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WINNING PROGRAMS PREVENT ADDICTION, DISEASE AND FALLS

The American Society on Aging's (ASA) 2006 Healthcare and Aging Awards bestowed laurels on six programs ranging from a community partnership in Portland, Maine, aimed at reducing unnecessary falls among elders to a healthy-lifestyles effort in Milwaukee focused on decreasing the development of diabetes type 2 and other chronic ailments among older American Indians. The honors were presented at ASA's spring annual conference in Anaheim, Calif., by the association's Healthcare and Aging Network and sponsored by the Pfizer Medical Humanities Initiative.

Following are descriptions of three of the programs. One of the six winning programs, the Caregiver Cooperative Respite Program at the Asian Community Center of Sacramento Valley in California, was discussed in the last issue of **Aging Today** because it is part of the center's Lifelong Learning and Wellness Program, which won one of ASA's Network of Multicultural Aging Awards. (Visit *www.agingtoday.org* and under the May–June 2006 issue, click on "ASA's First Multicultural Awards Honor Three Programs.")

Two other 2006 Healthcare and Aging Award-winning programs, Michigan's Coordinated Access to Food for the Elderly and the Palliative Care and Bereavement Program in Southern California, will be examined in the next issue.

FILLING THE GAP

When the staff of Lifespan's Geriatric Addictions Program (GAP) in Rochester, N.Y., first visited Louise, a 67-year-old widow, she was surrounded by empty vodka bottles and smelled of urine and feces. Disheveled, disoriented and with ankles and hands swollen from edema, she was in medical crisis. Louise had been in area hospitals 20 times in the previous six months, and local healthcare professionals had labeled her as "a noncompliant old drunk." Usually, they discharged her with little or no intervention for her alcoholism—and soon she would cycle back to the point of again needing an emergency room.

Wayne, age 70, was struggling with late-onset alcohol dependence. His life had deteriorated since he had retired five years earlier. Although he'd had a successful career, retirement sapped his sense of involvement and Wayne started drinking. One evening he fell, hit the kitchen table and couldn't get up, even with his wife's assistance. Wayne agreed to examine his drinking, but rejected a substance-abuse treatment program out of hand.

These two cases are typical of those GAP has treated since it began in 2001, according to Paul L. Caccamise, Lifespan's vice president for programs. He explained that cases like Louise's represent a longstanding pattern of dependence complicated by comorbid, chronic medical conditions. In other cases, such as Wayne's, the substance abuse originated later in life but is complicated by depression or other mental health issues, such as loss and bereavement.

Nationally, the federal Substance Abuse and Mental Health Services Administration estimates that the number of adults ages 50 and older who need alcohol or drug treatment will increase from 1.7 million in 2001 to 4.4 million in 2020. Misuse of alcohol and prescription drugs affects about one in six older adults

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in the United States, but addiction in elders is underdiagnosed and undertreated, Caccamise said. Nevertheless, healthcare providers tend to overlook substance abuse and misuse among older adults, and most alcohol and substance-abuse treatment programs are not geared toward the specialized needs of older adults. He added, "Few communities recognize that this problem requires not only a special approach but also systemic change."

AN UNUSUAL APPROACH

Lifespan, a nonprofit agency serving elders, developed GAP as part of the Rochester area's Consortium on Elderly Substance Abuse. GAP uses an unusual nonmedical approach to treat geriatric addictions. The program employs a community-based approach that provides substance-abuse intervention directly to older clients in their homes without requiring them to register and be seen in a substance abuse clinic, a stipulation usually attached to licensed treatment agencies.

Even though funding for chemical-dependency programs is tight and limited to licensed agencies, GAP chose not to apply for a license "because it would change the nature of the program," Caccamise said. Additionally, government and private insurance programs will not pay for in-home services. GAP obtained funding, though, from local foundations, one-time government grants, and development funds provided by Lifespan.

