United Way of Tarrant County

LIVE WELL Health Initiative

Evaluation Final Report

July 2010 – June 2019

Center for Applied Health Research

Baylor Scott & White Health
Texas A&M School of Public Health

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Executive Summary

LIVE WELL Initiative of United Way of Tarrant County

The United Way of Tarrant County (UWTC) identified a three-armed initiative in its 2020 strategic plan to improve the financial, educational, and health-related aspects of its community. In response to the United Way of Tarrant County’s 2020 Bold Goal, the LIVE WELL Initiative (formerly, Healthy Aging and Independent Living Initiative) developed a Bold Goal of having improved the lives of 17,000 adults with ongoing health concerns by the year 2020. To achieve the Bold Gold, UWTC partnered with community-based organizations (CBOs) who provide evidence-based programs that decrease preventable hospitalizations, emergency department visits and improve quality of life through healthy behaviors and self-management techniques. Three strategies guided the LIVE WELL Initiative: early management of chronic disease, evidence-based services during transitions in care and other periods of high risk, and system change in how citizens of Tarrant County receive health services.

LIVE WELL Initiative Key Partners and Programs

Seven partner CBOs received a total of $11,558,488 from July 2010 to June 2019 to support the delivery of 10 programs:

- Sixty and Better (formerly Senior Citizen Services):
  - A Matter of Balance (AMOB): Falls prevention
  - Chronic Disease Self-Management Program (CDSMP): Chronic disease self-management
  - HomeMeds: Medication management
- Meals on Wheels, Inc. Tarrant County
  - Diabetes and Nutrition Screening & Counseling
  - HomeMeds: Medication management
  - Community Health Navigator: Patient activation and engagement
  - HealthyMoves: Physical activity
- Alzheimer’s Association North Central Texas Chapter
  - REACH-TX: Alzheimer’s caregiver support
- Easterseals North Texas
  - Respite Care: In-home respite services
- North Texas Area Community Health Center
  - DiabetesSalud!: Diabetes counseling and education
- University of North Texas Health Science Center
  - Health Literacy: Building of health-literate institutions
- Baylor Scott and White Health, Center for Applied Health Research
  - Evaluation

1 HomeMeds was provided by two CBOs.
2 UNT Health Science Center was in charge of the evaluation for FY 10-12.
LIVE WELL Initiative Performance Attainment

Since the completion of Year 9 (July 2010-June 2019)

- The LIVE WELL Initiative has served 44,790 clients, 63,102 clients have been touched and 18,149 clients have maintained and improved their health\(^3\).
- This represents 100.2% of the Lives Touched Bold Goal and 106.8% of the Lives Improved Bold Goal at the completion of Year 9.
- The lives touched bold goal and lives improved bold goal has been met and exceeded.

LIVE WELL Initiative Bold Goal Attainment

\textit{Bold Goal: LIVE WELL Initiative will have improved the lives of 17,000 adults with ongoing health concerns by 2020}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|c|c|c|}
\hline
& Year 1 & Year 2 & Year 3 & Year 4 & Year 5 & Year 6 & Year 7 & Year 8 & Year 9 \\
\hline
Adults with Maintained/Improved Health Status & 915 & 1,525 & 813 & 714 & 2,313 & 3,465 & 3,426 & 2,685 & 2,293 \hline
\hline
\hline
\hline
Lives Touched & 5,873 & 6,202 & 8,122 & 3,870 & 8,087 & 8,407 & 7,924 & 7,028 & 7,589 \hline
\hline
\hline
\hline
TOTAL & 18,149* & & & & & & & & \\
\hline
\hline
TOTAL & 63,102* & & & & & & & & \\
\hline
\end{tabular}
\end{table}

*An unduplicated cumulative count of lives touched and maintained/improved from the LIVE WELL Initiative are counted within each organization. Counting unduplicated lives across years and organizations is unavailable. Many individuals served through LIVE WELL programs have multiple chronic conditions/issues and need multiple LIVE WELL services. Additionally, the evaluation team was only able to receive de-identified data from The LIVE WELL programs, and as such only count unique clients within each organization that has multiple programs.

Performance Achievements

LIVE WELL Initiative programs collected two sets of outcome measures: common measures and program-specific measures.

- Common measures were collected using the CDC Healthy Days Core Module data and NHIS Health Care Utilization at baseline and follow-up.
  - The overall percent of participants who rated their health good, very good, and excellent improved from 52.1% at baseline to 66.6% at follow-up assessment (CDC Healthy Days Module).

\(^3\) The current evaluation team was unable to verify the data on the touched lives and improved lives for first 2 years. Lives touched and improved for the first 2 years provided by United Way staff and former evaluator were included and calculated.
The average healthy days for clients improved from 18.2 days at baseline to 21.0 days follow-up assessment (CDC Healthy Days Module).

