National Rural Health Association

The John A. Hartford Foundation

Compendium of Best Practices for Rural Age-Friendly Care

2024

National Rural Health Association

The John A. Hartford Foundation

Compendium of Rural Age-Friendly Best Practices

Developed as part of the National Rural Age-Friendly Initiative

2024

Preface

The National Rural Age-Friendly Initiative is a joint effort between the National Rural Health Association (NRHA) and The John A. Hartford Foundation (JAHF) to develop resources, partnerships, and strategies to build age-friendly care for the one in five older adults living in rural geographies.

NRHA aims to achieve these goals through four approaches: convenings, communications, educational activities, and community health worker trainings. While we recognize rural-specific challenges, the diversity, innovation, and resilience of rural communities can be leveraged to improve care and quality of life for older adults who choose to call rural home.

The partnerships NRHA has formed through this work continue to strengthen and broaden the reach of the initiative. This compendium is a product of that collaboration and innovation, highlighting best practices from across the United States that can be built upon in rural communities.

KEYWORDS

Age- friendly care
Rural health
Aging adults
Community health care

Foreward

We are aging from the moment we are born, and the National Rural Health Association recognizes that rural communities have unique strengths and challenges in promoting healthy aging for all.

NRHA is uniquely positioned to bring together a national network of rural health experts, researchers, policymakers, providers, community-level organizations, federal partners, and other funders to address all facets of rural aging and support engagement in the age-friendly ecosystem. We have identified places to lead, support, and follow as we move toward the goal of access to age-friendly care for all older adults choosing to call rural communities their home.

Our team is committed to bringing together partners, members, and community leaders who were already dedicated to supporting healthy aging for rural residents and strengthening their access to resources to achieve our shared goal.

Alan Morgan
National Rural Health Association CEO

Contents

Contents

Submissions by category

Please note that submissions may be listed in multiple categories.

Care coordination

Caregiver support & resources

Mental & behavioral health

Submissions by category

Community programming

Community health workers (CHWs)

4Ms: Mentation, Medication, Mobility, & What Matters

State-level priorities

Delano Regional Post-Acute Network

North Kern South Tulare Hospital District
California

Care coordination

Purpose: The North Kern South Tulare Hospital District launched and coordinated a care network to improve communication across the continuum of care. Every other month, the district gathers post-acute providers at the Delano Regional Post-Acute Network meeting. This includes skilled nursing, independent/assisted living, home health, and hospice providers, who meet with the acute and acute psychiatric hospital discharge planners and attending physicians to share best practices, improve communication, and reduce avoidable hospital readmissions.

Summary: Key initiatives include:

- Reducing discharge time from hospitals
- Improving process for same-day admissions to post-acute care
- Reducing readmission rate to acute care hospital
- Reducing emergency room visits
- Improving access for patients in need of psychiatric consult
- Improving communication with emergency department when post-acute patients present

Continues on next page

The post-acute network requires engagement for the hospital to be successful, as traditionally post-acute providers are motivated to support hospital priorities and programs because of dependence on a high volume of referrals to ensure profitability. While the district CEO leads the meeting, the involvement of the hospital discharge planner and community relations team is critical for the continued success of the post-acute network. Leaders also seek input from active physicians who are discharging, serving as SNFist, and doing home visits.

Dr. Josh Luke, District CEO presents at the PAN meeting and time is left at the end for networking.

Through trial and error in other regions, post-acute networks seem to be most successful when meeting every other month. Meeting monthly is often overkill, and meeting quarterly makes it difficult to keep providers engaged. The host provides lunch and creates a specific agenda to keep the meetings on task, with an open forum at the end of the agenda.

There was no funding needed beyond the expense of lunch. If funding is an issue, then the meeting can be held without lunch. Our leader has led post-acute networks in other regions, wrote the first book for the American College of Healthcare Executives Health Administration Press on the hospital readmission penalty, and is experienced in keeping the meeting focused.

Continues on next page

Lessons learned from other post-acute networks include relying on post-acute providers to provide data on readmissions and other statistics. By relying too much on data, providers often do not have the resources to accurately collect it, resulting in less engagement in the post-acute network as a whole. When data is requested from post-acute providers, it is often inaccurate or exaggerated to portray the provider more favorably.

The post-acute network is an excellent way for the acute hospital to identify preferred post-acute providers or create a narrow network or official partnership with a post-acute provider. At each meeting, we showcase a local program, such as PACE, transportation, adult daycare, or non-medical home care options. We try to keep these showcases to less than five minutes to keep the meetings short – our goal is to be finished within an hour. Our schedule is 11:30 a.m. arrival and networking, 11:50 a.m. lunch served, and noon to 1 p.m. meeting.

Impact and efficacy: Because the post-acute network is relatively new, we do not yet have any quantitative data. We do, however, have a new spirit of cooperation in the region and have witnessed an increased desire for providers to step in and help each other regardless of the need.

Sources of funding: There was no funding needed beyond the expense of lunch to the host. If funding is an issue, then the meeting can be held without lunch.

Rural Multisector Plan for Aging Initiative

University of California, Davis
California

Care coordination
Caregiver support & resources
Community programming
Mental & behavioral health
State-level priorities

Purpose: When the California Department of Aging launched its statewide master plan for aging (MPA) in 2021, there was a recognition that to truly implement change, local MPAs should also be developed at the county and city levels. However, rural communities across California did not have the capacity to invest in this type of planning. To address this need, the SCAN Foundation launched a two-year Rural MPA Initiative in January 2022, funding three advocacy coalitions to develop local MPAs covering seven counties. Through this initiative, many lessons were learned, and a process was developed that could be replicated in other regions.

Summary: The California Department of Aging's MPA included a local playbook to guide communities in developing local MPAs. There was a recognition that to truly implement change, advocacy needs to occur at the state, county, and city levels. While many of California's urban counties have already worked on local plans for aging, rural communities have not had the capacity to invest in this type of work.

To address this need, one of CDA's philanthropic partners, the SCAN Foundation, launched a two-year rural MPA initiative in January 2022, funding three advocacy coalitions to develop local MPAs covering seven counties. The Diversability Advocacy Network focused on Shasta, Butte, and Glenn counties; the Central Valley Long-Term Services and Supports Coalition focused on Kings and Tulare counties; and the Inland Coalition on Aging focused on San Bernardino and Riverside counties.

