economic downturn created challenges in developing partnerships. Many organizations were grappling with a loss of funding and could not take on an additional commitment. Despite these challenges, Alivio succeeded, especially in partnering with many churches. With their strong volunteer bases, many of the churches committed to continuing the program. This will help with sustainability, a concern raised by Dr. Prohaskaôs study.

Alivio did an excellent job of using the programôs evaluation tools. At the conclusion of the grant, Alivio had followed up with approximately 70 percent of the programôs participants (some had only recently completed the program and were scheduled for later evaluation). Ninety percent of participants indicated they understand their chronic condition better. Eighty percent reported they stuck to their goals and were making new ones. Eighty percent reported ongoing physical activities, including participation in regular exercise. Seventy-five percent reported no hospitalizations or serious health issues related to their chronic conditions. An equal percent indicated they were making regular visits to their healthcare providers. These are promising results although longer-term impact was not measured, as in Dr. Prohaskaôs study.

Alivioôs chronic disease self-management program delivered what it promised. It also put Alivio in a good position to develop new opportunities to serve older adults. As the grant period was ending, Alivio was collaborating with Dr. Sue Hughes at UICôs Center on Health and Aging to develop the Spanish version of Fit and Strong, another evidence-based health promotion program. Most important, Alivioôs approach to serving older adults became much more inter-disciplinary. It expanded an educational program for children with weight issues to include a family focus and involve grandparents. Its Compañeros (health advocates) and Senior Programs began working together on a much more regular basis to extend the reach of health and wellness programs to seniors throughout the communities served by Alivio.

Three Organizational Capacity Building Projects Succeed

In the past few months, three RRF grantees successfully completed their organizational capacity building (OCB) projects. The purpose of the OCB Program is to encourage nonprofit organizations serving the elderly to improve their management and governance, and by doing so, enhance and sustain their services to the elderly.

Center of Concern received a one-year, $8,000 grant for succession planning. The purpose of the grant was to enable the Center to ensure strong leadership transition when its Executive Director of 27 years, Mary Schurder, announced her retirement. The Board of Directors decided to use this opportunity to engage in both strategic and succession planning to prepare for and find a new Executive Director. RRFôs funds covered the cost of a consultant to guide the organization through succession planning and to advise it during the transitional period once the new Executive Director was hired.

The consultant led the Centerôs Board through an organizational assessment and preliminary strategic plan. She provided search materials to help the Center identify the new Executive Director, including key characteristics or traits, a job description, sample interview questions, and other tools. She also prepared a transition plan with an outline of activities, steps, and a timeline.

The Board decided to hire an Interim Director for six months to give itself sufficient time to consider the type of management style that would be appropriate for the organization at this point in time and to conduct a very thorough search. The search was successful and resulted in the hiring of John McNabola.

During the grant period, the Centerôs Board and new Executive Director benefitted from the services of an OCB Coach. The coach assisted the Centerôs new Executive Director in prioritizing tasks during his start-up period. She assisted in the creation of an organizational chart that clarified appropriate staff responsibilities; the development of short-term goals to communicate expectations; and the streamlining of operations to improve efficiency. She also advised on the Boardôs restructuring, including creation of a Marketing Committee, recruitment of two new members, and transition of three who had previously served into advisory roles.

Northwest Side Housing Center (NWSHC) recently completed a one-year $20,000 RRF grant to develop a three-year strategic vision and plan for the organization. This was the first time this relatively young organization engaged in a strategic planning process. The timing was ripe because the foreclosure crisis had spurred considerable growth for NWSHC, in terms of number of clients and size of budget. Keeping up with client demand during the foreclosure crisis left little time for planning. However, the organization realized it needed to pause and take stock to determine what its direction should be after the housing crisis. RRF funding supported the cost of a consultant to facilitate NWSHCôs planning process.

NWSHC formed a Task Force, including members of the staff, Board, and other constituents. Working with the consultant, the Task Force conducted an organizational SWOT analysis (strengths, weaknesses, opportunities, and threats). The Task Force developed a shared vision of expected outcomes of NWSHCôs work for the next three years. The plan included service/program offerings and the infrastructure needed to support them. The Task Force determined key actions and activities necessary to achieve the desired outcomes. An action plan with timeline was created to guide NWSHCôs work through 2014. The project culminated in the production of a formal written strategic plan.