- The overall percent of clients who had hospitalized overnight declined from 15.9% at baseline to 8.9% at follow-up assessment (NHIS Health Care Utilization).
- The overall percent of clients who had emergency room visits declined from 22.4% at baseline to 16.0% at follow-up assessment (NHIS Health Care Utilization).

- LIVE WELL Initiative programs showed improved program specific outcomes from baseline to follow-up assessment (See Appendices A to J).

**Collective Impact & Systems Change**

- As a systemic approach by broad cross-sector coordination, the UWTC and LIVE WELL Initiative partners have worked together to achieve the following five components of collective impact:
  - Common agenda
  - Shared measurement system
  - Centralized infrastructure with a dedicated project staff (Accountability)
  - Ongoing communications among organizations
  - Mutually reinforcing activities

- Systems change is also achieved by representing advocacy efforts of the Initiative to strengthen the local community’s abilities and support for individuals with chronic conditions and their caregivers (e.g., attending to meetings and conferences at local, state, and national level).

**LIVE WELL Initiative Evaluation**

As a partner and an independent team, Baylor Scott and White Health, Center for Applied Health Research (CAHR), led LIVE WELL Initiative evaluation from Year 3. CAHR played the following roles:

- Conducted an unbiased, formal evaluation of the programs' outreach, efforts, and impact
- Provided meaningful data about the service provisions to partner organizations and UWTC
- Devoted efforts to dissemination on the success of the LIVE WELL Initiative program implementations with scientific format: original research manuscripts, presentations at local and national conferences, and grant application submissions

**Conclusion**

- The LIVE WELL Initiative successfully achieved and exceeded its Bold Goal of having improved the lives of adults with ongoing health concerns.
  - 63,102 cumulative adults served and/or received home-based care and evidence-based programs.
  - 18,149 adults maintained and improved health status.
- The LIVE WELL Initiative partners and UWTC should work on the best strategy to disseminate the success of the Initiative for the organizations, community, and nationwide.
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Introduction

I. United Way of Tarrant County

The foundation of what is today United Way of Tarrant County (UWTC) started in 1922 when a group of Fort Worth’s community leaders gathered to consolidate the fundraising efforts of several local charities. Instead of competing for volunteer time and funding, they pooled their resources to create the Fort Worth Community Chest – the first Community Chest in the Southwest and forerunner of United Way of Tarrant County. In 1962, a community-planning group transformed the Fort Worth Community Chest into the United Fund and Community Services, Inc., which became the organization officially recognized today as the United Way of Metropolitan Tarrant County in 1973. UWTC expanded to serve the growing Texas communities by establishing United Way—Arlington in 1981, and United Way—Northeast, in 1986.

Today, United Way of Tarrant County continues to improve lives in Tarrant County by uniting the power of companies, organizations, cities, religious entities and individuals to advance the common good. In 2010, the UWTC turned its focus to three main efforts to build a stronger community through Education, Income, and Health - the building blocks for a good quality of life. To achieve its 2020 Bold Goal of significantly affecting the population of Tarrant County, in 2010, UWTC launched three community initiatives: LEARN WELL, EARN WELL and LIVE WELL.

II. LIVE WELL Initiative

In response to the UWTC’s 2020 Bold Goal, the LIVE WELL Initiative (formerly, Healthy Aging and Independent Living Initiative) identified a health Bold Goal of having improved the lives of 17,000 adults with ongoing health concerns by the year 2020. Strategies to improve health outcomes for adults with ongoing health concerns were established. Specifically, the strategies focused on identifying effective ways to help adults over age 35 with chronic disabling conditions live independently and with dignity to promote a higher quality of life. Also recognizing that many adults with chronic disabling conditions cannot stay at home without the support of family caregivers, the initiative placed a special emphasis on supporting caregivers so that they may be able to provide essential support for a longer time.

The Live Well Initiative provides proven strategies woven into a comprehensive set of evidence-based health programs that target individuals at high risk of placement into a nursing facility and other poor outcomes such as preventable hospitalizations, as well as services that promote healthy lifestyles in the management of chronic conditions. Partnering with six key community-based organizations (CBOs), progress towards the LIVE WELL 2020 Bold Goal was achieved. This partnership aligned with the strategies to address both the short- and long-term impacts of health and well-being for individuals served through the LIVE WELL programs, thereby working together to achieve the Bold Goal of improved health.

III. LIVE WELL Initiative Strategies and Framework

The LIVE WELL Initiative has established three strategies to support those living with chronic illness and their family. Each strategy guides to navigate target populations and mechanisms of action for services. Outcomes and programs for each strategy are presented in Figure 1.
1. **Early management of chronic disease**: This strategy focused on supports for adults living with chronic disabling conditions (e.g., heart disease, diabetes, and physical and mental impairments). Education, engagement, and self-management of health behaviors programs were used for stabilizing and sustaining home-based care, improving confidence and feelings of self-efficacy, and building capability to activate change which nurtures and bolsters continued successes. A Matter of Balance, Chronic Disease Self-Management program, Medication Management, Community Health Navigation, and Diabetes Management programs were implemented as part of this strategy.

