# Texas Aging and Disability Resource Centers State Advisory Committee Meeting Minutes

***Monday, January 27, 2014 - 1:30 pm - 3:30 pm***

*In Attendance: Ryan Ward, Evelyn Greenfield-Johnson, Sue Fielder, Elisa J. Garza, Norma Almanza, Susanne Elrod, Yvette Lugo, Martha Diase, Kaires Bonales, Lee Brown, Millie DeAndes, Joseph Gonzalez, Donnie Green, Anita Guy, Brandi Ivey, Robyn Johnston Alex Koons, Alison Little, George Losoya, Richard McGhee, Viola Monrreal, Deborah Moore, Beth Noah, Michelle Parker, Andree Ramirez, Janice Sparks, Martha Spinks, Alesha Willis, Mary Klentzman, Toni Packard, William A. Fuller, Patricia Bordie, Betty Ford, Paula Leatherwood, Adriana Salazar, Leigh Schroeder, Wes Yeager*

**Welcome**

- Staff welcomed all in attendance and distributed handouts for review.

**DADS Unit Staff Changes**

- Access and Intake Staff discussed the changes to the DADS Access and Intake organizational structure:
    - The Community Access and Grants Unit, Community Access and Guardianship Unit, and Community Services Unit have been combined under the Strategic Operations and Grants Unit under the leadership of Wes Yeager.

**ADRC Expansion**

- The Department of Aging and Disability Services in Coordination with Health and Human Services Commission Procurement and Contracting Division anticipate posting the tentative award announcements for the ADRC Request for Proposals (RFP) soon.
- Staff reviewed the handout regarding the expansion of the existing ADRCs. Some of the current ADRCs will be serving additional counties. Handouts attached.
- New standalone contracts will be issued in March to all existing ADRCs and will include the expansion counties.

**Balancing Incentive Program (BIP)**

- Staff provided an update on the progress of the Balancing and Incentive Program.
- DADS staff held the first Access & Intake stakeholder meeting for the Long Term Services and Support (LTSS) screen on January 27 at 9:00am DADS Access & Intake "front door" partners were provided an overview of the screening questions and referral processes.
- Staff announced that there will be a broader external stakeholder meeting on Friday January 31st, 2014 at the Brown Heatley public hearing room. Staff will send a follow-up email with the time and call-in information.
- Staff announced that the estimated roll out date for the LTSS Screen is tied to Information Technology (IT), feedback from users, and other factors.

**Follow-Up from Last Meeting (State and Local Partners)**

- Advisory committee reiterated that after each quarter ADRCs are to share one success and one challenge.
- Staff discussed that Housing Navigator is funded through Money Follows the Person Grant.
    - Five ADRCs have been involved in coordinating with systems (Housing navigator, Public Housing Associations, and other housing services).
- HCBS Strategies , the Technical Assistance contractor for the Balancing Incentive Program conducted a site visit from January 21-23. DADS ADRC program staff worked with the contractor on the draft processes and protocols for person-centered options planning and system navigation as related to the standardized "NO Wrong Door" system. Staff discussed that final approval for general ADRC BIP funding formulas is pending.Thehe formula is based on the population over the age of 60, size of the minority population, and size of the population in poverty, number of Medicaid recipients.
- Assistant Commissioner Garza commented that many of the success stories the ADCS share might be appropriate for the DADS Facebook page.
    - **https://www.facebook.com/TexasDepartmentOfAgingAndDisabilityServices**
    - The Department of Aging and Disability Services through DADS Facebook is interested in promoting the great work ADRCs engage in every day. Please e-mail Leigh Schroeder at Leigh.Schroeder@dads.state.tx.us with any ADRC success stories. "Like" and "Share" the DADS Facebook page today so you can make use of this valuable communications tool.

**Project Highlights (Local ADRCs)**

- Presentation on the Community Research Center Progress Report from Richard McGhee, Director at the Central Texas ADRC.
- Local ADRCs shared successes and challenges from the past quarter including:
    - Alamo Service Connection
    - Brazos Valley ADRC
    - Care Connection ADRC
    - Central Texas ADRC
    - Coastal Bend ADRC
    - Concho Valley ADRC
    - Connect to Care ADRC
    - East Texas ADRC
    - El Paso and Far West Texas ADTRC
    - Lower Rio Grande (Rio Net) ADRC
    - Lubbock County ADRC
    - North Central Texas ADRC
    - Tarrant County ADRC
    - West Central Texas ADRC

**Action Items:**

- ADRCs are requested to share one success and one challenge in the next quarterly State Advisory Council Meeting.
- Allison Little from HHSC announced that there is an ADRC Coalition meeting scheduled for tomorrow, but informed attendees to watch for weather issues.
- The ADRC committee currently has a member slot open for a Hospital Discharge Planner. Hospital discharge planners are a key "critical pathway" and the council could benefit from the input and expertise of a skilled discharge planner representative on our council. Please e-mail Leigh Schroeder at Leigh.Schroeder@dads.state.tx.us, if you are interested in learning more about this opportunity or know someone who may be interested.
- The next State Advisory Committee Meeting is scheduled for:

  Monday, April 21st, 2014 from 1:30 p.m. to 3:30 p.m.