NWSHC accomplished several outcomes during the first six months of implementing its strategic plan. It revised the organizationôs mission statement and created a ñlitmus test,ò or guidelines for making decisions about which new projects and partnerships it would develop if it is to remain focused and strategic about its growth. Through the process, NWSHC recognized the need to expand the Executive Directorôs role into a full-time position. NWSHC engaged in a successful recruitment and transition process. NWSHC also added a health insurance plan for employees.

NWSHC began refining its messages and communication strategies. Using the new tools, it cultivated several new funding partners. NWSHC was able to obtain first-time funding from the Pierce Family Foundation, Wieboldt Foundation, and the National Community Reinvestment Coalition.

NWSHC used an OCB coach during the implementation phase of the project to help keep the Task Force on track. The Task Force provided very positive feedback on its experience with the coach. It also rated its consultant very high. As the result of its planning process, NWSHC now has a clear roadmap for defining its future.

Maplewood Housing for the Visually Impaired (DBA Friedman Place) received a one-year $27,500 RRF grant to improve and implement evaluation strategies.

Friedman Place is a residential facility for low-income older adults who are blind or have extremely limited vision. RRF funds were used to retain a consultant to help the organization establish systems to measure, learn about, and improve the impact of its services, and to better communicate results to potential donors and funders.

Friedman Placeôs first objective was to develop efficient and effective methods for collecting the information it needed to understand its programs, without overburdening staff with undue data collection. To gather information in a standardized way, a system was developed in which some staff members were selected to serve as Resident Care Advocates. Each Advocate was assigned a caseload of residents. Advocates gather information about residentsôneeds and progress on a quarterly basis, document the information, work to resolve problems, and report any quality improvement needs. The consultants developed standardized forms and tracking mechanisms for this function and created position descriptions. A Committee was formed to review the Advocatesôdata on a regular basis. The Development Associate was selected as the point-person to ensure that evaluation tasks do not fall by the wayside. A variety of tools were produced to help with data collection and analysis.

The second objective was to transform itself into a ñlearning organizationò in which planning and program adjustments would be made on the basis of regular evaluation data analysis. A number of procedures were developed to encourage continuous learning and engagement by both the staff and Board. The Board approved annual funding to support evaluation and ensure that the process continues.

Improving communications with stakeholders and donors by creating clear and effective messages about impact was the third objective. The organization began using clearer messages in its proposals and annual appeal. Friedman Place received two new general operating grants based on proposals that relayed its impact more clearly. While it is difficult to know whether the clearer messages truly made the difference, Friedman Place attributes its success to this improvement.

Friedman Place became so enthusiastic about the evaluation process that it created, both in print and Braille, a button for staff to wear with the message ñItôs all about MOIò (Measuring Our Impact). The buttons served as a talking piece to engage residents in evaluation and inform them about changes that would be occurring.

Three Houses of Worship Make Accessibility Improvements

In the past few months, three Chicago-area houses of worship completed accessibility improvements with funding under RRFôs Accessible Faith Grant Program. AFG grants are made for up to 50 percent of a projectôs cost (and a maximum of $30,000).

Our Lady of Peace is a 2,000-member Roman Catholic Church located in the South Shore neighborhood. The parish is primarily African-American; 40 percent of its members are older adults. In addition to many worship opportunities, the Church offers a number of fellowship programs for seniors, hosts a Haitian congregation and many

community groups, including Chicago Alternative Policing Strategy (CAPS) and a food ministry.

Our Lady of Peace received a $6,000 Accessible Faith grant to implement phase two of its three-part accessibility improvement plan. The first phase involved installation of a platform lift, which RRF previously supported. This second phase involved installation of an automatic door opener for the entry to the platform lift to allow for independent access. It also included the replacement and widening of the sidewalk leading to the entrance. The church now has an entirely accessible entrance to the church and lower level.