2. **Evidence-based services during transitions in care and other periods of high risk**: This strategy targeted home-bound individuals with food insecurity who had recently developed diabetes, and family caregivers who were vital in the support of community living of an older adult. The services under this strategy emphasize to ensure family caregivers are recognized and getting the support they need from community delivered services and address high cost of care topics. REACH-II, Respite Care, and Diabetes Nutrition Counseling are included in this strategy.

3. **System change in how citizens of Tarrant County receive health services**: This third strategy is apart from the specific health programs provided to individuals. Targeting leaders of community-based health program, this strategy encouraged inter-organizational collaboration and support programs that addressed health literacy. This strategy encourages building health-literate organization by assessing needs and services for patients, families, health care providers, and community-based organizations with a systems approach. Emphasizing three components (symposium, clinical engagement, and library training), this strategy address the unmet need of health literacy in Tarrant County.
Figure 1. LIVE WELL Initiative Framework

**Bold Goal:** LIVE WELL Initiative will have improved the lives of 17,000 adults with ongoing health concerns by 2020

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**Strategies:**
1. Early management of chronic disease
2. Evidence-based services during transitions in care and other periods of high risk
3. System change in how citizens of Tarrant County receive health services

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**Priority Population:**
- Adults with chronic conditions
  - Family caregivers of adults with chronic diseases
  - Homebound older adults with chronic conditions
- Adults age 35+ with chronic conditions and their caregivers

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**Mechanisms of Action:**
- Patient education and engagement in healthy behaviors
- Patient self-management of symptoms
- Management of medications
- Screenings
- Community delivered services
  - Target high cost of care topics
  - Innovative care services
- Assessment of needs and services that includes patients/families, healthcare providers, and CBOs
- Community education and engagement in health; health literacy
- Development of other payers for strategies 1 & 2

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**Outcomes:**
- Quality of Life: CDC Healthy Days
  - Quality of Life - caregivers
  - Utilization of formal care
- # of organizations engaged
- # of new payers
- Assessment of collective impact

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**Programs:**
- A Matter of Balance
- Stanford Chronic Disease Self Management
- HomeMeds
- Community Health Navigation/Patient Activation Measure
- DiabetesSalud!
- REACH II
- Respite Care
- Diabetes/Nutrition Counseling
- Health Literacy
Key Partners

The UWTC partnered with six key community-based service organizations to provide health programs that address the immediate needs of individuals at risk of poor health outcomes. The programs also provide health promotion activities that engage adults in self-management techniques and healthy behaviors that are associated with better health and, long term, with lower healthcare costs (e.g., fewer hospitalizations, less need for nursing home care). Program evaluation activities were provided by a regional health care system. Organizations are presented below.

Sixty and Better
Sixty and Better, Inc., formerly Senior Citizen Services of Greater Tarrant County, Inc., was established in 1967 and is devoted to providing programs and services to empower older adults to live with purpose, independence and dignity. Sixty and Better provides nutritious meals, transportation, socialization and volunteer opportunities in addition to wellness programs such as A Matter of Balance and Health for Me / Chronic Disease Self-Management in neighborhood activity centers throughout Tarrant County. A nonprofit, nonpartisan organization, Sixty and Better serves more than 3,000 older adults annually.

Meals on Wheels
Meals On Wheels, Inc. of Tarrant County (MOWTC) is a 501(c)(3) not-for-profit charitable organization that started in 1973 as a collaboration between 11 faith-based organizations in downtown Fort Worth to bring food to the elderly in the central city area. Over the years, MOWTC has grown and now serves all of Tarrant County, providing approximately 1 million meals each year to some of Tarrant County’s most frail citizens. By providing home-delivered meals, professional case management, and other needed items or services to their homebound, elderly and disabled clients, MOWTC enables them to continue living independently in their own homes, surrounded by a lifetime of memories.

Alzheimer’s Association North Central Texas Chapter
The North Central Texas Chapter is committed to helping people with dementia and those who care for them in whatever ways it can. In addition to core programs such as Helpline, education events and support groups, the Chapter offers innovative early stage and personalized support programs.

Easterseals North Texas
As a nonprofit organization, Easterseals North Texas has provided services for individuals with disabilities and their families since 1939. Each year, with the assistance by Easterseals North Texas, over 5,000 individuals of all abilities are able to live, learn, work and play in their communities. Easterseals North Texas has a longstanding history in their community of providing unique programs and services for individuals with a wide variety of disabilities, including Autism Spectrum Disorder, Alzheimer’s disease, Down syndrome, Cerebral Palsy, Mental and...
Developmental Delays. The services from Easterseals North Texas continue to evolve with the needs of the community, and are provided in Fort Worth and North Dallas centers. In some cases, they can bring our services to client’s home.