# Revised ADRC Service Areas

| Alamo Service Connection (13 Counties) | | | | | | |
|---|---|---|---|---|---|---|
| Atascosa | Bandera | Bexar | Comal | Frio | Gillespie | Guadalupe |
| Karnes | Kendall | Kerr | McMullen | Medina | Wilson | |
| **Brazos Valley ADRC (7 Counties)** | | | | | | |
| Brazos | Burleson | Grimes | Leon | Madison | Robertson | Washington |
| **Care Connection ADRC (13 Counties)** | | | | | | |
| Austin | Brazoria | Chambers | Colorado | Fort Bend | Galveston | Harris |
| Liberty | Matagorda | Montgomery | Walker | Waller | Wharton | |
| **Central Texas ADRC (7 Counties)** | | | | | | |
| Bell | Coryell | Hamilton | Lampasas | Milam | Mills | San Saba |
| **Coastal Bend ADRC (11 Counties)** | | | | | | |
| Aransas | Bee | Brooks | Duval | Jim Wells | Kenedy | Kleberg |
| Live Oak | Nueces | Refugio | San Patricio | | | |
| **Concho Valley ADRC (13 Counties)** | | | | | | |
| Coke | Concho | Crockett | Irion | Kimble | Mason | McCulloch |
| Menard | Reagan | Schleicher | Sterling | Sutton | Tom Green | |
| **Connect to Care ADRC (1 County)** | | | | | | |
| Dallas | | | | | | |
| **East Texas ADRC (14 Counties)** | | | | | | |
| Anderson | Camp | Cherokee | Gregg | Harrison | Henderson | Marion |
| Panola | Rains | Rusk | Smith | Upshur | Van Zandt | Wood |
| **El Paso and Far West Texas ADTRC (6 Counties)** | | | | | | |
| Brewster | Culberson | El Paso | Hudspeth | Jeff Davis | Presidio | |
| **Lower Rio Grande (Rio Net) ADRC (3 Counties)** | | | | | | |
| Cameron | Hidalgo | Willacy | | | | |
| **Lubbock County ADRC (15 Counties)** | | | | | | |
| Bailey | Cochran | Crosby | Dickens | Floyd | Garza | Hale |
| Hockley | King | Lamb | Lubbock | Lynn | Motley | Terry |
| Yoakum | | | | | | |
| **North Central Texas ADRC (14 Counties)** | | | | | | |
| Collin | Denton | Ellis | Erath | Hood | Hunt | Johnson |
| Kaufman | Navarro | Palo Pinto | Parker | Rockwall | Somervell | Wise |
| **Tarrant County ADRC (1 County)** | | | | | | |
| Tarrant | | | | | | |
| **West Central Texas ADRC (19 Counties)** | | | | | | |
| Brown | Callahan | Coleman | Comanche | Eastland | Fisher | Haskell |
| Jones | Kent | Knox | Mitchell | Nolan | Runnels | Scurry |
| Shackelford | Stephens | Stonewall | Taylor | Throckmorton | | |

**Progress Report**

*Community Research Center for Senior Health* ("the Center"), a multi-institutional, multi-disciplinary research center, was created to develop, implement, evaluate and disseminate evidence-based interventions that address multiple social and behavioral determinants of senior health. The Center is a partnership among Scott & White Healthcare (S&W), the Texas A&M, School of Rural Public Health (SRPH) and the Texas Area Agencies on Aging and Aging and Disability Resource Centers (AAA/ADRCs). It is built on the partners' capacity to conduct state-of-the-art applied health science research to improve senior health. The mission and vision statements of the Center are:

- Mission: To engage individuals and their communities in programs that improves senior health and wellbeing
- Vision: To be a valued national leader in efforts to promote senior health through trusted partnerships among academic, healthcare, and community organizations

The proposed Specific Aims of this research project were: (1) to establish a sustainable infrastructure that will foster strong academic-community partnerships for enhancing translational research; (2) to advance science and improve public health by engaging community leaders and soliciting community input to prioritize research endeavors in research; and (3) to provide technical expertise in research concepts and methods related to translational and dissemination research processes (e.g., implementing broader community diffusion of best practices and evidence-based treatments via training centers). The Specific Aims were not changed from those proposed in the original application.

Specific Aims guided the implementation of research, education and community outreach activities aligned with the overall Center goal of creating a sustainable infrastructure necessary to build capacity for integrating a community engagement perspective into all aging and community living research across Texas. Activities included pilot research programs to promote Senior Health research, partnerships that provided evidence-based health interventions in our communities and mentoring of researchers interested in applied health interventions. Based on the activities of the Center, which included a broad range of health scientists, academic researchers, organizations that provide health and support services, and senior perspectives, training materials and toolkits that facilitate implementation of evidence-based health interventions have been developed and will be disseminated by the Center. *Successful accomplishment of our Specific Aims has had the predicted result of establishing a core group of scientists, clinicians and community leaders who are providing critical infrastructure that is leading to new research and implementation of health projects totaling approximately 3.8 million dollars.*

This final report to the NIH includes: a) a review of Center activities that were strategically aligned with our three specific aim, b) a review of new Senior Health projects that are supported by Center infrastructure but funded from revenue sources outside of the Center, c) a list of publications linked to Center specific aims as well as projects supported by Center infrastructure, and d) our vision of future Center activities.

**Specific Aim 1: Infrastructure and Integration**

We conducted activities designed to create a sustainable infrastructure via interdisciplinary and multi-contextual approaches to Senior Health intervention research. After establishing a physical presence of the Center, we embarked in a process of funding interdisciplinary teams partnered with community-

based organizations to conduct pilot research projects. A summary of all the projects awarded by the Center through Scott & White Research Grants Program is attached. (Appendix 1).
The following specific activities were carried out to accomplish our aim.