The project was successfully completed early and within budget. Apparently, the congregation learned quite a bit from problems it had encountered during the first phase. For phase two, the Church already had an experienced project team. The team understood the process of working with the Archdiocese and used a familiar vendor. The pastor was very strategic in breaking down needed accessibility improvements into manageable phases. This helped with fundraising and planning for use of the facility during construction.

The Church has already added programs such as a summer camp, which will produce some revenue, and a food outreach program. Older parishioners have begun returning to church on a regular basis. The pastor referred to the ñsmall yet powerful testimoniesò elders have been providing about the value of the improvements.

Carey Tercentenary Church is a 245-member African Methodist Episcopal Church located on Chicagoôs Westside. It is primarily a low-income, African-American congregation; more than 25 percent of its members are seniors. The church hosts many services and activities for the community, including CAPS meetings and health education programs in partnership with Mt. Sinai Health Clinic.

Carey Tercentenary received a $30,000 Accessible Faith grant to install an enclosed platform lift between the main level of the church and the basement where several of the groups meet. There are two flights of steps between the main level and the basement, making it quite difficult for many elders and people with disabilities to participate in activities.

The project was successfully completed although it experienced delays and increased cost. In his final report, the reverend indicated he expects to see a 20 percent increase in attendance by seniors at programs as a result of improved accessibility. Hopefully, the congregationôs tenacity in seeing this project to completion will pay off in terms of greater involvement by members of the congregation and community.

Epiphany Parish is a 1,500-member Roman Catholic Church in the Pilsen neighborhood. The parish is almost entirely Hispanic and primarily low-income. Thirty percent of the parishioners are seniors. This very active congregation sponsors weekly ministries and religious education programs, a food pantry, classes in English as a Second Language, health programs through St. Anthony Hospital, and housing counseling through Neighborhood Housing Services.

Epiphany received a $30,000 Accessible Faith grant to construct two ramps--one to the sanctuary and the other to the basement community center. Prior to the grant, getting to the sanctuary required ascending ten to twelve steps, and getting to the basement involved another flight. The ramps make the two levels accessible.

Although the project took longer than anticipated, it was successfully completed. Parish members have been providing much positive feedback on the new ramps.

Little Sisters of the Poor's Chicago Province Installs New Data Management System

In 2010, a $50,000 RRF grant was awarded to the Little Sisters of the Poor, St. Joseph's Home for the Elderly, to enable the Chicago Province to participate in technology improvements that all 29 Little Sisters nursing homes were undergoing. The Chicago Province includes 11 of the 29 nursing homes. RRF's grant supported implementation of the technology and staff training.

The technology enhancement involved installation of a new data management system that integrated financial and clinical functions. The goals of the project were to: 1) upgrade financial and accounting systems for more efficient processing of accounts receivable, billing, and reporting; and 2) transition clinical nursing staff from paper files to electronic medical records to deliver resident care more efficiently.

The project went relatively smoothly, despite some initial technology glitches and delays. At the time of the report, nine of the Chicago Province's nursing homes were fully using the new software. The remaining two were expected to be up and running shortly after the grant period ended. Most of the nursing homes had also been set up with secure wireless connections to allow for mobility of the medication cart and laptop without loss of Internet access. With this capacity, assessments and medication administration records could be documented immediately at the bedside.

The grantee provided several examples of improvements resulting from the technology enhancements. Month-end reconciliation for bookkeepers became faster and more accurate and required less manual correction. Reporting of resident census data and provision-of-care data became more accurate, resulting in better and timelier reimbursement for services rendered. Certified nurse assistants were putting documentation directly into the electronic system instead of having a separate coordinator do it for groups of CNAs after their shifts. This allowed more time for review of data and elimination of the additional possibility of human error. Nurses were electronically documenting care at the time of service instead of waiting until their shift ended to complete paper work. This cut down on the amount of extra time and cost spent on non-clinical tasks. Such time-savings, financial benefits, and improved accuracy should serve the Province well for years to come.

Touchette Hospital Expands Seniors I.Q. Program

In 2011, RRF made a $40,000 grant to Touchette Hospital to continue its Seniors I.Q. Program. Along with its nine federally qualified health centers, Touchette is the only safety-net hospital in the region and the primary source of health care for low-income persons in East St. Louis and surrounding communities. East St. Louis ranks among the ten poorest communities in the nation. Its 31,000 older adults (age 65 and over) are primarily low-income and African American. Ninety-five percent have an income at or below 200 percent of the federal poverty level.