North Texas Area Community Health Center
Founded as a collaboration of area residents, faith-based groups, and health and social services providers, North Texas Area Community Health Centers (NTACHC), Inc. (formerly, Fort Worth Northside Community Health Center) operates three clinics strategically located in the Northside and Southeast Fort Worth and in Arlington. The NTACHC offers a full range of quality family-oriented comprehensive primary and preventive services, including Family Medicine, Pediatrics, OB-GYN, family planning services, prenatal care, behavioral care services (depression and anxiety counseling) and health education promotion and disease prevention services.

UNT Health Science Center
Located in the Fort Worth cultural district, the University of North Texas Health Science Center is a values-based institution whose mission is to transform lives in order to improve the lives of others. The University enrolls 2,700 graduate students who are pursuing degrees in public health, medicine, bio-medical science, pharmacy, physical therapy, and physician assistant studies. The University is well-positioned for rapid expansion, matching the growing population and economic vitality of the DFW Metroplex. Under the LIVE WELL Initiative, the University of North Texas Health Science Center takes a lead to implement a systems approach to addressing health literacy in Tarrant County.

Evaluation Team: Baylor Scott and White Health: Center for Applied Health Research
Baylor Scott & White Health (BSWH) is the largest non-profit healthcare provider in Texas. BSWH includes 50 hospitals and more than 1,000 patient care sites. The research programs of the Center for Applied Health Research are diverse, demonstrating collaborative efforts on advanced applied health research. The full spectrum of health care delivery research includes respective analyses of EHR clinical and administrative data, development and testing of innovative care models within healthcare and community settings, the impact of care delivery on the health and well-being of individuals and families, and the larger impact of health programs on population health.

LIVE WELL Program
The A Matter of Balance program is an evidence-based, award-winning program designed to reduce the fear of falling and increase activity levels of older adults who have concerns about falling. The program is a structured group intervention which utilizes a variety of activities to address physical, social, and cognitive factors affecting fear of falling and to teach fall prevention strategies. The activities include group discussion, problem solving, skill building, assertiveness training, videotapes, sharing practical solutions and exercise training.

The Chronic Disease Self-Management Program is an evidence-based program developed by the Division of Family and Community Medicine in the School of Medicine at Stanford University. The purpose of the
original research was to develop and evaluate, through a randomized controlled trial, a community-based self-management program that assists people with chronic illness in 1996. Since then, the program has been implemented in 47 states and 22 countries. The program has been proven worldwide to reduce emergency room visits, hospitalizations, and nursing home placements. The workshops focus on teaching participants how to better manage their chronic health problems, how to deal with pain and isolation, proper use of medications, strategies for exercise and nutrition, and improved communication with family and health professionals. Following a proven curriculum, the trained lay leaders take a lead on six workshops.

The **HomeMeds** program is a licensed, evidence-based medication management program, which is designed to identify, address and resolve medication problems. The system collects consumer information along with three symptom-related questions (regarding falls, dizziness, and confusion). The case manager and/or pharmacy tech enters in the consumer’s list of medications into the web-based system which analyzes the data for potential medication problems. If an alert is generated, the pharmacy tech or individual charged with the project informs the consulting pharmacist who will advise on whether it is a confirmed problem that requires corrective action. The pharmacist will follow up if needed with the consumer’s physician or family to determine any medication changes.

The **Community Health Navigation** program uses trained Community Health Navigators (CHN) to work one-on-one with the target population to become better consumers of healthcare and improve communication with health care providers. Trained CHNs will use the evidence-based Patient Activation Measure (PAM) model to assess the client’s knowledge, skills, and confidence relative to self-management, and then develop an individually tailored plan to help the client become more confident and competent in self-management.

The **DiabetesSalud!** program is a replication of the Diabetes Equity Project (DEP) implemented by Baylor Health Care System in five charity clinics. The program provides clients diagnosed with diabetes with counseling and education to help them better self-manage their condition and improve or maintain their health status.

**Healthy Moves for Aging Well (HealthyMoves)** program is an evidence-based physical activity program designed to enhance health outcomes for frail, high-risk, and diverse older adults receiving services in the home. The program teaches older clients living at home exercises and teaches them how to maximize their independence by building strength, increasing flexibility, and helping to reduce the risk of falls.