1. **Center Identity/Mission and Vision Statements:** The Center is physically located within the Center of Applied Health Research (http://researchers.sw.org/cahr/cahr-landing), the umbrella organization of applied research groups located in a single office within the Temple, Texas business district to promote community access. A Center logo and website were created with the help of the staff in the Scott and White Marketing Department. The Center's website URL is http://SeniorHealth.sw.org
   a. **Local advisory committee meeting:** A local advisory committee was formed that included key community leaders. The Center leaders met periodically with the local advisory committee members to facilitate the goal of advancing interdisciplinary translational research into the community. Critical accomplishments of the local advisory committee include creation of the Center's mission and vision statements, identification of the roles and expertise of each of the members and the committee as a whole, and brainstorming steps in the Center's outreach to community members. These meetings provided guidance to Center leaders and feedback on the Center's activities.
   b. **External advisory committee (EAC) meeting:** The Center leadership formed EAC of five nationally recognized investigators to solicit advice and evaluation on Center activities. Members of EAC are listed in Appendix 2a. The first meeting of the EAC was held in April, 2011, at the Center in Temple, TX. The purpose of this meeting was to orient the members of the committee to the three partner organizations, describe the foundation work of the Center, and discuss major activities that were planned in support of the goals (i.e., the three specific aims) of the Center. In September, 2012, the EAC members were updated on the Center's progress in a conference call where the members were presented with an overview of the Center's ongoing activities. A summary report from the first meeting and a PPT presentation from the second meeting are attached (Appendix 2b and 2c, respectively.)

2. **Funding Opportunity Announcement (FOA) on Senior Health through the S&W Research Grants Program:** An FOA was created to encourage pilot research projects of interventions that impact the health and well-being of older adults in their communities. The applicants were required to demonstrate a partnership between academic, community and healthcare organization. The program was set up to provide up to $50,000 for two years to projects. A copy of the FOA is attached (Appendix 3a). Applications were reviewed by a committee of clinicians, academicians and community representatives to ensure that community perspective was considered when making funding decisions. Two applications were funded. One project "ICANFIT: Designing and Testing a Mobile Application for Older Cancer Survivors to Use Community Resources" was designed to create and evaluate a web- and mobile phone-based program to assist older cancer survivors in finding community resources to support physical activity. Other study "Achieving Healthy Weight Loss in Obese Older Patients with Obstructive Sleep Apnea (OSA)" compared the use of three interventions to treat obese older patients with sleep apnea. A brief summary of these two projects is given below.

   The overall purpose of ICANFIT project is to determine whether a web and mobile based solution that provides personalized suggestions for types of and nearby locations for physical activity (PA),

tracking, motivational coaching/feedback and social collaboration with peers can increase PA among older cancer survivors. This study is currently underway. So far the team has registered a domain for the project (www.icanfit.org) and completed formative research and developed the protocol of ICANFIT website. Currently, they are conducting beta-testing of ICANFIT website and its tools. The team is actively recruiting older cancer survivors for the phase III of the project. The aim is to recruit 100 older cancer survivors by May 2014 for the pilot-test of ICANFIT. The project is expected to be completed by September, 2014. The process of developing of ICANFIT protocol was published in a peer-reviewed journal.

The purpose of the second funded project is to test the impact of a multi-component OSA and weight loss program on improving measures of health and weight loss. This randomized control trial is comparing changes in physical activity levels and weight loss among patients with three different treatment plans. The main hypothesis is that a program utilizing a multi-targeted approach of behavioral therapy and technological feedback will result in more weight loss and increased physical activity in obese older patients with OSA. The study is expected to contribute new evidence on behavioral weight loss support options and has the potential to significantly advance the treatment of OSA in older patients by producing evidence on the effects of self-management tools for weight loss. This is an ongoing study and expected to be completed in the next six months. The study team has achieved 85% of the recruitment goal of 75 participants. No data analysis has been done so far.

3. **Funding Opportunity Announcement on Senior Health through the S&W Research Grants Program for Clinical Researchers:** A revised version of the pilot grant FOA described above was developed to specifically support clinical scientist (See Appendix 3b). Clinical scientists from Scott & White Healthcare, interested in senior health research, were invited to submit their research ideas. The expected product is a manuscript for submission to an aging or health-focused peer reviewed journal. The Center's post-doctoral fellows were available to help the clinical scientists with their research on an as needed basis. Three clinical scientist-led interdisciplinary teams were funded $20,000 each for research projects.
   - A rehabilitation medicine physician investigating the impacts of an "intelligent walker" (a walker equipped with a sensor to alert users to its presence and prompt users to use the walker) on falls prevention
   - An oncology fellow investigating the impacts of the evidence-based program *Fit & Strong!* on cancer survivors.
   - A cardiac surgeon investigating predictors of neurological deficit after cardiac surgery

The project "A study of the consistency of walker use without and then with a cueing device that encourages use of the walker" aims to develop an intelligent walker (a cueing device placed on an individual's own walker) and assess the impact of this walker on the consistency with which the seniors use their walkers. It is expected that use of this device would reduce the fall injuries in elderly persons. The project is being prepared for submission to IRB. The "intelligent walker" has a provisional patent and a non-provisional patent will be filed within next month.

