

# Evidence-Based & Best Practice Programs for Healthy Aging, Caregiving, and Care Transitions

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Evidence-based programs are proven programs that work. In order to be considered “evidence-based,” programs must be extensively evaluated using a control/comparison group, with documented and published outcomes. Programs that are considered “best practices” have not undergone this rigorous evaluation, but are based closely on existing research on effective approaches.

The list below indicates with an asterisk (\*) programs that are considered “evidence-based” by the Centers for Disease Control and Prevention, the Administration for Community Living, or the Substance Abuse and Mental Health Administration. Many of these programs are described in more detail on the National Council on Aging’s website at <https://www.ncoa.org/resources/highest-tier-evidence-based-health-promotion-disease-prevention-programs/>

Programs currently offered in Oregon are indicated with an (O). The current list includes programs addressing the following areas:

- A. Chronic disease self-management
- B. Physical activity and falls prevention
- C. Healthy eating
- D. Medication management
- E. Depression and mental health
- F. Alzheimer’s and caregiving
- G. Care transitions

Please contact Jennifer Mead with any comments or questions at 971-673-1035 or [jennifer.mead@state.or.us](mailto:jennifer.mead@state.or.us). This list is also available on-line at <http://www.oregon.gov/dhs/spwpcd/pages/sua/hlthy-aging.aspx>



## **A. Chronic Disease Self-Management**

1. **\*Living Well with Chronic Conditions (Stanford Chronic Disease Self-Management Program (CDSMP))** Living Well (Stanford University’s Chronic Disease Self-Management Program, or CDSMP) is a six-week

workshop that provides tools for living a healthy life with chronic health conditions, including diabetes, arthritis, asthma and heart disease. The workshop provides support for normal daily activities and dealing with the emotions that chronic conditions may bring about. Stanford chronic disease self-management programs also include **Tomando Control de su Salud**, a Spanish-language, culturally adapted version of Living Well; the **Positive Self-Management Program (PSMP)** for people with HIV; **Diabetes Self-Management Program** specifically for people with diabetes; **Arthritis Self-Management Program**; **Chronic Pain Self-Management Program**; and **Better Choices, Better Health**, an on-line version of the workshop. Four-day leader training for these programs are held regularly in locations around the state. [www.healthoregon.org/livingwell](http://www.healthoregon.org/livingwell) or 888-576-7414 or <http://patienteducation.stanford.edu/>. (O)

2. **\*National Diabetes Prevention Program**  
This lifestyle change program significantly reduces the risk of developing type 2 diabetes among people at high risk, including those with pre-diabetes or a history of gestational diabetes. Participants work with a lifestyle coach in a group setting to make modest and attainable behavior changes, such as improving food choices and increasing physical activity. The intervention lasts for one year, including 16 weekly core sessions and six monthly post-core sessions. [www.cdc.gov/diabetes/prevention/about.htm](http://www.cdc.gov/diabetes/prevention/about.htm). (O)
3. **\*EnhanceWellness (EW):** EnhanceWellness is a six-week individualized, community-based wellness intervention for older adults at risk of functional decline. A nurse and social worker work with the individual to develop a plan, and support and encourage that individual to achieve the goals of his/her plan. The program was developed by the University of Washington in collaboration with Senior Services. [www.projectenhance.org](http://www.projectenhance.org)
4. **\*Healthy Lifestyles:** Healthy Lifestyles is a 3-day health promotion intervention for people with disabilities developed by the Oregon Office on Disability and Health (OODH) at Oregon Health & Science University. The workshop is offered in English and Spanish by OODH through Oregon's Independent Living Centers. Healthy Lifestyles uses an integrated wellness and empowerment approach and provides participants with knowledge and skills to adopt healthy behaviors. [www.ohsu.edu/healthylifestyles](http://www.ohsu.edu/healthylifestyles) (O)