**Resources for Enhancing Alzheimer’s Caregiver Health – Texas (REACH-TX)** program is a national award winning evidence-based intervention adapted for the community setting. Built upon the findings of REACH I, REACH II was funded in 2001 to design and test a single multi-component intervention among family caregivers of persons with Alzheimer’s Disease or related disorders (ADRD) at six participating national sites. The program provides tools, education and counseling that can help Alzheimer’s and dementia caregivers reduce stress and depression. The objectives of REACH-TX are to 1) identify and reduce modifiable risk factors among diverse family caregivers of patients with ADRD, 2) enhance the quality of care of the care recipients, and 3) enhance the well-being of the caregivers.

The **Respite Care** program provides temporary relief for caregivers including an array of services provided to dependent older individuals who need supervision. Services are provided in the older individual’s home environment for up to six months while the primary caregiver is unavailable or needs relief. In addition to supervision, services may include meal preparation, housekeeping, assistance with personal care and/or social and recreational activities. This allows caregivers regular opportunities to relax and take care of

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[4] Healthy Moves program was funded in Year 9 only.
themselves, which improves caregiver’s health and well-being while also lowering the risk of loved ones being placed in nursing homes.

The **Nutrition-Counseling** program screens clients for diabetes and nutritional risk and provides in-home and phone-based counseling by a registered dietitian. This program serves home-bound older adults in need of assistance in better managing their chronic conditions to reduce preventable hospitalizations and emergency room visits. During the summer of 2009, the National Association of Area Agencies on Aging awarded United Way’s Area Agency on Aging the First Place Achievement and Innovation Award for its Diabetes Screening and Counseling Program. Through the LIVE WELL Initiative, this program has been replicated and expanded, utilizing tools and protocols from the evidence-based Diabetes Detection Initiative.

The **Health Literacy** initiative employs a multi-prong approach to create systems change in addressing health literacy in Tarrant County. This initiative is charged to develop and strengthen networks and connections among clinical organizations, organizations providing community-based health resources, and health professionals in general, to build health-literate institutions. Because it addresses the underlying causes of hospitalizations, health literacy among patients and organizations plays an integral role in achieving desired outcomes in all areas of the LIVE WELL initiative. Evidence-based programs such as AMOB and CDSMP have been embraced by four local hospital systems and University of North Texas Health Science Center as part of the wellness efforts.

**LIVE WELL Funding**

Table 1 below shows the total funding amounts that each LIVE WELL organization received from 2010 to 2019.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Program</th>
<th>Amount Invested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sixty and Better (formerly Senior Citizen Services)</td>
<td>A Matter of Balance (AMOB)</td>
<td>$1,756,905</td>
</tr>
<tr>
<td></td>
<td>Chronic Disease Self-Management Programs (CDSMP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HomeMeds</td>
<td></td>
</tr>
<tr>
<td>Meals On Wheels</td>
<td>HomeMeds</td>
<td>$3,051,731</td>
</tr>
<tr>
<td></td>
<td>Community Health Navigator/Patient Activation Measure (PAM)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes and Nutrition Screening &amp; Counseling</td>
<td></td>
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<tr>
<td></td>
<td>Healthy Moves</td>
<td></td>
</tr>
<tr>
<td>North Texas Area Community Health Center</td>
<td>Diabetes Salud!</td>
<td>$680,333</td>
</tr>
<tr>
<td>Alzheimer’s Association</td>
<td>REACH II</td>
<td>$1,908,021</td>
</tr>
<tr>
<td>Easter Seals North Texas</td>
<td>Respite Care</td>
<td>$3,339,452</td>
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<tr>
<td>UNT Health Science Center</td>
<td>Health Literacy</td>
<td>$247,046</td>
</tr>
<tr>
<td>Baylor Scott and White Health</td>
<td>Evaluation</td>
<td>$575,000⁵</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$11,558,488</td>
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</tbody>
</table>

⁵ This includes $10,000 that was paid to UNT Health Science Center for the evaluation in FY 10-12.
Performance Overview

In line with the overall UWTC 2020 Bold Goal, LIVE WELL Initiative set the bold goal of improving the lives of 17,000 adults by 2020. Moreover, LIVE WELL Initiative acknowledged the importance of health screening by setting a second Bold Goal of touching the lives of 63,000 adults with ongoing health concerns by 2020. From 2010 to 2019, LIVE WELL Initiative served 44,790 clients of whom 18,149 have documented positive health outcomes (i.e., lives improved by maintaining or improving standardized health outcomes). A total of 63,102 lives were touched with health screening activities. This translates into 106.8% of the Lives Improved Bold Goal and 100.2% of the Lives Touched Bold Goal being achieved and exceeded.