The goal of the Seniors I.Q. Program is to provide older adults with needed resources and services to improve their quality of life and enable them to continue living independently in their own homes. The program provides free information, assistance, and referrals; counseling to assist older persons to enroll in health insurance programs; and case management. It conducts health education at Touchette, senior buildings, churches, and other sites in the community.

This was the third year of support for the Seniors I.Q. Program. At the end of the grant period, there were 1,653 seniors enrolled in the program, including 395 new members. Although the program recruits through its nine health centers, churches, senior buildings and other community sites, by now most of the new members learn about the program from existing members.

The program provides each new member with an in-home safety assessment. Continuing members receive annual in-home follow-ups on the anniversary of joining the program. Staff arrange for emergency life lines, hospital beds, wheelchairs, scooters, walkers, ramps, railings, and step repairs. The program also arranges transportation to medical appointments.

Seniors I.Q. staff members are counselors trained and certified by the State Health Insurance Program (SHIP) and the State Health Assistance Program (SHAP). The staff helps older adults navigate and obtain health care coverage from programs such as the Low-Income Subsidy (ExtraHelp), Medicare Savings Programs, and LIHEAP (energy assistance). They help seniors to interpret and compare benefits and advocate with government personnel on behalf of clients. The staff also accompanies seniors to help them complete applications when in-person appointments are required.

The program has improved the tracking of actual benefits seniors receive as a result of its counseling and advocacy efforts. Total benefits for clients were valued at $1.4 million during the grant period. The program had estimated that the value of benefits would be closer to $2 million, but the elimination of the Illinois Cares Rx Program significantly reduced this figure. The staff was not able to track the value of coverage seniors got from pharmaceutical companiesôfree drug programs.

Seniors I.Q. conducted at least 25 health presentations and screening events, in cooperation with several partners in the community. Many of these presentations were not one-time events, but rather a series, such as the diabetes self-management program.

Latino Alzheimer's Disease Support Groups Launched

In 2011, RRF awarded a $10,000 grant to the Latino Alzheimer's and Memory Disorders Alliance (LAMDA) for first-year support of the start-up of a support group for Latino families with an elder suffering from dementia. Entitled *En Familia*, the program offers twice monthly support groups year-round (every other Saturday). A total of 132 families, including 287 caregivers, participated in the first year of the program. *En Familia* included educational sessions by experts for the caregivers, followed by facilitated discussions. Respite care was provided for the elders with dementia since many caregivers brought them to the program. Casa Central social workers provided the respite care.

LAMDA recruited families through Alivio Medical Center, churches, and other venues serving seniors. It also made excellent use of Latino television and radio. LAMDA was given a permanent desk at the Mexican Consulate where it scheduled information sessions on a regular basis. This turned out to be its most effective recruitment strategy.

LAMDA trained two facilitators to run the program. The facilitators are health promoters who work at the Mexican Consulate during the week. Two caregivers who attended the program stepped up to help lead sessions as well.

The program met at Casa Maravilla where Alivio runs a Senior Center. Originally Alivio committed to provide two of its advocates (compañeras en salud) to assist with the support groups. Because of their interest, however, 24 compañeras volunteered to assist with outreach, provide information on resources for the caregivers, help them navigate benefits, and assist with memory screenings for elderly. At the close of the grant, the compañeras were being trained to become SHIP (State Health Insurance Program) counselors to improve their ability to assist seniors with healthcare coverage choices.

Both Alivio and Mt. Sinai Hospital provided follow-up primary care for families as needed. Ninety-two caregivers were referred for such care. The program also made other referrals, e.g., to the Social Security Administration for benefits and to Rush University Medical Center for additional memory screening.

LAMDA's objective was to serve 143 families. It met 92 percent of its goal. Given that this was the first year of the program, it had to overcome a lack of awareness about dementia among Latinos as well as a distrust of services.