## **B. Physical Activity and Falls Prevention**

5. **\*Active Living Every Day (ALED)** This program was developed by the Cooper Institute and Human Kinetics. It is a 12 week, self-paced course to help people with sedentary lifestyles become and stay physically active. The course can be offered in a group or one-on-one format, and focuses on behavior change to help sedentary adults adopt and maintain physically active lifestyles. (“Active Choices” and “Active Living Every Day” were jointly disseminated/researched under the name Active for Life.)  
[www.humankinetics.com/ppALP](http://www.humankinetics.com/ppALP)
6. **\*Active Options:** A 6-month telephone-based individualized program that provides guidance and support and builds self-management skills. Developed by the Stanford Prevention Research Center.  
<http://hip.stanford.edu/organizational-consulting/>
7. **\*Arthritis Foundation Exercise & Aquatics Programs:** Originally developed by the Arthritis Foundation, this program offers low-impact exercises that can be done either sitting or standing to help relieve stiffness and pain and to build strength and stamina. Classes meet 2-3 times per week for at least eight weeks. The programs were developed by physical therapists specifically for people with arthritis or related conditions, although are also appropriate for other frail or deconditioned older adults. Information on training: <https://www.aeawave.com/AFProgram.aspx> .  
[www.arthritis.org/exercise.php](http://www.arthritis.org/exercise.php) In Oregon, check [www.healthoregon.org/takecontrol](http://www.healthoregon.org/takecontrol). (O)
8. **\*Arthritis Foundation Tai Chi Program:** Designed for people with arthritis, this 12-movement Sun-style Tai Chi program was developed by Paul Lam and is supported by the Arthritis Foundation. [www.arthritis.org/tai-chi.php](http://www.arthritis.org/tai-chi.php) (O)
9. **\*Better Bones & Balance:** Based on research at Oregon State University’s Bone Research Laboratory, this strength and stepping exercise class is designed to reduce the risk of osteoporosis-related fractures. Outcomes include improved strength, balance and mobility, and reduced bone loss.  
<http://extension.oregonstate.edu/physicalactivity/bbb> (O)
10. **\*EnhanceFitness (EF):** EnhanceFitness, developed by the University of Washington in collaboration with Senior Services, is a group exercise program for older adults focusing on stretching, flexibility, balance, low impact

aerobics, and strength-training. Classes meet 3 times per week and are led by a certified fitness instructor. [www.projectenhance.org](http://www.projectenhance.org) (O)

11. **Fallproof Balance & Mobility** program classes are held in community settings and use a multidimensional approach to balance-related problems. Balance and gait assessments are provided to determine the most suitable training program. The group-based program is available for individuals identified as low-to-moderate risk for falls. [hhd.fullerton.edu/csa/FallProof/](http://hhd.fullerton.edu/csa/FallProof/) (O)
12. **\*Fit and Strong!:** Developed by the University of Chicago, this physical activity program for older adults with arthritis is designed to be offered three times/week for 8 weeks. Each session includes a 60-minute exercise program and a 30-minute education and group problem-solving session to help participants develop ways of incorporating exercise into their daily lives. [www.fitandstrong.org](http://www.fitandstrong.org) (O)
13. **\*Healthy Moves for Aging Well:** Developed by the Partners in Care Foundation in collaboration with other Southern California organizations. This physical activity program is offered one-on-one to home-bound frail, high-risk sedentary older adults. The program was designed to be supported by case managers as an additional service of their community-based case management program. [www.picf.org/landing\\_pages/22,3.html](http://www.picf.org/landing_pages/22,3.html)
14. **Healthy Steps for Older Adults:** Developed by the Pennsylvania Dept of Aging, the program for adults age 50+ provides fall risk assessments, and 2.5 hour workshop on falls prevention, and follow-up with participants' physician. <http://www.aging.pa.gov/aging-services/health-wellness/Pages/Healthy-Steps-for-Older-Adults.aspx#.Vnxhy6PTncs>
15. **\*Matter of Balance (MOB):** Adapted from Boston University Roybal Center by Maine's Partnership for Healthy Aging, this community workshop teaches practical coping strategies to reduce the fear of falling. The group-based course is led by trained lay leaders over 8 weekly 2-hour sessions. [www.mainehealth.org/mob](http://www.mainehealth.org/mob) In Oregon, contact Kayt Zundell, OHSU's ThinkFirst Program, at 503-494-5353 or [zundel@ohsu.edu](mailto:zundel@ohsu.edu). (O)
16. **\*Otago Exercise Program:** This is an individually tailored falls prevention exercise program that is delivered in participants' homes. A trained physical therapist provides four home visits followed by phone support and a booster

session. Exercise includes a series of leg-strengthening, balance-retraining exercises, and a walking plan that get progressively more difficult. <https://www.med.unc.edu/aging/cgec/exercise-program>. For information on the program in Oregon: [www.healthoregon.org/fallprevention](http://www.healthoregon.org/fallprevention). (O)