I. LIVE WELL Initiative Bold Goal Attainment

**Bold Goal: LIVE WELL Initiative will have improved the lives of 17,000 adults with ongoing health concerns by 2020**

### Adults with Maintained/Improved Health Status

<table>
<thead>
<tr>
<th>Year</th>
<th>Adults with Maintained/Improved Health Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11</td>
<td>915</td>
</tr>
<tr>
<td>2011-12</td>
<td>1,525</td>
</tr>
<tr>
<td>2012-13</td>
<td>813</td>
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<tr>
<td>2013</td>
<td>714</td>
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<td>2014</td>
<td>2,313</td>
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<tr>
<td>2015</td>
<td>3,465</td>
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<td>2016</td>
<td>3,426</td>
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<tr>
<td>2017</td>
<td>2,685</td>
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<tr>
<td>2018</td>
<td>2,293</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>18,149</strong></td>
</tr>
</tbody>
</table>

### Lives Touched

<table>
<thead>
<tr>
<th>Year</th>
<th>Lives Touched</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11</td>
<td>5,873</td>
</tr>
<tr>
<td>2011-12</td>
<td>6,202</td>
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<tr>
<td>2012-13</td>
<td>8,122</td>
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<tr>
<td>2013</td>
<td>3,870</td>
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<tr>
<td>2014</td>
<td>8,087</td>
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<tr>
<td>2015</td>
<td>8,407</td>
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<tr>
<td>2016</td>
<td>7,924</td>
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<tr>
<td>2017</td>
<td>7,028</td>
</tr>
<tr>
<td>2018</td>
<td>7,589</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>63,102</strong></td>
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6 The current evaluation team was unable to verify the data on the touched lives and improved lives for first 2 years. Lives touched and improved for the first 2 years provided by United Way staff and former evaluator were included and calculated.
II. **Participant Reach**

Identifying and serving the largest number of citizens of Tarrant County with health-related needs essential to achieving the UWTC 2020 Bold Goal. Thus, the UWTC worked with partner organizations to set yearly goals for the number of individuals served by the partner organizations. This was defined as “output targets.” Output achievements for 9 years are presented in Table 2.

<table>
<thead>
<tr>
<th>Strategy</th>
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<tbody>
<tr>
<td>Early management of chronic disease</td>
</tr>
<tr>
<td>Sixty and Better (formerly Senior Citizen Services)</td>
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<tr>
<td>Evidence-based services during transitions in care and other periods of high risk</td>
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<td>REACH-TX</td>
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<tr>
<td>Easter Seals</td>
</tr>
<tr>
<td>in-home respite services</td>
</tr>
<tr>
<td>Meals On Wheels</td>
</tr>
<tr>
<td>Individualized diabetes and/or nutritional counseling</td>
</tr>
<tr>
<td>Screening for diabetes and nutritional risk</td>
</tr>
<tr>
<td>System change in how citizens of Tarrant County receive health services</td>
</tr>
<tr>
<td>University of North Texas Health Science Center</td>
</tr>
<tr>
<td>Health Literacy Universal Precautions Toolkit Training for Clinicians</td>
</tr>
<tr>
<td>Health Literacy Symposium</td>
</tr>
<tr>
<td>Health Literacy Training for Librarians</td>
</tr>
</tbody>
</table>

Table 2: Summary of Output Achievements for Clients Enrolled July, 2010 – December, 2018 by Strategy

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Organization</th>
<th>Program</th>
<th>Number Served*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early management of chronic disease</td>
<td>Sixty and Better (formerly Senior Citizen Services)</td>
<td>A Matter of Balance</td>
<td>3,675</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chronic Disease Self Management</td>
<td>2,888</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening for diabetes and nutritional risk</td>
<td>12,313</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HomeMeds</td>
<td>753</td>
</tr>
<tr>
<td>Meals On Wheels</td>
<td>HomeMeds</td>
<td>15,427</td>
<td></td>
</tr>
<tr>
<td>North Texas Area Community Health Center</td>
<td>Community Health Navigator</td>
<td>1,144</td>
<td></td>
</tr>
<tr>
<td>North Texas Area Community Health Center</td>
<td>DiabetesSalud!</td>
<td>2,642</td>
<td></td>
</tr>
<tr>
<td>Evidence-based services during transitions in care and other periods of high risk</td>
<td>Alzheimer’s Association</td>
<td>REACH-TX</td>
<td>2,381</td>
</tr>
<tr>
<td>Easter Seals</td>
<td>in-home respite services</td>
<td>1,273</td>
<td></td>
</tr>
<tr>
<td>Meals On Wheels</td>
<td>Individualized diabetes and/or nutritional counseling</td>
<td>9,779</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Screening for diabetes and nutritional risk</td>
<td>29,923</td>
<td></td>
</tr>
<tr>
<td>System change in how citizens of Tarrant County receive health services</td>
<td>University of North Texas Health Science Center</td>
<td>Health Literacy Universal Precautions Toolkit Training for Clinicians</td>
<td>1,050</td>
</tr>
</tbody>
</table>

* Duplicate clients across programs and years are included.
III. Participant Impact

Since outcome measures are the most reflective of the health of those served, the UWTC worked with the Evaluation Team to set goals for the level of health improvement expected from each program. UWTC’s health outcome goals were defined as “performance standards” as they reflect the performance (or impact) of the program on the clients who received services. The performance standards indicate a meaningful measure for both the organization and UWTC by combining output and outcome data. Table 3 presents the performance standard achievements for 7 years.