Along with a substance-abuse assessment, the GAP intervention protocol includes a clinical evaluation and a social- work assessment of the need for geriatric care management—such as in-home care services, socialization services, Meals on Wheels or legal services. A mental health screen is routinely included in the clinical evaluation to identify depression or signs of dementia. Specially trained staff also gauge each client's position along the stages-of-change continuum and help clients move toward the goals of increased health, safety and functioning. Caccamise added that, when appropriate, clients are linked to traditional chemical-dependency treatment programming.

REMARKABLE RESULTS

To date, Caccamise reported, GAP has served approximately 450 older adults. In 2005 alone, he said, GAP staff trained 471 professionals, older adults and family members about substance abuse among older people. Analysis has shown that about 20% of cases involved elder abuse. GAP found that 40% of referrals have come from families in crisis, whereas less than 10% originated from primary healthcare providers, he said. In addition, the first two years of client data revealed that more than 40% of GAP clients had a dementia—most often undiagnosed prior to GAP involvement; 32% had chronic medical problems; and 45% required intensive case management, a service not reimbursed by traditional substance-abuse programs or insurance.

Working with the University of Michigan and the University of Rochester, GAP collected and analyzed outcomes from the first 120 cases. The analysis found, for example, that 80% of those who entered inpatient care after GAP intervention completed treatment, compared with 57% of older adults who were offered generic chemical-dependency treatment services.

Furthermore, GAP has trained more than 850 professionals and 650 nonprofessionals and caregivers in the recognition and dynamics of geriatric addictions. In 2002, GAP began hosting the area's only Alcoholics Anonymous meeting that targets older adults. In 2005, GAP led the way in organizing the Monroe County Geriatric Substance Abuse Coalition, involving more than 30 professionals working in substance abuse, mental health, medicine and aging, as well as funders and government officials.

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INDIAN-ELDER WELLNESS

Even though the majority of American Indians and Alaska Natives in the United States today live in cities, not on reservations, federal healthcare policy continues to focus largely on the needs of those on reservations in rural areas, according to Linda Cieslik, program coordinator for community health at the Milwaukee County Department on Aging. The department partnered with Milwaukee's Indian Council of the Elderly (ICE), which operates a senior center, and others to develop a wellness program to provide exercise, nutrition and related activities to Indian elders to help them prevent and control type 2 diabetes and maintain heart health.

"Obesity, high blood pressure and associated health problems are overrepresented in the Indian population," Cieslik observed. Nationally, about 12% of Native American adults have diabetes, 2.5 times the rate for non-Hispanic whites. In Milwaukee, she added, among diabetics seen at the Gerald L. Ignace Indian Health Center, 47% are ages 45 to 64 and 25% are age 65 or older.

Cieslik's department initiated the wellness program in 2004, after a three-month review of evidence-based practices in health promotion for older Native Americans, combined with discussion of potential program elements with numerous elders about their needs and preferences. American Indians of any tribal affiliation are welcome to join the program if they are age 45 or more and attend the ICE senior center.

"Indian Council of the Elderly is a small and underfunded program, and the Ignace Indian Health Center is a small and underfunded community clinic," Cieslik stated. "Both agencies are in a constant struggle to provide quality services with limited funds to already underserved populations that have great health and social service needs," she said.

The wellness program, which began with 15 elders and now serves 25, not only provides health education and lifestyle-management activities, but also gives participants an extra day of socialization and access to services that could not be provided under the current level of funding for ICE, she said.

Once a week, the wellness program transports elders from the ICE senior center to the Ignace Center to participate in supervised fitness activities, nutrition counseling and education programs. At the health center, a registered dietician plans menus that include traditional Indian foods, and the group participates in meal preparation on site after a morning exercise and health-education session supervised by the health center's fitness manager. Each participant receives a folder with a workout plan and goals, as well as copies of recipes and nutrition handouts for future reference.

With support from the Milwaukee County Department on Aging, University of Wisconsin-Milwaukee and Covenant Health, project partners developed a baseline picture of the health of participating elders before the program began by recording each person's fasting blood glucose, full lipid panels, body-mass index, blood pressure and heart rate. As the program continued, staff recorded weight, blood pressure, heart rate, and waist and hip measurements weekly for each participant. Once per month, a healthcare professional visited ICE to consult with participating elders about their progress.