17. **\*SAIL (Stay Active & Independent for Life):** A strength and balance fitness class developed in Washington for older adults that includes education on preventing falls. The classes meet three times/week for an hour. Exercises can be done seated or standing and include moderate aerobic, strength, and stretching exercises. Instructor training is available in-person or online through Pierce College. [www.synapticseminars.com](http://www.synapticseminars.com). (O)
18. **\*Stepping On:** Developed at the University of Sydney, Australia, this program is designed to improve fall self-efficacy, encourage behavior change, and reduce falls. The program involves a seven week, two-hour/week, group program sessions with a home visit or phone call and booster session. Designed to be taught by a professional who works with older adults and a peer leader, the program also brings in other professionals (i.e. pharmacist, physical therapist) to speak during some of the sessions. <http://wihealthyaging.org/stepping-on> For information on the program in Oregon: [www.healthoregon.org/fallprevention](http://www.healthoregon.org/fallprevention). (O)
19. **Strong Women:** A group strength-training exercise program developed at Tufts University and designed for midlife and older women. Outcomes include increased strength, improved bone density, improved health and self-confidence. [www.strongwomen.com/](http://www.strongwomen.com/) (O)
20. **\*Strong For Life:** Developed by Boston University, this six-week home-based exercise program increases strength, balance, and overall health. Volunteer coaches instruct frail homebound participants on how to exercise using an exercise video and monitor their performance. [www.ncoa.org/improve-health/center-for-healthy-aging/strong-for-life.html](http://www.ncoa.org/improve-health/center-for-healthy-aging/strong-for-life.html) (O)
21. **\*Tai Ji Quan: Moving for Better Balance** (*also known as Tai Chi: Moving for Better Balance or YMCA Moving for Better Balance*) Developed by the Oregon Research Institute in Eugene, this simplified, 8-form version of Tai Chi, offered in community settings, has been proven to decrease the number of falls and risk of falling in older adults. Classes meet 2-3 times/week for at least three months. Program outcomes include decreased falls, and a decrease

in fear of falling. A two-day instructor training is offered in the Eugene area, and occasionally in other areas of the state with support from the DHS Public Health Division. Contact Dr. Fuzhong Li at the Oregon Research Institute, [www.ori.org](http://www.ori.org) or 541-484-2123, or for more information on the program in Oregon, visit [www.healthoregon.org/fallprevention..](http://www.healthoregon.org/fallprevention..) (O)

22. **\*Walk with Ease Program** The Arthritis Foundation *Walk With Ease* Program is a community-based physical activity and self-management education program. It is conducted in groups of 12-15 people led by trained leaders in a structured six-week program. One-hour sessions are held three times a week over the six-week period for a total of 18 sessions. While walking is the central activity, *Walk With Ease* also includes health education, stretching and strengthening exercises, and motivational strategies. Group sessions include socialization time, a brief scripted pre-walk informational lecture, warm up and cool down, and a 10-35 minute walking period. Walk with Ease was specifically developed for adults with arthritis who want to be more physically active, but is also appropriate for people without arthritis, particularly those with diabetes, heart disease and other chronic conditions, who want to get more active. Instructor training is offered on-line. For more information, visit <http://extension.oregonstate.edu/fch/walk-with-ease> or [www.healthoregon.org/takecontrol](http://www.healthoregon.org/takecontrol). (O)

### C. **Healthy Eating**

23. **Eat Better Move More:** A 12-week program developed for congregate meal program participants, and usually led by individuals with a nutrition background. Weekly 30 minute sessions provide basic activity and nutrition education and encourage participants to be physically active and eat a more healthy diet. A second 12-week series is available for sites that have completed the first series. [http://nutritionandaging.fiu.edu/You\\_Can/index.asp](http://nutritionandaging.fiu.edu/You_Can/index.asp)
24. **Healthy Eating for Successful Living in Older Adults:** Developed by the Lahey Clinic in collaboration with other Boston-area organizations, this is both an education and support program to assist older adults in self-management of their nutritional health. The workshop is conducted over 6 weekly 2 ½ hour sessions with a peer leader and a RD/nutritionist resource person. [www.ncoa.org/improve-health/center-for-healthy-aging/healthy-eating-for-successful.html](http://www.ncoa.org/improve-health/center-for-healthy-aging/healthy-eating-for-successful.html)

25. **Eat Smart, Live Strong:** This program was designed to improve fruit and vegetable consumption and physical activity among low-income able-bodied 60-74 year olds who are eligible for SNAP or other publically-funded nutrition programs. <http://snap.nal.usda.gov/resource-library/nutrition-education-materials-fns/eat-smart-live-stong>