The project "Fit and Strong! physical activity intervention for older cancer survivors" is a test of feasibility and impact of implementing "Fit& Strong!" (An evidence based physical activity program)

among cancer survivors to find out whether similar benefits occur in this population as were demonstrated for older adults with osteoporosis. 71 eligible cancer survivors participated in one of 5 sessions offered out of which 49 participants completed the study. The participants reported a significant increase in minutes of physical activity pre and post survey and significant decrease in negative feelings pre and post QOL survey. Final data analysis is underway. Part of this study was recently presented as a poster at MD Anderson survivorship conference. A manuscript reflecting the results of this study is currently under development and being targeted for inclusion in a compilation of evidence-based programs for older adults to be published in Frontiers Public Health Education and Promotion.

The project, "To study the predictors of neurologic deficit among senior cardiac surgery patients" was discontinued due to competing demands and an inability of the investigator to actively pursue the proposed research.

4. **Senior Health Grand Rounds:** The external and local advisory committees suggested that we reconsider our plans for Senior Health Grand Rounds based on the feasibility and acceptability of this educational format. More specifically, an external advisor recommended that the Center explored the possibility of implementing Schwartz Center Rounds. The Center learned that the Palliative Care Team was in the process of bringing Schwartz Center Rounds to Scott & White. After further research, the Center recognized that the introspective and sensitive nature of the Schwartz Center Rounds model was not suitable for the attendance of community members. This activity was not carried out any further.

**Specific Aim 2: Community Engagement**

We proposed to utilize and expand our existing community partnerships to improve our understanding of local needs and to encourage community participation in all types of research. Following activities were carried out to accomplish our aim.

1. **Funding Opportunity Announcement (FOA) for the Implementation and Evaluation of Evidence-Based Interventions by Community Organizations:** In the process of engaging community in Senior Health research, the Center established a new service, "Healthy Seniors, Healthy Communities" where the Center partnered with community groups interested in promoting the health and well-being of Seniors. The Center provided these community groups with financial support and professional consultation in selection, implementation and evaluation of evidence based programs (EBPs) for adults 60 years or older.

   A FOA stating that the proposals were being sought from the community groups interested in implementing evidence-based health programs, was developed and circulated widely throughout the target areas (See Appendix 3c for a copy of FOA). A maximum of $30,000 was available to be awarded, with a maximum award of $10,000 to a single group. Information sessions about these opportunities were held in Bell County and Brazos Valley areas. Example of online databases for EBPs was provided to all the interested groups. The organizations were asked to submit a letter of interest (LOI) providing the information about the Senior Health Issue they were most interested in addressing and the EBP they were interested in providing. The information included in LOI was used

to determine if that organization was selected to complete a mini-grant application. A simple application was developed that included the following pieces: A brief description of the proposed program; description of the organization's role in community; specific activities of the program; an evaluation plan, a statement of how the project supported their organization's mission; qualifications of the program coordinator; what data would be collected, sustainability of the program and a budget.

We received letters of interest from eight organizations. Based on the information provided in LOI, four organizations met the criteria and were invited to apply for a mini-grant. All four eligible organizations submitted an application. A multidisciplinary review committee consisting of a public health professor, an evidence-based program expert, and a physician, scored the proposals based on the review criteria developed by researchers at the Center. Three community based organizations were funded. Two organizations, Brazos Valley Council of Governments Area Agency on Aging (BVAAA) and City of Navasota Parks and Recreation Department (CNPRD), were funded to implement "*Fit and Strong*!" and another organization, Heart of Central Texas Independent Living Center (HOCTIL), was funded to carry out "Active Living Every Day" in the Bell County area. The description of these EBPs and results are presented in the following Table. A manuscript describing the results of this program is currently under development.

Table: Evidence based programs implemented by community based organizations and their results

| Organization | EBP | Program Description | Site | # of Classes | Total Participants | Completion Rate (%) |
|---|---|---|---|---|---|---|
| HOCTIL | Active Living Every Day | • Addresses physical inactivity and unbalanced eating<br>• 12 week, one hr/wk<br>• Integrates more activity into daily lives<br>• Set goals, overcome challenges, enlist support and avoid pitfalls. | Belton | 2 | 16 | 68 |
| BVAAA | *Fit & Strong!* | • Adapted to multiple older populations<br>• Integrates the fundamentals of physical activity and behavior change,<br>• 3 classes/wk, 8 wk<br>• 60 min of senior-safe physical activity + 30 min of health education | Bryan, College Station (Urban), Hilltop Lakes Madisonville (Rural) | 7 (Urban) + 2 (Rural) | 163 | 53 |
| CNVRD | *Fit & Strong!* | | Navasota | 3 | 41 | 30 |

2. **Community Input**: The Center worked with multiple community-based organizations to seek input on Senior Health issues and research, and, in many cases, worked directly with Seniors from our communities who provided input via focus groups, direct correspondence with Center staff and through formal surveys.
   a. Community Needs Assessments. As stated in our proposal, two community needs assessments were conducted in the months prior to the start of our Center. Information from these surveys

were analyzed by Center faculty and post-doctoral fellows resulting in 13 publications. Information was also reported to community leaders and providers of health and support services in our target communities of Bell County and the Brazos Valley of Texas.

The Bell County Needs Assessment was conducted to understand the needs of residents in Bell County, Texas. A survey was conducted by the Bell County Community Needs Coalition between April and June 2010. A total of 2893 questionnaires were completed. The final analytic sample consisted of 1422 participants. Approximately 20% of Bell County residents reported experiencing barriers to needed care in the past year. The most common barriers reported were issues related to health care access and socioeconomic barriers. These findings were published in The Journal of Texas Medicine.