Continues on next page

Our first task in each region was to establish local advisory committees with multisector representation from local government, elected officials, health systems leaders, area agencies on aging, independent living centers, community-based organizations, and other key stakeholders. In Northern California, the DAN coalition was already an established leader, and they were able to hit the ground running in January. The coalition in the Inland Empire experienced a change in leadership in 2020 that coincided with the beginning of the COVID pandemic, and it was challenging to rebuild momentum in that region. Fortunately, a leader of the Inland Caregiver Resource Center stepped up to volunteer as co-chair, taking on considerable responsibilities to engage key stakeholders. In Kings and Tulare Counties, staff turnover at the start of the project meant the advisory committee was delayed in their launch until May 2022.

Provided photo of participants showcasing the outcomes of a craft project.

Once the advisory committee was in place, a needs assessment was conducted to understand current conditions and unmet needs related to housing, transportation, health care access, quality of care, long-term services and supports, behavioral health, caregiving, food access, Alzheimer's and other dementias, and connection to resources. The regions reviewed existing data and local plans such as community health improvement plans, area agency on aging plans, county housing and transportation documents, incoming call data to United Way/211, the AARP livability index, and more.

Continues on next page

Community input was gathered through dozens of focus groups engaging providers, older adults, adults with disabilities, and caregivers. Relationships were formed and expanded with providers and cultural institutions to engage participants representing diverse geographies and perspectives, such as LGBTQ+, American Indian, Black, Latinx, Hmong and Mien populations, veterans, farmworkers, wildfire survivors, and those who were low-income, unhoused, or formerly incarcerated. In some cases, new advocates were identified through the focus groups and invited to join local advisory committees.

Series of provided photos of participants engaging in creative projects.

Needs assessment findings were presented to advisory committees to drive strategic planning of cross-sector programs, policies, and practices and promote change in the region. Simultaneously, further input was gathered through an iterative process of presenting needs assessment findings and hearing recommendations from transportation, housing, and health care leaders.

To build community support and awareness of local MPAs, in fall of 2023 each region hosted a public event engaging elected officials, government and health care leaders, community- based organizations, and advocates. The events provided an added benefit of sparking media attention. A series of local news features, radio interviews, and media spots further increased awareness and support of local MPAs.

Continues on next page

Impact and efficacy: In December 2023, the three coalitions presented a webinar about their 2022-2023 rural MPA initiative processes, lessons learned, and next steps. The webinar drew 265 attendees, including 19 senators and assemblypersons, rural leaders throughout California, and representatives from Washington, D.C., Illinois, Iowa, Texas, Maine, New Jersey, Colorado, and Washington state. The webinar is available online: bit.ly/ruralMPAwebinar2023.

Furthermore, a Toolkit for Rural Leaders is being developed to facilitate Rural MPAs in other regions across the US, and will be available on The SCAN Foundation website by November 2024.

Two of the regions have attracted $200,000 each in additional funding to continue implementation efforts through the California Department of Aging's Local Aging and Disability Action Planning grant program.

Here is the link to the Shasta/Butte/Glenn report, which summarizes needs assessment findings and includes 26 primary recommendations and 49 secondary recommendations for local leaders to advocate, educate, coordinate, or implement: https://bit.ly/SBGlocalMPA.

Here is the link to the Inland Empire report, which summarizes needs assessment findings and includes 70 cross-sector recommendations pertaining to housing, transportation, health care access, behavioral health, Alzheimer's and other dementias, caregiver support, and resource awareness: https://bit.ly/IElocalMPA.

At the end of the two-year TSF Rural MPA Initiative, the Central Valley region dove into MPA implementation with oversight from the Kings and Tulare Area Agency on Aging in conjunction with Tulare County Adult Services. The Kings/Tulare MPA includes 5 goals, 14 strategies, and 60 activities: bit.ly/KTlocalMPA

Sources of funding: The SCAN Foundation funded the Rural MPA Initiative.

End

Dementia Live: A training program to increase quality of life and services for people living with dementia and their care partners

AGE-u-cate™ Training Institute
Texas

Caregiver support & resources
Community health workers
Community programming

Purpose: Dementia Live® serves a pivotal role in tackling the challenges encountered by individuals living with dementia and their care partners. With a dedicated emphasis on fostering education and awareness, particularly within rural communities in North Central Texas, this initiative strives to bridge knowledge gaps and enhance understanding. Through integration of the Dementia Live program in harmony with the Texas state plan for Alzheimer's Disease, our goal is to systematically cultivate a nurturing and informed atmosphere in rural areas. This program seeks to propel a collective effort toward a more compassionate and skilled community aligning with the state of Texas plan.

Summary: The Dementia Live program stands as an immersive educational initiative meticulously crafted to deepen participants' insight into the daily realities of living with dementia. Employing simulation and sensory experiences, the program skillfully transports participants into the multifaceted challenges faced by individuals with Alzheimer's disease and various forms of dementia. Its core objectives include fostering empathy, raising awareness, and instilling a commitment to person-centered care, extending its impact to caregivers, health care professionals, and the broader community.

Under the guidance of Director of Aging Doni Green, the North Central Texas Area Agency on Aging has championed the implementation of Dementia Live throughout a 28-county area. This visionary program has been strategically introduced to benefit a spectrum of entities, including area agencies on aging, aging and disability resource centers, home-delivered meal providers, local authorities, and diverse

Continues on next page

community partners. Through a robust collaboration with the Dementia Friendly North Central and East Texas Initiative, Dementia Live has transcended traditional boundaries. It now encompasses partner trainings for police officers, first responders, and health care professionals, amplifying its reach and impact.

A pivotal aspect of Dementia Live's success lies in its commitment to sustainability. The program extends its influence by conducting train-the-trainer sessions, empowering leaders in rural areas to perpetuate dementia training within their local communities. This approach ensures an enduring framework for providing support and care to individuals living with dementia and their care partners.

Provided photo with first responders participating in a training.

Despite the challenge of in-person engagement limitations, the Dementia Live program has demonstrated adaptability. Recognizing obstacles such as scheduling conflicts, transportation limitations, and individual preferences for social connections, the program pivoted to include virtual platforms in addition to in-person sessions. This solution has enabled participants to seamlessly join sessions from remote locations or the comfort of their homes, ensuring accessibility without compromising the program's impact.

Continues on next page

Here are refined examples of program implementation:

1. **Home-delivered meal staff and volunteers**
- Conducted both live and virtual Dementia Live training.
- Adapted the program to incorporate warning signs that staff and volunteers may observe, such as uneaten meals and stacks of unpaid bills.
- Enhanced the training with local resource information for better support.

2. **Local intellectual and disability authority staff**
- Successfully executed virtual training sessions.
- Tailored the training to address the unique ways dementia may manifest among individuals with intellectual and developmental disabilities.
- Provided additional resource information to enhance staff capabilities.