## **D. Medication Management**

26. **\*HomeMeds:** The HomeMeds program (formerly called the Medication Management Improvement System or MMIS) was adapted from the Vanderbilt University Medication Management Model by the Partners in Care Foundation in California. This intervention is designed to enable case managers, social workers and nurse case managers to enter a participant's medication into a computer-based alert system, and to resolve identified medication problems with involvement of a consulting geriatric pharmacist. [www.homemedes.org](http://www.homemedes.org) (O)

## **E. Depression & Mental Health**

27. **\*Brief Intervention and Treatment for Elders (BRITE):** Developed in Florida with support from SAMHSA, this program modifies the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model specifically for use with older adults with substance misuse/abuse. The program helps people age 55+ to identify nondependent substance use or prescription medication issues, and to provide effective service strategies that can prevent substance abuse. <http://brite.fmhi.usf.edu>
28. **ElderVention:** Developed in Arizona, this program of community workshops and in-home visits provides prevention education for older adults who are at risk for depression and suicide. Workshops are held at multiple venues, such as senior centers and long-term care facilities. Individual home-based education is provided for isolated, at-risk older adults. Referrals to mental health treatment services are also provided. (O)
29. **Healing Pathways:** A peer-implemented group mental health program for women with physical disabilities who are dealing with depression, this 14-week program was developed by researchers at OHSU and evaluated in partnership with several Oregon Centers for Independent Living. (O)

30. **\*Healthy IDEAS:** Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. This case manager-led program typically lasts for 3-6 months. It was developed by the Huffington Center on Aging at Baylor College of Medicine, Sheltering Arms and the Care for Elders Partnership in Houston.  
<http://careforelders.org/default.aspx/MenuItemID/290/MenuGroup/Initiatives+%26+Tools.htm> (O)
31. **\*IMPACT:** IMPACT is a program for older adults who have major depression or dysthymic disorder. The intervention is a stepped, collaborative care approach in which a nurse, social worker, or psychologist serves as Depression Care Manager, working with the participants' regular primary care provider to develop a course of treatment. Patients receiving IMPACT care were twice as likely as usual care patients to experience a 50% or greater reduction in depression symptoms. Two training options are available: a 2-3 day in-person course or free on-line training. [www.impact-uw.org](http://www.impact-uw.org).
32. **\*PEARLS:** PEARLS is a time-limited and participant-driven program that teaches depression management techniques to older adults with minor depression or dysthymia. It is offered to people who are receiving home-based services from community services agencies. The program consists of in-home counseling sessions followed by a series of maintenance session contacts conducted over the telephone. Community-based depression care managers use problem-solving treatment, social and physical activity planning, and pleasant events in a series of eight 50-minute sessions over a 19-week period with 3-6 subsequent telephone contacts. [www.pearlsprogram.org](http://www.pearlsprogram.org) (O)

## F. **Alzheimer's and Caregiving**

33. **\*Stress-Busting Program for Family Caregivers.** A nine-week community workshop to improve the quality of life of family caregivers providing care for people with Alzheimer's disease or other dementias. Developed at the University of Texas, the program uses two trained facilitators to conduct the nine weekly 90-minute sessions. [www.caregiverstressbusters.org](http://www.caregiverstressbusters.org)