The 2010 Brazos Valley Health Status Assessment allowed for comparison of health status and various indicators over time within the Brazos Valley. This allowed for comparison between two previously completed health assessments, highlighting progress, as well as continuing and emerging needs, concerns, issues and opportunities for community health improvement. The 2010 report pointed to the high prevalence of chronic diseases among older adults and the need for self-management programs and better coordination between community and clinical programs. Specifically, the 2010 Survey provided needed information to justify the creation of the Texas A&M Evidence-Based Program, a Resource Center for helping communities identify evidence-based programs, implement and sustain them for seniors in the 9 country region.

The most recent 2013 report included community concerns surrounding a growing older adult population and a lack of supporting community resources and services for both older adults and their caregivers. Various community organizations, such as local hospitals, used these findings to refocus efforts to support healthy aging amongst the communities' older adults, including providing local health and wellness evidence-based programs.

b. Survey Research. An additional clinical research study was developed and conducted by a clinical scientist embedded within the Center, Dr. Cathleen Riveria. Dr. Riveria's study aligned with the Center's mission of engaging seniors about specific health issues. More specifically, the aims of the study were to identify barriers to the use of aspirin for secondary prevention of cardiovascular disease and to examine the differences in barriers for groups defined by various characteristics such as age, gender, ethnicity and education. This is a cross sectional survey study. Participants who met the inclusion criteria were using the Scott & White electronic medical record (EMR) database. A survey on aspirin use, dosage, reasons for taking or not taking aspirin etc. was mailed to 3000 participants. Data was collected from the returned surveys (711) and is currently analyzed. The preliminary results has shown that the lack of daily use of aspirin is mainly due to patient barriers such as lack of awareness about aspirin use or taking too many medicines and not wanting to take an extra pill. Future intervention studies are being planned to target these barriers with the goal of increased use of aspirin for secondary prevention.

c. Participation in Community-Based Health Activities. A primary focus of our activities has been on the training, implementation and research of evidence-based health and wellness programs within

the community through various partnerships. Our single most important accomplishment is likely the creation of the Texas A&M Evidence-Based Program Resource Center. Dr. Marcia Ory (Co-Director of the Center) serves as the Director of the Texas A&M Evidence-Based Program Resource Center which includes community activities undertaken in both the Bell County as well as the Brazos Valley. Projects are done in conjunction with healthcare providers and applied health researchers. Importantly, health projects are selected based on input from a wide range of public officials, healthcare providers and citizens. This work is critical to Texas' Medicaid Waiver 1115 from CMS.

Dr. Ory's Program on Healthy Aging also served as the state-wide evaluator for the Texas Healthy Lifestyles Program administered by the Texas Department of Aging and Disability Services (TDADS) in partnership with the Department of State Health Services (DSHS), the Health and Human Services Commission (HHSC) and five AAA partners (Bexar/Alamo AAA, Central Texas AAA, East Texas AAA Coalition, Rio Grande AAA, and Tarrant County AAA). The five regions span across 67 out of the 254 Texas counties.

Over approximately two years (April 2010 – June 2012), the partner agencies were responsible for delivering CDSMP/DSMP classes to at least 4,098 enrollees and 2,095 completers. The target population for the grant was older adults, age 60 and older, with a focus on serving minority persons, persons who live below the poverty level and persons with one or more chronic health conditions. Some of the partner agencies were to target Hispanic populations with limited English proficiency and tribal communities.

Program evaluation was conducted by Texas A&M, School of Rural Public Health. The evaluation team developed a protocol for partner agencies to collect and report data in an efficient and consistent manner. The core of the data collection protocol was the individual monthly phone calls between Texas A&M and each region and the monthly state phone call lead by TDADS. The 'check-in' calls allowed for real time fidelity checks for class structure and data collection.

The program exceeded its primary goal and delivered CDSMP/DSMP classes to 4,458 enrollees and 3,194 completers. Testimonials indicate the program was valuable to participants and helped older adults with chronic diseases better manage their health. As a result of the Texas Healthy Lifestyles program, Texas now has an infrastructure for training and sustainability and is continuing to expand CDSMP and DSMP into new regions across the state.

**Specific Aim 3: Technical Support**

The Center employed a number of strategies to support the technical needs of researchers, clinicians and community organizations who had embarked on Senior Health research and service projects. A primary strategy was to make available research scientists who could assist with data analysis, including the use of local needs assessment and EMR databases to support the development of new proposals for health interventions. This included structured mentoring to junior facility and post-doctoral fellows. A secondary strategy was developed to support community-based adoption and evaluation of health interventions.

1. **Data Warehouse Support:** The Scott &White healthcare provided access to administrative and clinical data within its well established EMR as well as access to the recently constructed Virtual Data Warehouse (VDW). Access to these data facilitated efficient use of information systems to improve care and conduct health science research. The VDW is linked to the HMO Research Network (HMORN), a collaboration of non-profit health plans that share data for research use. The VDW allowed convenient and safe data sharing across the Center investigators and HMORN members. Center staff available to support use of these databases included a PhD health economist, multiple PhD post-doctoral fellows, program managers and data analysts.

2. **Mentoring and Post-Doctoral Training Program:** Center funding facilitated the recruitment and support of new post-doctoral trainees in our existing Community and Translational Research Post-Doctoral program.

   Center leaders from Scott & White Healthcare and School of Rural Public Health lead a mentoring program that involves seven post-doctoral fellows and three clinical researchers. Center investigators provide consultations to the early career researchers who have shared research interest with established investigators. The group met twice a month to discuss projects and training activities of the trainees. Meetings provide an opportunity for sharing across trainees and group mentorship. An indicator of success is that some of the postdoctoral fellows have gotten permanent positions and continue to engage with and mentor the more junior mentees.