3. **Area agencies on aging (AAAs)**
- Delivered comprehensive training to our staff.
- Conducted webinars for other AAAs, aligning with their requirement for dementia training using evidence-based or evidence-informed programs.

4. **Family caregivers**
- Offered specialized training for Spanish-speaking individuals.
- Adapted the training to include valuable resource information for family caregivers supporting individuals with dementia.

5. **General outreach**
- Conducted training sessions for churches, fostering awareness and understanding.
- In the process of preparing training for retirement communities to meet the specific needs of their residents.

These examples showcase the diverse and targeted approach taken in our program, ensuring that different groups receive customized training with relevant resources.

Continues on next page

Impact and efficacy: During the contract term, NCTCOG has conducted training for 93 home-delivered meal staff members and volunteers relative to its output goal of 100 participants. The purpose of the training is to increase participants' understanding of dementia and awareness of community resources.

Series of provided photos of participants engaging with the Dementia Live training

Preliminary outcome data indicate that the one-hour training program resulted in positive change relative to the following evaluation criteria:

1. **Knowledge**

- A comparison of all participants' pre- to post-test scores shows a 22.8 percent increase in knowledge that dementia is not a part of normal aging.

2. **Attitudes**

- A comparison of pre-test to post-test scores shows a 30.7 percent increase in confidence interacting with a person with dementia (PwD).
- Participants' self-reported confidence to respond to PwD with understanding increased by 16.4 percent.
- Participants' awareness of community resources for PwD increased by 51.8 percent.

Continues on next page

Evaluation data were not uniformly positive. There was a minor decline in knowledge that "PwD may express themselves or communicate through actions instead of words," with a change of -3 percent (from pre-test 95.7 percent to post-test 92.7 percent). There was also a decline in understanding that "PwD need to be respected just like anyone else," with a change of -1.9 percent in positive attitudes (from pre-test 94.6 percent to post-test 92.7 percent). Evaluators noted that the curriculum did not emphasize attitudinal changes, and NCTCOG will amend and strengthen the curriculum accordingly. In addition, negative changes may reflect participants' beliefs that they need to treat PwD with special attention as opposed to "like anyone else," and/or participants may have had negative experiences interacting with PwD. Evaluators suggested changing the statement to "I know how to make people with dementia feel respected" or "I can respond to PWD with respect" for future program evaluations.

Sources of funding: Alzheimer's Disease Programs Initiatives Grant.

End

Program of All-Inclusive Care for the Elderly (PACE)

National PACE Association
Kansas

Care coordination
Caregiver support & resources
Digital health
Mental & behavioral health
State-level priorities
4Ms

Purpose: Midland Care Program of All-Inclusive Care for the Elderly (PACE) is an innovative, fully integrated care model serving older adults with complex health care needs across 15 Kansas counties, both urban and rural, and growing. Our provider-led care model helps enrollees maintain their independence and safety in their homes and communities for as long as possible, avoiding nursing home care. PACE addresses the medical, behavioral, and social needs of enrollees, with the goal of improving the quality of life for older adults and ensuring that they remain a vital part of our community.

Summary: For over four decades, Midland Care has been a pioneer and leader in responding to the most challenging health care needs in our community. In 2007, Midland Care became the nation's 37th PACE program, a national program that provides community-based care and services to people who would otherwise need a nursing home level of care. Midland Care PACE served 27 participants in its first year and has grown substantially each year. Today, Midland Care PACE serves more than 575 Kansans daily across 15 urban and rural counties and is one of 150 PACE programs serving more than 70,000 enrollees (referred to as participants) across the United States.

The backbone of Midland Care PACE is our comprehensive interdisciplinary team (IDT) comprised of 11 different disciplines, including primary care providers, nurses, physical therapists, occupational therapists, recreation therapists, social workers, dietitians, personal care aides, and drivers. The IDT assesses each participant and their living environment to identify needs and determine solutions. As a result, an individualized care plan is

Continues on next page

developed to respond to all of the participant's needs – 24 hours a day, seven days a week, 365 days a year. In addition to covering all Medicare Parts A, B, and D benefits and all mandatory Medicaid-covered benefits, PACE benefits include vision, dental, hearing, behavioral health, and long-term care services and supports, along with any other services or supports that are medically necessary to maintain or improve the health status and well-being of participants.

PACE organizations like Midland Care PACE are particularly adept at serving populations facing significant challenges in accessing care and services, such as people living in rural and medically underserved locales. Utilizing a "hub and spoke" approach, Midland Care PACE connects our rural PACE sites operationally to a non-rural (or urban) PACE component within driving distance. This approach helps us spread our indirect costs over multiple programs and provide greater sustainability for our smaller programs in rural areas, especially during periods of low enrollment. In fact, in our experience, rural markets have a higher market penetration rate that can help offset the lack of people eligible for PACE. In Lyon County, Kan., there are 144 people eligible to receive PACE services (NPA feasibility study, 2021). Currently, 66 of those 144 are served through the PACE program at Midland Care's Emporia Center. This is a market penetration rate of 45 percent. Midland attributes the success to a lack of other alternatives or community-based options in Lyon County.

While PACE has grown steadily in Kansas due to a variety of policy factors including a favorable state environment, it has not been without challenges. Barriers to accessing PACE in rural Kansas and across the country include population density, provider shortages, and transportation challenges including longer travel distances to the PACE center. Midland Care PACE has deployed community partnerships and pooled resources to help mitigate some of these issues. In Midland's rural service areas, partnerships with senior housing, police and fire

Continues on next page

departments, senior centers, and aging and disability resource centers have proven successful in identifying and bringing PACE services to individuals in those areas.

Photo of the Midland Care PACE Center in Emporia, Kansas. Courtesy of Midland Care Connection, Inc.

In 2023, the Department of Health and Human Services' National Advisory Committee on Rural Health and Human Services selected PACE as one of two chief focus areas. To further their understanding, the committee participated in site visits to Midland Care Connection Inc.'s headquarters in Topeka, as well as our rural PACE site in Emporia. The committee's work culminated in a comprehensive policy brief containing eight concrete recommendations to the HHS secretary to better utilize PACE in rural America. The recommendations focus on opportunities to expand access to PACE, including administrative reforms at the federal level, delivery and workforce considerations, and opportunities to expand telehealth coverage. Addressing these challenges is critical to promoting access to PACE in rural communities that have become increasingly diverse, tend to have older and lower-income populations, and typically offer fewer home and community-based options than urban communities.