34. **\*New York University Caregiver Initiative:** A 6-month counseling and support intervention for spouse caregivers that is intended to improve the well-being of caregivers and delay the nursing home placement of patients with Alzheimer's disease. The program uses social workers or mental health providers to provide individual and family counseling sessions, support groups, and follow-up counseling and phone support.  
<http://nrepp.samhsa.gov/ViewIntervention.aspx?id=74>
35. **\*Powerful Tools for Caregivers:** This six-week education program developed by Legacy Caregiver Services, focuses on the needs of the caregiver, and is for family and friends who are caring for older adults suffering from stroke, Alzheimer's, Parkinson's disease or similar long-term conditions. The class provides participants with the skills and confidence you need to better care for yourself while caring for others. [www.powerfultoolsforcaregivers.org/](http://www.powerfultoolsforcaregivers.org/) (O)
36. **\*REACH II (Resources for Enhancing Alzheimer's Caregiver Health):** A six-month multi-component home and phone-based intervention provided by case managers for Alzheimer's family caregivers. The intervention is designed to reduce caregiver burden and depression, improve caregivers' ability to provide self-care, provide caregivers with social support, and help caregivers learn how to manage difficult behaviors in care recipients.  
<http://nrepp.samhsa.gov/ViewIntervention.aspx?id=129>
37. **\*RDAD (Reducing Disability in Alzheimer's Disease):** Developed at the University of Washington, this program encourages exercise and problem-solving to help reduce depression among adults with dementia and their family caregivers. The program uses trained consultants to provide approximately 12 one-hour home visits over a 12-week period.  
[www.aoa.gov/AoA\\_Programs/HPW/Alz\\_Grants/reducing.aspx](http://www.aoa.gov/AoA_Programs/HPW/Alz_Grants/reducing.aspx) (O)
38. **\*Savvy Caregiver:** This is 12-hour training program is usually delivered in 2-hour sessions over a 6-week period. Developed at the University of Minnesota, the program focuses on helping caregivers think about their situation objectively and providing them with the knowledge, skills, and attitudes they need to manage stress and carry out the caregiving role effectively. Research has demonstrated significant positive outcomes regarding caregivers' beliefs about caregiving, their reactions to the behavioral symptoms of their care recipient, and their feelings of stress and burden.  
[www.rosalynncarter.org/caregiver\\_intervention\\_database/dementia/savvy\\_caregiver/](http://www.rosalynncarter.org/caregiver_intervention_database/dementia/savvy_caregiver/) (O)

39. **\*STAR-C:** Developed by the University of Washington’s School of Nursing Northwest Research Group on Aging, the STAR-Caregivers (STAR-C) program is a home-based behavioral intervention to decrease depression and anxiety in individuals with Alzheimer’s disease and their family caregivers. It consists of eight weekly hour-long in-home sessions followed by four monthly telephone calls. [www.aoa.gov/AoA\\_Programs/HPW/Alz\\_Grants/star-c.aspx](http://www.aoa.gov/AoA_Programs/HPW/Alz_Grants/star-c.aspx) For information on STAR-C currently being offered in Multnomah, Jackson, and Josephine counties, contact [Jennifer.mead@state.or.us](mailto:Jennifer.mead@state.or.us) (O)

## **G. Care Transitions**

40. **\*Bridge Program:** A hospital-based 30-day intervention that uses a trained social workers to provide a hospital visit and follow-up phone visit and phone support linked to aging services in the hospital and community. [www.transitionalcare.org/the-bridge-model/](http://www.transitionalcare.org/the-bridge-model/)
41. **\*Care Transitions Intervention:** Developed by Eric Coleman, this 4-week community or hospital-based intervention uses trained “transition coaches” to do a hospital visit, home visit, and three follow-up phone calls addressing four pillars: use of a patient medical record, medication reconciliation, knowledge of red flags or warning signs, and follow-up with a primary care provider. [www.caretransitions.org](http://www.caretransitions.org) (O)
42. **\*Guided Care:** Developed by Chad Boulton, this primary care based program uses a nurse to provide in-home assessment, care planning, self-management support, and support for care transitions for older adults with complex health conditions. [www.guidedcare.org](http://www.guidedcare.org)
43. **\*GRACE (Geriatric Resources for Assessment and Care of Elders):** An ongoing primary care-based intervention that uses a social worker, nurse practitioner, interdisciplinary team, and clinical protocols addressing common geriatric conditions to improve quality of care and effective care transitions. The program is designed to improve the quality of geriatric care so as to optimize health and functional status, decrease excess healthcare use, and prevent long-term nursing home placement. <http://medicine.iupui.edu/IUCAR/research/grace.aspx>

44. **\*Project BOOST (Better Outcomes for Older Adults through Safe Transitions):** A hospital-based intervention that is designed to identify high-risk patients on admission, and reduce 30 day readmission rates. The intervention uses risk assessment tool, patient records, a teach-back process, and risk-specific interventions and discharge processes.  
[www.hospitalmedicine.org/BOOST/](http://www.hospitalmedicine.org/BOOST/)
45. **Project RED:** Also known as the Re-Engineered Discharge, this hospital-based program works with patients to organize post-discharge plans, follow-up visits, and patient understanding of their condition, medications, and warning signs. [www.bu.edu/fammed/projectred](http://www.bu.edu/fammed/projectred)
46. **\*Transitional Care Model:** Developed by Mary Naylor, this 1-3 month intervention uses a transitional care nurse to provide hospital and home visits, participation in a follow-up physician visit, and telephone support.  
[www.transitionalcare.info/](http://www.transitionalcare.info/)