LAMDA is providing a unique and valuable service to Latino caregivers of persons with dementia. In addition, LAMDA is building awareness among service providers about the importance of culturally appropriate services for Latinos with dementia and their families. Along with Alivio, LAMDA is working with the National Council of La Raza to plan the first National Latino Alzheimer's Conference, scheduled for the spring of 2013.

Aurora Family Services Brings Elder Family Health into Family Therapy Training Program

In 2010, RRF awarded a one-year $49,524 grant to Aurora Family Service in Milwaukee to incorporate knowledge about aging in its Family Therapy Training Institute. The Institute is a two to three year, post graduate training program in family systems therapy. Students learn to assess, diagnose, understand, and intervene to facilitate change in dysfunctional family patterns. Aurora developed and piloted the Elder Family Health curriculum with the Institute in response to increased demand for counseling services by families of elders. The Institute's training manager recognized the need to develop learning opportunities that focused on the dynamics of aging and offer training experiences to increase the competency of professionals working with families of elders.

The objectives of the Elder Family Health project were to deliver the curriculum on aging to 25 of the Institute's students; expand training to non-clinical services providers; create field placement opportunities for five of the students; and present lessons learned and curriculum concepts at one state and one national conference.

Based upon family systems theory and practice, an innovative model of family caregiving engagement was created. The curriculum includes four modules: 1) a theoretical framework linking individual and family development to family relationships; 2) methods to help families navigate transitions related to retirement, housing changes, and loss of friends and family; 3) strategies for nurturing family relationships between elders and their grandchildren, siblings, spouses, and adult children; and 4) ways to help families manage chronic illness and death.

Twenty-three of the Institute's trainees completed the training program. Training was expanded to 125 non-clinical service providers through presentations at St. John's on the Lake (a continuing care retirement community in Milwaukee), at the American Society on Aging's national conference and the Generations Together Conference in Milwaukee.

Field placement opportunities were provided in the community for five Institute students who chose an elder-focused practicum. However, counseling services (consisting of at least six family therapy sessions per family) were delivered to only nine families with elders, much less than expected. There was simply less demand for the services than expected.

Despite the lower demand for family therapy at the practicum sites, Aurora Family Services reported there has been growing interest in the Elder Family Health curriculum. For example, United Community Center (an RRF grantee) has expressed an interest in collaborating with Aurora Family Services on a six-month pilot of family therapy to better address the mental health needs of their Latino elders and families.

Illinois Pioneer Coalition Expands its Reach

In 2010, the Illinois Pioneer Coalition (IPC) received a one-year $50,300 RRF grant to expand culture change practice in Illinois. The goal was to increase awareness of, and appreciation for, culture change among professional, institutional, and public audiences and to help those working in long-term care settings understand how to implement the person-centered philosophy in their facilities.

IPC reached a far larger audience than expected. IPC-sponsored local, regional, and statewide trainings reached a total of 3,889 individuals--far more than the 1,850 projection. On average, 30 percent of training participants reported that they were first-time attendees of an IPC-sponsored event. Many were staff at long-term care facilities that had begun work on culture change and indicated their administrators had supported their participation. Others were from facilities where culture change had not yet begun.

Three new regional coalitions on culture change were created--two in Northeast Illinois (DuPage and northern Cook County) and one downstate. It is noteworthy that two of the three are urban/suburban. Culture change has previously taken hold more in rural parts of Illinois than in urban/suburban areas.

IPC forged strategic relations during the course of the grant. It built relations with the Illinois Department of Public Health and its surveyors. It worked more closely with the Illinois Association of Nursing Home Administrators, which began incorporating sessions on culture change in its programs. IPC also developed relations with the two for-profit nursing home membership organizations. One began offering culture change programs for free CEU credits.

IPC had previously received funding from the state, but was cut in 2011. As a result, IPC had to eliminate its only paid staff position. Thus, all the trainings were done by IPCôs volunteer Board of Directors. IPC hopes to use its strengthened relations with the Illinois Department of Public Health to obtain a civil monetary penalty grant for outreach and ongoing training.

Note: *RRF staff takes much of the information for Grant Highlights directly from grantees' final reports. Staff often asks questions and holds discussions with grantees to get a more complete understanding of the results of grants and to understand challenges grantees faced.*