Continues on next page

Impact and efficacy: Research indicates that the PACE model is associated with improved health outcomes, including fewer hospitalizations and emergency room visits, fewer unmet needs, and better caregiver support. Recently, HHS' assistant secretary for planning and evaluation assessed capitated Medicare enrollment options for dual-eligible individuals for their effectiveness. The assessment concluded that "[t]he PACE program, known for its focus on home and community-based service (HCBS) provision and full integration of a range of medical services and long-term services and support, stands out from our analysis as a consistently 'high performer.' We found that full-benefit dual-eligible beneficiaries in PACE are significantly less likely to be hospitalized, to visit the ED, or be institutionalized, while their mortality risk is not significantly higher compared to regular MA enrollees." The rate at which PACE participants experienced potentially preventable hospitalizations was also substantially lower than the comparison populations: 44 percent lower than the rate for dual-eligible Medicaid nursing home residents and 60 percent lower than dual-eligible HCBS waiver enrollees. In fact, numerous studies across more than 20 years of research demonstrate the association between PACE enrollment and reduced hospitalization.

In addition to medical care and outcomes, PACE improves the quality of life for its participants and their caregivers. PACE participants report fewer unmet needs and higher satisfaction with their quality of life. Family caregivers report high levels of support associated with a reduction in the level of burden they experience. This in turn increases their ability to care for their own health and that of younger family members. Caregivers of PACE participants often report being able to resume employment because of the care provided by PACE to their loved one.

Additional evidence suggests that PACE organizations promote health equity within the communities they serve. PACE addresses several

Continues on next page

social determinants of health (SDOH) as part of the care model, such as transportation, food security, social integration, support systems, and access to high-quality, linguistically and culturally appropriate health care services. PACE organizations commonly leverage partnerships with other community-based organizations to ensure that SDOH above and beyond those offered through the care model such as housing are addressed. In this work, partners include area agencies on aging, centers for independent living, Meals on Wheels, supportive housing organizations, and other community-based organizations.

The results PACE achieves for participants and families are supported by its capitated payment model, which incorporates the features of value-based rather than volume-based payment. Fully at risk for all costs of care under the capitated payments it receives, PACE's financial incentives align the goals of improving health and independence with reducing costs of care. PACE organizations help individuals maintain the highest possible level of health and independence by emphasizing preventive and primary care, long-term services and support, and comprehensive care coordination. This emphasis has the twin virtues of improving quality of life and reducing the use of high-cost acute care and institutional care settings.

Sources of funding: As a permanent Medicare program and a Medicaid state plan option, PACE organizations like Midland Care PACE receive fixed, prospective Medicare and/or Medicaid capitation payments per month for each enrolled PACE beneficiary. In limited instances, PACE services are funded by private premiums (i.e., for individuals without Medicaid or Medicare).

Connected Care for Older Adults

Clinical Advisory Panel of the Columbia Gorge Health Council
Oregon

Community health workers
4Ms

Purpose: Connected Care for Older Adults is an innovative program that uses community health workers (CHWs) to address quadruple-aim goals for frail older adults in rural areas. In this model, CHWs conduct home visits and implement protocols related to the 4Ms. They provide health education, connect patients with existing community services, and relay important information back to the primary care provider. The model seeks to improve the quality of care delivered to older adult patients, improve the patient, caregiver, and provider experience with care, decrease the need for higher levels of care, and decrease high-cost utilization among participating patients.

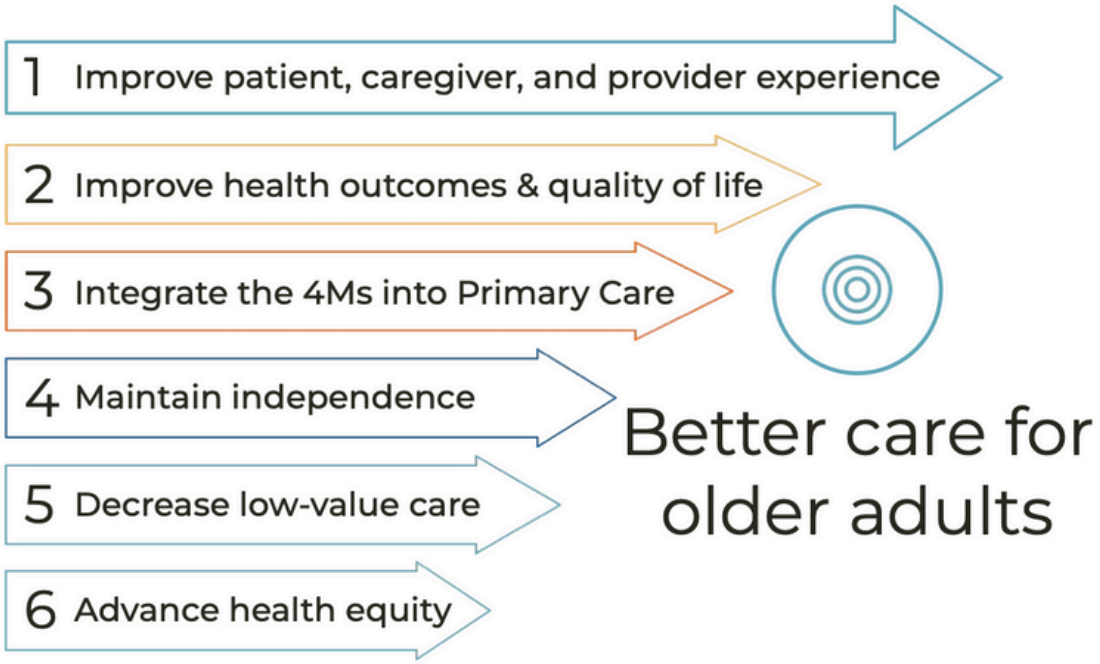
Photo of a person and a caregiver in a field with the sun setting.

Summary: Connected Care for Older Adults is an innovative program that uses CHWs working in partnership with primary care clinicians to improve care for frail older adults in rural areas. Through Connected Care, specially trained CHWs conduct a series of home visits with patients and families. They implement the Connected Care protocols based on age-friendly health systems (what matters, medication, mobility, and mentation).

Continues on next page

Connected Care serves patients 55 and older who live independently (without home health or hospice support) in rural communities and are considered “medically frail” by a primary care provider (PCP). Frailty is determined by PCPs based on the Edmonton Frail Scale. Priority is given to patients 85+ and those coming home from a hospital or skilled nursing facility stay. The pilot seeks to emphasize enrollment for non-English speaking patients, Indigenous patients, patients enrolled in both Medicare and Medicaid, and uninsured patients. Demographic enrollment of patients should be representative of regional demographics.