![Table 3. Performance Standard Achievements for Clients Enrolled July, 2013 – December, 2018](image)

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*Performance standards for Years 1-2 were not available to evaluate.*
**IV. Outcome Achievements**

Partner organizations collect data on the impact of services on the health and well-being of clients who were served. Collecting standardized outcome measures prior to service delivery (baseline) and at meaningful time points after service delivery (follow-up) allowed the impact of services on the health and well-being of clients to be assessed. Each program collected two sets of outcome measures; a) common measures used to assess all programs, and b) program-specific measures to assess outcomes unique to each program.

### A. Common Measures

**CDC Healthy Days.** The following two charts present two outcome variables from the common measure CDC Healthy Days Core Module data at baseline and follow-up for each LIVE Well program. Below is an accumulative summary for all programs.

<table>
<thead>
<tr>
<th>Program</th>
<th>Outcome Measures</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meals On Wheels</td>
<td>50%/50% Healthy Moves participants will Maintain or have an improved number of</td>
<td>Physical or mental health days at follow-up assessment</td>
</tr>
<tr>
<td></td>
<td>demonstrate improved physical strength at follow-up assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>indicate that they somewhat or more likely to continue exercising at follow-up</td>
<td></td>
</tr>
<tr>
<td></td>
<td>assessment</td>
<td>66</td>
</tr>
<tr>
<td>Alzheimer's Association/Easter Seals</td>
<td>65%/65% REACH II/Respite Care caregivers will Maintain or have an improved number</td>
<td>Physical or mental health days at follow-up assessment</td>
</tr>
<tr>
<td></td>
<td>of physical or mental health days at follow-up assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>have an improvement in their quality of life at follow-up assessment</td>
<td>2,219</td>
</tr>
<tr>
<td></td>
<td>Less than 20% of care recipients will be placed in a nursing home within 6 months</td>
<td></td>
</tr>
<tr>
<td>Meals On Wheels</td>
<td>65% Diabetes/Nutrition Counseling participants will Maintain or have an improved</td>
<td>Physical or mental health days at follow-up assessment</td>
</tr>
<tr>
<td></td>
<td>number of physical or mental health days at follow-up assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2,176</td>
</tr>
<tr>
<td>System change in how citizens of Tarrant</td>
<td>University of North Texas Health Science Center 50%/50%/50% Health Literacy</td>
<td>Demonstrate improved capacity to engage clients/patrons/patients in</td>
</tr>
<tr>
<td>County receive health services</td>
<td>trainees will Maintain or have an improved number of physical or mental health</td>
<td>accessing, obtaining, and understanding health information/resources.</td>
</tr>
<tr>
<td></td>
<td>days at follow-up assessment</td>
<td>80</td>
</tr>
</tbody>
</table>

* Performance standard for each program is shown in Year 9 or its last funding years.

** Improved numbers in Years 1 and 2 are not included.
1. **CDC Healthy Days Module - General Health**
   - All programs showed overall percent improvement for participants who rated their general health good, very good, and excellent from baseline to follow-up assessment (Figure 2).

![Figure 2. Good, Very Good, Excellent Health Condition at Baseline & Follow-up](image-url)
2. **CDC Healthy Days Module- Healthy Days**
   - All programs showed improved healthy days\(^8\) from baseline to follow-up assessment (Figure 3).

---

\(^8\) Healthy Days estimates the number of days when a client’s physical and mental health was good (or better) and is calculated by subtracting the number of unhealthy days from 30 days.
**NHIS Health Care Utilization.** Below is an accumulative summary for all programs for two outcome variables from the common measure NHIS Health Care Utilization Core Module data at baseline and follow-up for the LIVE Well program. Since health care utilization varied greatly across and within programs, data are presented in aggregate (Figure 4).

- The overall percent of clients who had hospitalized overnights declined from 15.9% at baseline to 8.9% at follow-up assessment (NHIS Health Care Utilization).
- The overall percent of clients who had emergency room visits declined from 22.4% at baseline to 16.0% at follow-up assessment (NHIS Health Care Utilization).

![Figure 4. NHIS Health Care Utilization at Baseline & Follow-up](image)

**B. Program Specific Outcomes**

Each program collects standardized outcomes to show the impact of targeted services with program objective. Table 4 presents selected program specific outcomes and achievements from baseline to follow-up. The service delivery and impact of services are summarized in detail on Appendices A to J.