3. **Supporting the Use of Evidence-based Interventions - EvidenceToProgram.Org:** Community organizations are an excellent delivery channel for evidence-based programs, but they often find it challenging to access and implement programs that match their clients' needs. *In response to these challenges, we developed a web-based Toolkit to guide organizations through the selection, implementation, and evaluation of EBPs.* The purpose of the *Toolkit on Evidence-Based Programming for Seniors* is to build the capacity of community organizations to promote senior health and well-being through evidence-based programming. The toolkit will function as a guide that provides the basic information needed to select, implement, and evaluate an evidence-based program. For organizations with significant experience in evidence-based programming, the toolkit will function as a primer that is useful in evaluating their approaches to program selection, implementation, and evaluation. The toolkit is tailored to the characteristics and needs of organizations in Texas; however, much of the information contained in the toolkit is relevant to organizations across the nation. In the Toolkit, we have provided a comprehensive overview of program selection, implementation, and evaluation. The content is presented through narrative text, lists, diagrams, and tables. Throughout the Toolkit, we have also provided links to useful materials from other organizations. An especially useful feature of the Toolkit is an interactive flowchart that helps organizations estimate and increase their readiness to implement evidence-based programs. The Toolkit will be marketed locally and nationally. Scott & White Healthcare will financial support the website. A copy of the Toolkit content is attached (See Appendix 4). The site will be live on March 1, 2014. A presentation will be made about the development of the Toolkit at the American Society on Aging's 2014 Aging in America Conference.

4. **Advanced Data Management Support:** Interactions with community based organizations engaged in evidence-based programming suggested the need for data collection and management system designed to match the needs and capacity of these organizations. In partnership with the Tarrant County United Way (UWTC) and multiple community based organizations serving the health needs of seniors, we have created a platform that is capable of integrating data systems already in place in community organizations with the evaluation needs of local and state funders of these services. The goal of this system is to bring together program data collected by different community organizations and allow for linkage between various programs thus improving data entry and reporting. This work has been done in collaboration with MDB Consulting. To date, Center staff and MDB staff have worked with the Northwest Texas Alzheimer's Association to map data from their database (created by Client Track) into the system created by the Center and MDB. We are currently in the process of mapping data from two other organizations into our database. When complete, this system will allow data from multiple evidence based interventions to be pulled as a de-identified file, allowing for a more complete evaluation of current community based interventions.

## Senior Health Projects Supported by Center Infrastructure

Center leaders embarked on activities surrounding the Specific Aims with the expectation that achievement of the Specific Aims would lead to new projects from new funding sources. That is, the Center's infrastructure would stimulate new projects and make those projects attractive to new funding sources. In part, this would be due to community input and alignment of new projects with the health needs and acceptable health interventions. Center's leaders viewed this strategy as crucial to the Center's Mission and Vision and vital to its long term impact.

To date, 10 projects with budgets in excess of 3.8 million dollars are supported by the Center's infrastructure. See Appendix 5 for summary on these projects. Below we present a brief description of each project.

1. **Healthy Aging and Independent Living (HAIL):** The Center submitted an application to the United Way of Tarrant County and was awarded a contract to become the independent evaluator for Healthy Aging and Independent Living (HAIL) Initiative in 2012. The contract was extended in 2013. This is a multi-year initiative of the United Way with a goal of keeping older adults with chronic diseases to live healthy at home. The initiative is carried out by six agencies, which implement 10 evidence-based and evidence-informed programs. These programs include health literacy, Resources for Enhancing Alzheimer's Caregiver Health II (REACH II) caregiver support and education, respite care, Chronic Disease Self-Management Program, falls prevention, medication management, community health navigation/patient activation, and diabetes screening and education.

   The Center gathers de-identified data from each of the agency and generates quarterly and annual reports on initiative outcomes. Additionally, the Center provides technical assistance on a variety of topics to the agencies implementing the HAIL Initiative programs.

   Additionally, the Center has initiated two separate evaluation projects with Meals On Wheels (MOW) to assess the benefit of their services and evaluate their Walmart Vision Grant data. The evaluation

of the MOW services will start with an assessment of the meals program and then include other MOW services and programs (including the HAIL-funded CHN/PAM and HomeMeds programs). These projects are still in the beginning phases and should be completed in the next year.

As a result of the evaluation during the 2012-2013 UW grant year, the Center has been asked to be co-presenters to help the agencies disseminate their findings to the larger community. Presentations were made at the Meals On Wheels Association of America's 2013 Annual Conference (a joint panel discussion with Meals On Wheels) and the Gerontological Society of America's 66th Annual Scientific Meeting (a joint symposium presentation with the Alzheimer's Association). Proposals have also been submitted for the 2014 n4a National Association of Area Agencies on Aging Annual Conference (joint presentation with Meals On Wheels evaluation) and the Academy of Nutrition and Dietetics 2014 Food and Nutrition Conference (joint presentation with Meals On Wheels CHN/PAM program).

2. **Texercise:** In 2012, School of Rural Public Health received a contract to complete an evaluation of the Texas DADS' Texercise program. Texercise is a statewide health promotion physical activity program based on known best practices and behavior change principles with a focus on increasing participants' self-efficacy. As founding partners of the Center, SRPH and Scott & White staff collaborated to complete the evaluation. This project had two main objectives: (1) standardization of the existing program for widespread dissemination as an evidence-based program and (2) completing a systematic evaluation of the processes and outcomes associated with Texercise.