What are the goals of Connected Care?

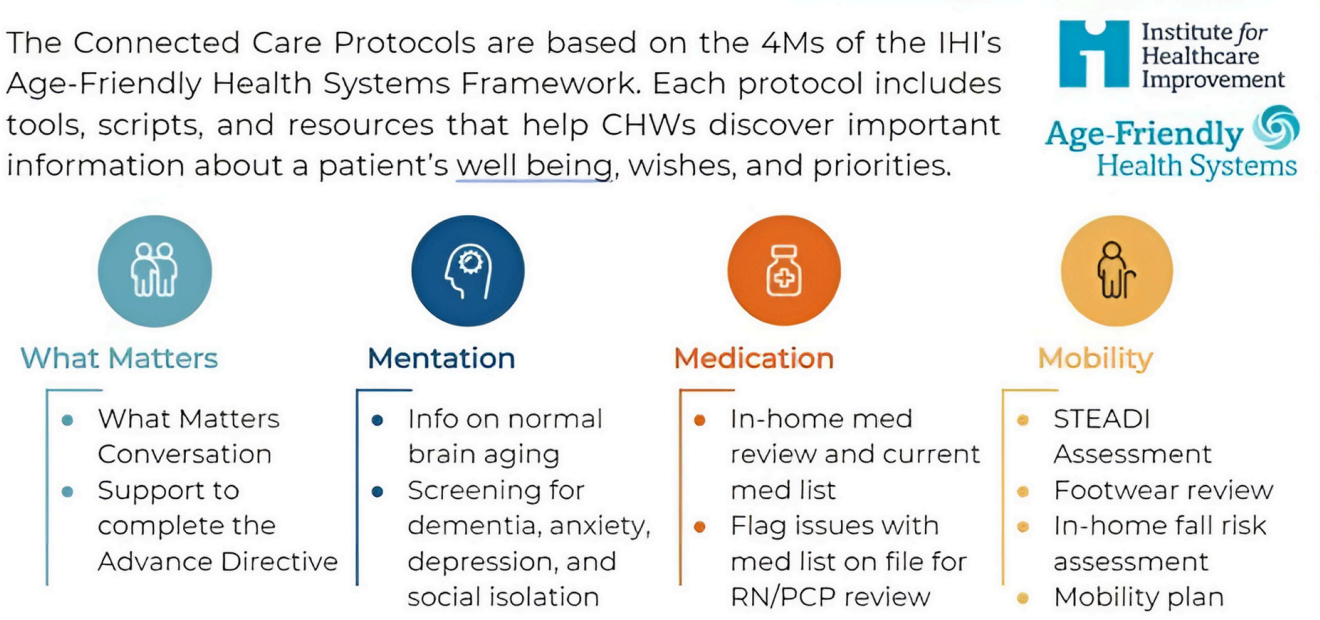


Connected Care was developed by an interdisciplinary team of physicians, community health workers, mental health liaisons, advocates, and program administrators to address a lack of support for frail older adults who were living independently in rural Oregon. With support from the regional Health Council’s Clinical Advisory Panel, the team identified an opportunity to apply the Institute for Healthcare

Continues on next page

Improvement's age-friendly framework to a CHW role and scope of practice. The team worked collaboratively to create five Connected Care protocols for CHWs based on the 4Ms. The protocols include a what matters conversation, completion of the advance directive, reviewing medications in the home for safety and accuracy, prescreening for mood disorders and cognitive decline, and completion of the STEADI assessment for fall prevention and the CDC's home safety checklist. Each protocol includes background context and tips for the CHW, the protocol, and a collection of vetted resources to share with patients and families. As CHWs complete each protocol, they provide information and education to patients and families, connect them with existing community services, and relay important information about a patient's well-being and priorities back to the PCP.

The Connected Care Protocols



CHWs have been described as agents of change in reducing health disparities in underserved communities. They typically reside in the communities they serve and reach residents where they live, eat, play, work, and worship. They are uniquely positioned to help

Continues on next page

increase access, provide better care, improve quality of life, decrease low-value care, and advance health equity in rural areas.

Providers benefit by having CHWs serve as a primary care "extender" to support older adult patients who might otherwise fall through the cracks and end up in the hospital. By going into patients' homes, CHWs can better assess a patient's stability and identify needs related to social determinants of health. They can take the time to learn about patients and their priorities and communicate this critical information back to the PCP so what matters can be integrated into a patient's care plan.

Connected Care for Older Adults first launched at One Community Health, a federally qualified health center in Hood River, Ore., in October 2022. It expanded to include the Asher Community Health Center in Fossil, Ore., in 2023. Patient, provider, and administrator feedback from early pilots was utilized to update the Connected Care protocols and processes related to pilot implementation and evaluation. Beginning in 2024, the program will expand to include five additional primary care clinics with the capacity to serve approximately 300 patients per year.

Impact and efficacy: Early evaluation shows broad satisfaction amongst clinicians, patients, and CHWs. The goal is to expand the pilot project in 2024-2026 to more diverse rural settings and evaluate the model for ease of use, effectiveness, efficiency, and cost savings as well as patient and clinician satisfaction.

As of January 2024, a total of 74 patients had been referred to the program by 20 primary care providers at two clinics. Thirty-four percent of enrolling

Continues on next page

patients were dually eligible (Medicare/Medicaid). Thirty-five percent had been hospitalized in the past 12 months, and 41 percent had visited the ED. Only 24 percent of patients had an identified caregiver, and 3 percent had completed an advance directive. Forty-two patients (57 percent) of those enrolled had graduated from the program as of January 2024. Sixty percent of those graduated because all relevant protocols were completed. Forty percent of graduating patients completed an advance directive during the program, 55 percent completed the STEADI assessment, and 50 percent had their medications reviewed for safety and accuracy. Ninety-four percent of patients said the program made a positive difference in their life, and 100 percent said they were “very satisfied” with Connected Care.

“[This program] keeps us aware that **there are those who care how we are doing**... [The CHW] has made a **tremendous difference in our day to day lives**.”

“It **brought us into their home** in a way that wasn’t threatening or invasive, but **just helpful**.”

One patient said, “[This program] keeps us aware that there are those who care how we are doing. The helpfulness to meet any need we might need help with. She has gone out of her way to even helping me get to appointments. [The CHW] has made a tremendous difference in our day-to-day lives." Another patient shared, “Being able to have someone come to your home and see your home setup is very helpful. Having that as an option is excellent.”

Continues on next page

One referring clinician said, “Our Connected Care CHW has helped navigate support systems for a caregiver in order for the caregiver to continue to care for the patient. That was a really profound improvement and impact on the patient's health, and I believe [the program] is preventing readmission to the hospital.”