Physical measurements taken from September 2004 through May 2005 showed that three-fourths of participants lost weight (on average, 12.4 lbs.), one-fourth maintained their weight and none reported gaining weight. One way the wellness program rewards progress is by charting the number of steps participants walk and the time they spend using treadmills or other exercise equipment.

A survey including 75% of the group indicated that as a result of the program, most eat more vegetables, fish, nuts, fiber and calcium-rich foods, as well as smaller portions. More than half reported that they now choose low-fat foods and eat less salt. All but two are now taking multivitamins. The survey also showed that participants report improvements in blood sugar and cholesterol control. In addition, most regular participants reported having more energy, decreased depression and increased ease in performing activities of daily living, such as stair climbing, bending, and rising from a chair. About half of participants reported having become more social by joining in new activities or groups.

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WELL BALANCED

Evidence has long shown that exercise and training to overcome elders' fear of falling can greatly reduce injuries among community-dwelling older adults. In the 1990s, the Roybal Center at Boston University developed A Matter of Balance: Managing Concerns About Falls, a program of eight two-hour sessions for elders led by professional facilitators. Research showed that A Matter of Balance was effective, but staff at MaineHealth in Portland and its Partnership for Healthy Aging (PFHA) found that the cost of using professionals for A Matter of Balance prohibited widespread dissemination of the program in multiple settings, according to PFHA director Peggy Haines.

To address this gap between research and practice, PFHA translated the original program into a lay-leader model facilitated by community-based volunteers, called coaches, instead of professionals. To do so, with funding from the U.S. Administration on Aging, the Maine program adapted the original curriculum for use with lay leaders, providing the volunteer coaches two days of training, as well as observation and feedback by healthcare professionals or master trainers. Employing a mentor model, PFHA

pairs new volunteers with an experienced coach, and adapted exercise components of the class to enable volunteer coaches to teach them safely, Haines said.

Preliminary research by the University of Southern Maine (USM) School of Social Work has determined that the new lay-leader approach is achieving the same or better results as those achieved with paid professional staff, Haines noted. Initial findings of the outcome evaluation indicate that participating older adults showed significant improvements in reducing their risk of falls, knowing how to deal with falls and preventing falls, she said. Participants also increased their level of exercise and reduced or eliminated the self-imposed social limitations resulting from fear of falling.

Haines said the original researchers for the program were concerned that reducing elders' fear of falling might lead to more falls if participants increased their activity levels. "It is striking to note that participants in the current study reported fewer falls during the six-month period after participating in A Matter of Balance than in the three-month period before taking the class," she added.

In addition to partnering with the USM School of Social work to develop the lay-leader model, PFHA has collaborated with the Maine Medical Center's Division of Geriatrics and Southern Maine Agency on Aging, Haines said. Also key to A Matter of Balance is the Project Advisory Committee, including 14 organizational members, a participant and a coach, to guide the development and oversight of the program's implementation and dissemination.

REDUCING FEAR

The program focuses on practical coping strategies to reduce elders' fear of falling during eight two-hour classes presented over a four-week period by trained facilitators using a detailed training manual and two instructional videos. The curriculum includes lectures, group discussions, mutual problem-solving, role- playing activities, exercise training, assertiveness training and home assignments. Participants learn about the importance of exercise in preventing falls; practice exercises to improve strength, coordination and balance; conduct a home-safety evaluation; and learn to get up and down safely. Maximum class size is 12 students.

Up to June 2006, the program has certified 28 sites where master trainers can instruct volunteer coaches (21 in Maine and seven in such locations as Charleston, S.C., Washington, D.C., and Seattle, Wash.). The program has 58 master trainers who have taught 125 volunteer coaches, and it has held 62 classes for 621 participants.

Working with the National Hispanic Council on Aging and the Merck Institute of Aging and Health, PFHA also aims to adapt the volunteer lay-leader model culturally and linguistically for Hispanic elders. The pilot program is titled Su Salud en Balance (Your Health in Balance).

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