   The original Texercise format was a relatively unstructured 12-week program designed to encourage individuals and communities to adopt healthy lifestyle habits, such as physical activity and good nutrition. While program materials and facilitator training were provided in a standardized format by DADS, variations in how communities implemented the program were permitted (e.g., types of physical activity, number of classes provided each week). Using evidence-based health and wellness program concepts and keeping the volunteer lay leader model, the research team developed a structured Texercise program. A facilitator training manual and training were also developed. The structured program, Texercise Select, was implemented in 12 weeks, including two weeks for participant recruitment, and 10 weeks of one and a half hour sessions, twice a week. The content of each session incorporates both interactive educational discussions and activities around physical activity and nutrition topics and 30 to 45 minutes of actual participant exercising.

   This evaluation has resulted in three manuscripts: 1) Texercise effectiveness: An examination of physical activity and nutrition outcomes, 2) Increasing the availability of physical activity programs for older adults: Lessons learned from Texercise stakeholders and 3) The establishment and evolution of Texercise: A lifestyle enhancement program for older Texans.

3. **AoA Evidenced-based Care Transitions:** The Evidence-Based Care Transition Program was implemented through a partnership between the Central Texas ADRC and Scott & White Healthcare. The project was funded through a grant from the U.S. Administration on Aging and Centers for Medicare and Medicaid Services (CMS) to the Texas Department of Aging and Disability Services (DADS), using the evidence-based Care Transitions Intervention® (CTI). In this project as well as in a prior project, we successfully embedded Transition Coaches from the Central Texas ADRC within

Scott & White Memorial Hospital with the employer of record being Scott & White. This employer model for the Coaches has worked well as it promoted teamwork and model fidelity. It also provided our Coaches with real time access to Scott & White's electronic medical records and allowed Coaches to function as colleagues of case managers, nurses and physicians – facilitating our ability to identify and enroll patients into CTI services at Scott & White.

The Scott & White team received 8190 referrals, of which, 2808 were screened eligible. We successfully enrolled 742 patients; 565 received at least a home visit and 437 completed the intervention.

4. **Dementia Care Specialist Training to Support REACH II Dissemination in Texas:** The Resources for Enhancing Alzheimer's Caregiver Health II (REACH II) intervention is one of the leading evidence-based approaches to supporting dementia caregivers. It has been the focus of numerous translational research projects. However, the creation of training materials for the purpose of training professional staff to deliver this complex intervention has been limited. Dr. Stevens, one of the creators of REACH II, will lead a Center effort to create the *Dementia Care Specialist Training Manual* to support the availability of REACH II across Texas. Supported by a contract from the Texas Department of Aging and Disability Services, training materials will be non-propriety. The Center is collaborating with the Rosalynn Carter Institute for Caregiving (RCI) to ensure a training program that is consist their efforts to make REACH II available across the US. In this one year contract, Center staff will develop the training manuals and will conduct training sessions across four diverse Texas communities. This work is linked closed to the Center's community partners the Aging and Disability Resource Centers (ADRCs) in Central Texas and Brazos Valley.

5. **Central Texas Community-based Care Transitions Program (CCTP):** The Center's community partner, ADRC, was the lead agency on an application for the CMS funded Community-based Care Transitions Program (CCTP). This is an initiative to reduce the preventable re-hospitalization rate and provides evidence-based transitional care services to high-risk Medicare FFS beneficiaries. CCTP funding comes from Section 3026 of the Affordable Care Act. This successful application to CMS include four area hospitals and one senior care facility management company (Scott & White Memorial Hospital, Hillcrest Baptist Medical Center, Metroplex Adventist, Hamilton General Hospital, and Harden Healthcare), to form the Central Texas Community-based Care Transitions Program (CCTP). These partners are using the grant, awarded in January 2013, to implement the first phase of a long-term plan for increased availability of the Care Transitions Intervention (CTI) to reduce preventable readmissions and bridge the gap that often occurs during transitions of care. CTI is a 30-day patient empowerment model where the participants receive one hospital room visit, one home visit, and two follow-up phone calls.

   The Center was a significant contributor to this program. Richard McGhee, Associate Director of the Center, worked closed with Dr. Stevens, Dr. Ory and multiple members of the Center to gather patient input and patient data needed for the application. Contributions included but were not limited to conducting root cause analysis within each hospital, conducting patient focus groups, coordinating data exchanges between the hospital and the Central Texas ADRC, and assisting with writing and editing of the application.

In the last six months, we have successfully identified 3675 high-risk patients; 1713 patients met our eligibility criteria; and 674 patients have been offered this program. Of these, 382 initially agreed to enroll in the program; 273 received the home visit, and 186 patients completed all steps of the program.

6. **CMMI Award:** The Central Texas ADRC, a CRC-SH founding partner, also partners with the Arkansas-based Schmieding Center for Senior Health and Education to provide Schmieding Method Home Caregiver Training to caregivers in Central Texas. The Schmieding Center was awarded a $3.5 million award from the Center for Medicare and Medicaid Innovation (CMMI) to support the development and dissemination of enhanced home caregiver training. A portion of this CMMI award will be used to demonstrate effective delivery of this training at the Central Texas ADRC and to provide microcredit funds for local caregivers to cover tuition.