A Connected Care CHW shared, “I’ve really had an evolution in my own thinking as a result of this project...The four areas that this program focuses on really hits on key areas for our older patients. In a rural area, this is even more important. In an urban area, you’ve got neighbors, more people looking out for you. Out here, our people are so isolated, they can degrade and go downhill really quickly. It brought us into their home in a way that wasn’t threatening or invasive, but just helpful. Those observations that we saw in the home were able to help the provider to focus on areas that were needed.”

Sources of funding: The pilot has been supported by the clinical advisory panel of the Columbia Gorge Health Council beginning with a feasibility study in 2018. Additional funding has been provided by the Oregon Community Foundation, the Oregon Health Quality Alliance, PacificSource, the Oregon Health Authority, Greater Oregon Behavioral Health, Inc., and the OHSU Foundation. Other partners include the Next Door, Inc., and Kristin Bodiford, PhD. With support from the Center for Disease Control, the Connected Care program is currently working with an evaluation consultant in partnership with the National Alliance of City and County Health Officials to further refine and scale its evaluation efforts. The output of this partnership will be a formative evaluation by June 2024.

End of submission

Healthy Aging Initiatives & Best Practices

Central Michigan University College of Medicine
Michigan

Care coordination
4Ms

Purpose: The CMU College of Medicine provides Healthy Aging initiatives with the goals to improve care access for older adults and enhance interprofessional education across health programs by engaging multi-disciplinary teams of medical students and health professional students in supporting older adults' access to health care in our mid-Michigan region. The Healthy Aging programs include Project INCLUDE, a care model for screening and alleviating loneliness and isolation for low-income older adults; the Interprofessional Home Visit and Health Improvement Program, which provides in-home health visits with student teams; and Rural Older Adult Mobile (ROAM) Care, which provides transportation and access to health care.

Summary: Central Michigan University (CMU) College of Medicine provides grant-funded Healthy Aging initiatives through various programs and projects. Under the leadership, innovation, and compassionate support of Dr. Jyotsna Pandey, these grants and programs are supporting health care education and improving access to care for older adults in our region. CMU involves health care students, community members, and health care providers in collaborations to improve the health of our seniors. Project INCLUDE is a collaborative care model for screening and alleviating loneliness and isolation for older adults in low-income assisted living facilities and older adults in Mid-Michigan counties, in collaboration with Presbyterian Villages of Michigan. Project INCLUDE works on the principle of improving social connections to reduce loneliness and isolation. This comprehensive social integration measure provides remedial support to older adults identified as experiencing or who self-report loneliness or isolation.

Continues on next page

Project INCLUDE includes mechanisms to detect lack of social connectedness and identify loneliness and isolation, as well as additional individualized screenings for perceived causes of loneliness. We develop individualized care plans with peer and external support to increase social connectivity, such as older adult peer support groups, socialization, education, and empowerment to create social connections with the help of trained professionals and students in social work, medical, and recreation therapy fields. We develop and strengthen local networking with systems of care to help prevent mental health and other issues linked to loneliness and isolation.

Provided photo of CMU medical student takes relevant medical history from Mid-Michigan patient during a Healthy Aging home visit. Photo Credit: Program Coordinator.

In collaboration with the Isabella County Commission on Aging (CoA), the CMU Healthy Aging program provides an experiential learning Home Visit and Health Improvement Program. CMU student teams conduct 100+ older adult home-based health assessments per year in our communities. Students provide follow-up support for health improvement interventions coordinated by CoA staff. The assessments and follow-up offer supportive actions for issues identified,

Continues on next page

such as fall risk, alcohol use, loneliness and isolation, hearing and vision screenings for isolation, and a basic oral exam.

The Home Visit and Health Improvement Program is an innovative and cost-effective approach to providing preventative health care services and improving health outcomes. Evidence suggests preventative health care (as provided by CMU) and sustained support by a community partner (CoA) improves health and reduces morbidity and mortality rates. This approach includes health professions students who assess older adults' health needs and expand and strengthen the workforce, possibly increasing the likelihood of students specializing in geriatrics. One impact will be more professionals trained and experienced in working with older adults, leading to improved health outcomes.

Provided photo of CMU medical student team take patient's vitals during Healthy Aging home visit. Photo Credit: Program Coordinator

ROAM Care addresses both of the Michigan Health Endowment Fund's cross-cutting goals by 1) strengthening and building workforce capacity and exposing CMED students to older adult populations and providing them with training in older adult assessment skills not typically received in traditional educational settings; and 2) providing an innovative, cost-effective health care integration model of home-based primary and preventative health care leveraging community resources to increase access for rural older adult populations to improve health outcomes and reduce emergency hospitalizations.

Continues on next page

The CMU Healthy Aging Initiative works in collaboration with the Clare County Senior Services/Council on Aging and provides home-based primary care to vulnerable older adults. The home visit team (nurse practitioner, social worker, supervising physician, and medical student trainees) develop integrated health care plans and coordinate the provision of services. A care coordinator is assigned to ensure that the mobile health clinic reaches patients at regular intervals or as required (annually for health checkups; periodically to follow up for those with chronic diseases, such as diabetes or hypertension; and as needed for those with acute conditions requiring near-term follow-up). The home visit teams provide primary health care assessments for older adults in rural Clare County and follow up on identified needs. Each year, 100 participants 60 years or older are enrolled for ROAM Care, providing a comprehensive assessment of health status and developing an individualized care plan to optimize well-being.

Impact and efficacy: Best practices can be observed in a few ways within the Health Aging Initiative, especially through the values of accessibility and comprehensive care. Participant data from 2017-2022 shows that Healthy Aging has served 335 distinct patients. These patients come from across the state of Michigan and represent at least 28 different cities, towns, or villages.

The programs offered by the Healthy Aging Initiative seek to provide a multifaceted approach to increasing overall well-being for older adults. Home visits provide individual fall risk screenings for patients. If risk factors are identified, recommendations can be made especially regarding home environment to reduce the risk of falls. Also, Living FREE receives referrals to perform at-home fall risk screenings on individuals who have been brought to the emergency room or had EMS called due to a fall. If lack of exercise is identified as an issue,

Continues on next page

they can be referred to the Otago Exercise Program, which provides exercise classes tailored for fall reduction in older adults. By providing these classes both in person at community locations and online, Otago ensures that the highest number of individuals can access it. Finally, Project INCLUDE attempts to identify loneliness and isolation and reduce them by coordinating social events, enlisting community leaders, and hosting educational opportunities and specific mental health interventions.

Provided photo of CMU Interprofessional student team talks with patient during Healthy Aging home visit, patient lives in a rural area of Mid Michigan. Photo Credit: Program Coordinator

The Health Aging Initiative represents a comprehensive approach to promoting well-being in older adults. It provides a clear pathway to not only identify individuals at risk for falls but also implement accessible programs to reduce their risk. To tackle loneliness, the initiative considers all environmental, social, and psychological interventions.

Sources of Funding: This program was funded by the Michigan Health Endowment Fund and Central Michigan University College of Medicine.

End of submission

Supporting older adults to age in place through a unique service exchange and time banking model

Partners in Care Maryland, Inc.
Maryland

Care coordination

Purpose: The purpose of Partners In Care Maryland, Inc.'s (PIC) Service Exchange and Time Banking model is to provide essential services to underserved older adults aged 60+ to empower them to age in place with dignity and respect.

Through our unique "neighbors helping neighbors" system, PIC members provide one another with transportation, home maintenance and repairs, personal support, and advocacy, as well as social opportunities that alleviate isolation and loneliness – a particular problem in rural areas.

We serve six Maryland counties, four that are recognized as rural, and are positioning PIC for expansion throughout the state and ultimately nationwide.

Provided photo Partners In Care's special event honoring our Veterans Helping Veterans members. Photo credit Derek Milley

Summary: PIC has been proudly serving older adults since our founding in 1993. We have grown from 26 members to more than 2,500, and the programs and services we provide through service exchange and time banking have expanded to include:

Continues on next page

1. **Ride partners**: PIC members use their own vehicles to provide no-cost, arm-in-arm transportation for older adults to non-emergency medical appointments, pharmacies, grocery stores, hair salons, errands, and other socialization services.
2. **Member care**: This program delivers individual support and social engagement opportunities for PIC's members, as well as advocacy on their behalf. PIC's member care team provides assistance with navigating county and state agencies, offering resource referrals, and completing forms and applications. Activities and gatherings are offered to address social isolation, build community, provide education and training, and help older adults form strong social networks that are easily accessible. Additional services include friendly visits and phone calls, picking up prescriptions, and light grocery shopping.
3. **Repairs with care**: PIC volunteers help members maintain their homes for safe and independent living. Services include light carpentry, painting, repairing leaky faucets and toilets, replacing light bulbs, and addressing safety issues by installing handrails, repairing stairs, and installing bathroom safety equipment.
4. **Boutiques**: At our “upscale resale” stores, we resell donated clothing, jewelry, accessories, books, kitchen/household items, vintage and antique items, furniture, and more, generating revenue for our programs and creating opportunities for members to volunteer and connect with their peers.
5. **Special programs**: PIC continues to evolve and expand its programs to best serve our members. For example, we are working to increase interest in our already successful Veterans Helping Veterans program, which honors and connects veterans to each other and the PIC network. Recognizing a specialized need at our Mid Shore site serving rural Caroline and Talbot counties, we created a program in partnership with Blind Industries and Services of Maryland for members with low vision. This group meets monthly to ensure that this population can get

Continues on next page

the best medical and emotional information. And, most recently, we launched an in-person and virtual series of seminars aimed at teaching our communities about online safety and security.

Over the course of our 30+ years, PIC has encountered various challenges, the most recent being the COVID-19 pandemic. Despite the pandemic's many hurdles, our dedicated staff and supportive community of members played a crucial role in maintaining a close connection throughout the shutdown. Thanks to their commitment, we were able to provide services safely and adapt to the circumstances.

Photo on the left shows Partners In Care's Repairs with Care program's home maintenance and repairs. Photo on the right shows Partners In Care's Ride Partners program provides arm-in-arm, door-through-door transportation to appointments. Photo credit: Derek Milley

Collaborating closely with local and state partners as well as our supporters, we worked diligently to safeguard and serve our members. Additionally, to address the challenges of isolation, we implemented innovative solutions such as securing grants for free tablets and training to enhance connectivity.

The response to the pandemic highlighted the strength of PIC's network, which is built on the foundation of neighbors helping neighbors. It underscored the resilience of our organization and the compassionate nature of our members.

Continues on next page

Impact and efficacy: Partners in Care assesses the effectiveness of our programs and services in several ways:

1. **The annual increase in our membership and their activities**. We have seen a steady increase in membership and services provided year after year, with the exception of 2020 and 2021, which were affected by the pandemic. We have since rebounded and surpassed pre-COVID numbers, highlighting the strength and resilience of our culture and the older adults who make it possible.
2. **We strive for a 90-95 percent fulfillment rate of services requested**. We consistently achieve -- and surpass -- this goal monthly and annually.
3. **Meeting the criteria to earn the Maryland Society of Nonprofits' Seal of Excellence**, which involves a rigorous, systematic evaluation process. PIC has earned this distinction since 2014.
4. **Increase in funding and other forms of support from government, nonprofit, and private organizations**. We have steadily increased our funding through the years and during the past three years have received notable – and diverse – new funding sources, including the Rural Maryland Council, Next50, and the Maryland Department of Housing and Community Development.
5. **Positive qualitative member feedback received consistently in person, over the phone, and through written communications**. We are relaunching our annual member survey in 2024 to collect up-to-date quantitative data about our members' experiences and satisfaction.
6. **Outside recognition and awards**:

- Received the 2023 Maryland Governor’s Community Service Award for Volunteer Programs.
- Named the nonprofit of the year by the Great Nonprofits organization based on input directly from the communities we serve.
- Received the National Family Caregiving Award and recognized by

Continues on next page

the National Council on Aging as a nationally replicable model.

- Awarded the Transportation Association of Maryland, Inc.'s Outstanding Nonprofit Agency Award and its Human Services and Partnership System Award.
- Featured on the National Center on Senior Transportation's website as a program success story.
- Spotlighted in AARP Magazine and the national AARP bulletin as a solution for older adults seeking to stretch limited resources.
- Received Home Instead Senior Care's Presidential Service Award.
- Recognized with the Program Achievement Award from the Maryland Gerontological Association.
- Received the prestigious National STAR Award for transportation excellence from the Beverly Foundation.
- Recognized in 2019 for innovativeness and sustainability by the National Opinion Research Center/University of Chicago study for the Federal Centers for Disease Control, Department of Health and Human Services. This was a national environmental scan of model programs for transportation programs serving older adults. PIC was recognized as only one of only four nonprofit transportation programs targeted at older adults.