   A unique contribution of our Center to the project was the creation of the Center for Caregiver Excellence, located in the Central Texas Council of Governments Building in Belton Texas. The Center for Caregiver Excellence offers a simulation lab called "the Care House" to provide elders, family caregivers, and local paid caregivers an opportunity to use a hands-on approach to elder patient care and treatment within a sophisticated, simulated home-like environment. In the Simulation Lab, elders, family caregivers, and local paid caregivers work with anatomically correct mannequins that help the caregiver to simulate specific to real-life home care scenarios like bathing, feeding, care of the patient within a home setting. "The Care House" is set up as an efficiency apartment offering living room, bedroom, and dining areas, as well as a kitchen and full bathroom for the caregivers to train within. The available of this resource, which was requested by caregivers from our community and designed by the Center's leadership team and reviewed by the EAC, was a significant factor in the subcontract coming from the primary grant awarded to University of Arkansas and the Schmieding Center.

7. **Texas A&M Evidence-Based Programs:** Funded through the Texas Health and Human Services Commission (HHSC), who received federal funding through the Centers for Medicaid and Medicare's (CMS) 1115 Transformation Waiver project, the Texas A&M Evidence-Based Programs provides a centralized resource for training, implementing, and evaluating evidence-based self-management and wellness programs. The EBP Resource Exchange seeks to facilitate health care providers and agencies' capacity to select and implement evidence-based health promotion/disease prevention to reduce the burden of illness in our nine county Regional HealthCare Partnership (RHP) 17 region.

8. **ARRA Communities Putting Prevention to Work: Chronic Disease Self-Management:** The National Council on Aging served as the Technical Resource Center for this Administration on Aging Initiative which sought to enroll over 50,000 older adults throughout the Nation in chronic disease self-management programs. An evaluation team at the School of Rural Public Health was responsible for the analytical aspects of the national evaluation. In collaboration with Stanford University, lead evaluators assessed the impact of the Chronic Disease Self-Management Program on self-reported health status, behaviors, and health care utilization among 1000 seniors.

9. **Pilot Evaluation of the Chronic Disease Self-Management Program:** This project funded by CMS was responsive to the requirements of Section 4202 subsection (b) of the Affordable Care Act (ACA) directing the Secretary of the Department of Health and Human Services to "conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries." This study examined the impact of the Chronic Disease Self-Management Program (CDSMP) on health outcomes, utilization, and costs in an existing sample of participating beneficiaries by linking CDSMP records to Medicare administrative data. The information generated by this pilot evaluation effort was used both to provide an initial reporting of program's effects in CMS's September 2013 report to Congress and to inform the methodology that will be used in future evaluation efforts of wellness and prevention programs. Working collaboratively with Stanford University, the Texas A&M Health Science Center Evaluation team was responsible for data linkage, analysis and report writing.

10. **The South, West, and Central Consortium, Geriatric Education Center of Texas (SWAC-C GEC):** The South, West, and Central Consortium, Geriatric Education Center of Texas (SWAC-C GEC) is based at the University of Texas Health Science Center at San Antonio. The SWAC GEC has facilitated the improvement of patient care for the aged through interdisciplinary partnerships with faculty and practitioners in the fields of gerontology and geriatrics. To date, the consortium has provided culturally appropriate geriatric training to more than 50,000 health professionals both on-site and by distance learning. As a Consortium Center, SRPH will focus on coordinating educational and training efforts related to chronic disease management, especially around the implementation, dissemination, and sustainability of evidence-based chronic disease management programs.

**Future Directions of the Community Research Center for Senior Health**

The three founding organizations remain fully committed to the long-term longevity of the Center. The three Center leaders (Stevens, Ory, McGhee) have also recommitted to their leadership roles. In addition to this endorsement of the Center, the accomplishments achieved in the first three years serves as a strong foundation for the future work of the Center. Moreover, the Center's Mission and Vision remain relevant, if not crucial, to the well-being of seniors, our communities and our organizations.

**Leadership**. The leadership team of Dr. Stevens, Dr. Ory and Mr. McGhee will continue to include the Center as a vital extension of their individual programs. The value of our collaboration is without question. Each leader has successful contributed to the overall success of the Center, used the Center to build upon the work of their individual programs and have advocated for the Center within their home organization. Lastly, each leader has bought a unique and valuable perspective to the Mission and Vision of the Center. We are committed to the high level of functional leadership that we have established.

**Infrastructure.** Sustainability has been a driving force in the development of the Center, ensuring that core infrastructure will remain post RC4 funding. Careful consideration was given to how each Center activity was designed and implemented with the goal of finding a long term sources of support. For example, pilot grant activities were embedded with the existing Scott & White Healthcare internal grants program to encourage ongoing internal support. Community based evidence-based programs were frequently embedded within agencies who received State and Federal funding to support these programs.

Long term support for evidence based programming in our communities will be facilitated by web-based tool kit to support adoption and implementation of evidence-based interventions. Direct support for infrastructure is also being provided. For example, Scott & White Healthcare continues to support an FTE for the Center's Coordinator and will support the internet hosting fees associated with our web-based tools.

**New Projects.** The Center is attracting new sources of financial support due to the strong infrastructure established by the NIH funded activities. As reported earlier in this final report, the Center made direct contributions to the awarding of 10 new projects across the three founding organizations. These 10 new projects are housed across the three organizations with the Center providing a critical service to the application or implementation process, including obtaining direct input from seniors to influence the design and roll out of projects. New funding is being used to support staff who were originally hired with NIH funds. We expect continued success in this arena. The Center's infrastructure, and growing reputation, is proving to be an asset to grant and contract applications. Pilot research project also show promise for future funding as do the community organizations that were supported to implement evidence based program. Moreover, the leadership team will continue to work with post-doctoral fellows and junior faculty who have been mentored by our Center.