Sources of Funding: This program was funded by Anne Arundel Country Maryland, Ausherman Family Foundation, Caroline Foundation, City of Annapolis, Delaplaine Foundation, Inc., Maryland Department of Housing and Community Development, The David and Barbara B. Hirschhorn Foundation, The Jones Foundation, Mid Shore Community Foundation – Albert and Diane Miller Fund, Maryland Transit Administration, Rural Maryland Council, and United Way of Frederick County.

Age-Friendly Health Systems Compendium of Resources

Institute for Healthcare Improvement (IHI)

National

4Ms

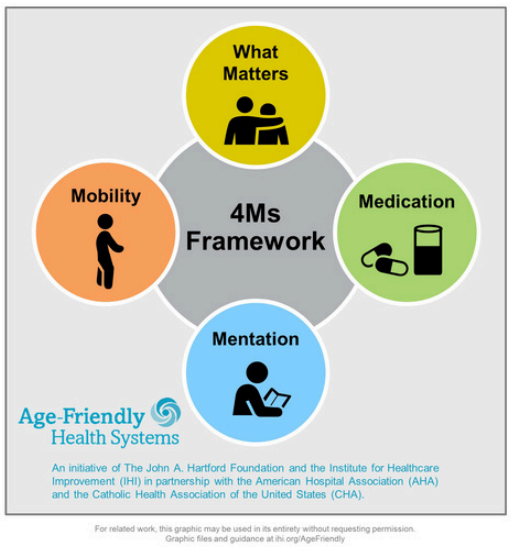
Purpose: Becoming an age-friendly health system entails reliably providing a set of evidence-based, geriatric best practice interventions across four core elements known as the 4Ms to all older adults in your system. The 4Ms are the essential elements of high-quality care for older adults and, when implemented together, represent a broad shift by health systems to focus on the needs of older adults. The 4Ms include what matters, medication, mentation, and mobility.

Summary: The United States is aging. The number of adults aged 65 years and older is growing rapidly. As we age, care often becomes more complex. Health systems are frequently unprepared for this complexity, and older adults suffer a disproportionate amount of harm while in the care of the health system.

Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States. Age-friendly health systems aim to follow an essential set of evidence-based practices, cause no harm, and align with what matters to the older adult and their family caregivers.

Continues on next page

Becoming an age-friendly health system entails reliably providing a set of evidence-based, geriatric best practice interventions across four core elements known as the 4Ms to all older adults in your system. The 4Ms are the essential elements of high-quality care for older adults and, when implemented together, represent a broad shift by health systems to focus on the needs of older adults. The 4Ms include what matters, medication, mentation, and mobility.



Provided diagram presenting the 4Ms Framework.

IHI currently recognizes hospitals, ambulatory practices, convenient care clinics, and nursing homes as age-friendly health systems. The John A. Hartford Foundation, IHI, and partners set an audacious goal to drive this social movement: reach 2,200 hospitals, ambulatory practices, convenient care clinics, and nursing homes that will be recognized as age-friendly health systems committed to care excellence, and 4,500 hospitals, ambulatory practices, convenient care clinics, and nursing homes total (including 700 hospitals) will be recognized as age-friendly health systems participants by June 30, 2026. As of February 2024, the Age-Friendly Health Systems initiative has impacted more than 3.75 million older adults with 4Ms care in more than 10 countries globally.

Continues on next page

There is no fee to health systems to participate in the initiative. Health systems can engage in a variety of methods through action communities run by IHI and AHA or through a do-it-yourself pathway. Numerous resources are available to help your team and organization practice age-friendly care and guide your journey toward becoming an age-friendly health system. IHI Insights, in addition to selected news and journal articles, will help you learn more about age-friendly health systems, including:

- Guides to using the 4Ms in the care of older adults in hospitals and ambulatory practices and to care of older adults in nursing homes
- Guide to recognition for geriatric emergency department accredited sites
- Guide to recognition for geriatric surgery verification hospitals
- Guide to using the 4Ms in the care of older adults in the convenient care clinic
- Age-Friendly Health Systems EHR implementation guides
- Age-Friendly Health Systems measures guide
- Spreading age-friendly care from one care location to reach older adults across your health system
- The business case for becoming an age-friendly health system
- "What matters" to older adults? Toolkit and conversation guide
- Focusing on equity at every step

All of these resources and more can be found at www.ihi.org/agefriendly

All these resources and more can be found online.

Continues on next page

Impact and efficacy: More than 300 journal and news articles have been written about this movement. Becoming an age-friendly health system entails reliably utilizing the 4Ms to focus on the needs of older adults. The 4Ms are a framework, not a program, to guide all care of older adults wherever and whenever they come into contact with your health system's care and services. The intention is to incorporate the 4Ms into existing care rather than layering them on top to organize the efficient delivery of effective care. This integration is achieved primarily through redeploying existing health system resources. Many health systems have found they already provide care aligned with one or more of the 4Ms for many of their older adult patients. Much of the effort then involves incorporating the other elements and organizing care so that all 4Ms guide every encounter with an older adult and their family or other caregivers.

Search and explore published Age-Friendly Health Systems journal articles

End of submission

Acknowledgments & Additional Information

This section includes further information such as websites and contact information for the submissions listed within this compendium.

Delano Regional Post-Acute Network

NORTH KERN SOUTH TULARE HOSPITAL DISTRICT
Josh Luke, CEO: josh_luke@nksthd.org

Rural Multisector Plan for Aging Initiative

UNIVERSITY OF CALIFORNIA, DAVIS
Pauline Martinez, Research & Community Engagement Manager: pdmartinez@ucdavis.edu

Dementia Live: A Training Program to Increase Quality of Life and Services for People Living with Dementia and their Care Partners

AGE-U-CATE™ TRAINING INSTITUTE
Doni Green: DGreen@nctcog.org

Program of All-Inclusive Care for the Elderly (PACE)

NATIONAL PACE ASSOCIATION
Shawn Sullivan, President and CEO, Midland Care Connection, Inc.: Ssullivan@midlandcc.org

Connected Care for Older Adults

CLINICAL ADVISORY PANEL OF THE COLUMBIA GORGE HEALTH COUNCIL
Jenny Anglin: jenny@gorgehealthcouncil.org

Healthy Aging Initiatives and Best Practices

CENTRAL MICHIGAN UNIVERSITY COLLEGE OF MEDICINE
Jyotsna Pandey, MD PhD: pande1j@cmich.edu

Supporting Older Adults to Age in Place Through a Unique Service Exchange and Time Banking Model

PARTNERS IN CARE MARYLAND, INC.
Mandy Arnold, CEO and President: grants@partnersincare.org

Acknowledgments & Additional Information