<table>
<thead>
<tr>
<th>Program</th>
<th>Outcome Measure</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMOB</td>
<td>Falls Efficacy Score</td>
<td>Clients who enrolled in AMOB program showed significant improvements in falls efficacy score from baseline to graduation.</td>
</tr>
<tr>
<td>CDSMP</td>
<td>Self-Efficacy Score</td>
<td>Clients who enrolled in CDSMP showed significant improvements in managing their health from baseline to graduation.</td>
</tr>
</tbody>
</table>
V. Collective Impact and Systems Change
The United Way and LIVE WELL Initiative partners have worked together to achieve collective impact and systems change. The evaluation team analyzed selected aspects of collective impact and systems changes. Below is a summary of the components in addition to systems change.

- **Common Agenda:** LIVE WELL programs are committed to empowering adults with chronic conditions to live with independence, purpose and dignity. Goals of the LIVE WELL programs align with goals of the LIVE WELL initiative and highlight the impact and successes of their services and further contribute to fewer hospitalization use, positive impact on quality of life measures, enhancing care, supporting all affected by the disease, and tax dollar savings.

- **Shared Measurement System:** All programs funded by LIVE WELL Initiative (except Health Literacy) collect common measures: CDC Healthy Days Module and NHIS Healthcare Utilization. Collected data have been primarily used for quarterly evaluation reports as well as for funding opportunities and local & national presentations to show improvement in health status. Some programs share de-identified data with other organizations inside and outside of the LIVE WELL Initiative. Programs share data for the purpose of seeking funding via grant writing, fundraising efforts, on-going evaluation, process improvement and to evaluate other research questions.

<table>
<thead>
<tr>
<th>Program</th>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS HomeMeds</td>
<td>Medication Adherence Score</td>
<td>The level of high medication adherence increased from baseline and follow-up assessments among clients who had medication reviews.</td>
</tr>
<tr>
<td>MOW HomeMeds</td>
<td>Utilize revised medication list</td>
<td>After the medication review, 88.8% of participants used or plan to use the revised medication list at an appointment of primary care provider.</td>
</tr>
<tr>
<td>CHN</td>
<td>Patient Activation Management Score</td>
<td>Over 60% of participants showed significant improvement in Patient Activation Management Score from baseline to follow-up assessment.</td>
</tr>
<tr>
<td>Diabetes Salud!</td>
<td>HgA1c level</td>
<td>Overall percent of participants with diabetes decreased from 82.0% at initial assessment to 57.9% at 6 month follow-up assessment.</td>
</tr>
<tr>
<td>REACH-TX</td>
<td>Caregiver’s Quality of Life</td>
<td>Caregivers who completed REACH-TX showed significant improvements over 6 months in all five domains of quality of life.</td>
</tr>
<tr>
<td>Respite Care</td>
<td>Care recipient’s Nursing Home Replacement</td>
<td>Only 7.4% of care recipients was placed in a nursing home within 6 months (OR, 92.6% of care recipients still stay at community living after receiving service for 6 month).</td>
</tr>
<tr>
<td>Nutrition-Counseling</td>
<td>Individual Goal Achievement</td>
<td>A total of 1,898 goals were met all of the time.</td>
</tr>
<tr>
<td>Health Literacy</td>
<td>Level of knowledge, practices, &amp; intentions of health literacy</td>
<td>Clients enrolled health literacy program showed significant improvement in knowledge, practices, and intentions of health literacy from baseline to follow-up assessment.</td>
</tr>
</tbody>
</table>
• **Accountability Structure**: Don Smith, a lead director of Community Development-Health as well as the Director of the Area Agency on Aging, served in leadership and provided sufficient structure and staff to support and empower programs and organizations in the LIVE WELL Initiative. Under his leadership, partners and the evaluation team sufficiently held programs accountable for program goals and accomplishing program goals.

• **Ongoing Communications**: Partners actively had ongoing communication with other LIVE WELL partners via face-to-face, phone, and email on a regular basis. Communications with partners was related to ways in which to collaborate in serving clients and reaching goals, co-planning events or presentations, program guidelines/processes, program eligibility criteria, referral process, case staffing, resource sharing, promotional materials, community outreach, continuity of care for client, identification of needs, and collaborative outreach.

• **Mutually Reinforcing Activities**
  o Health Education and Literacy Program (HELP) Consortium: Members of all LIVE WELL programs and United Way staff created the Health Education and Literacy Program (HELP) Consortium to increase collaboration among LIVE WELL partners and create a more streamlined initiative overall. Joint marketing materials were developed and a centralized HAIL referral line was established at the AAA/ADRC (Year 6).
  o A symposium at the Gerontological Society of America (GSA) Conference LIVE WELL partners together organized a symposium at the GSA in November, 2015. The Evaluation team led and worked with United Way staff, MOWI, and SCS (now known as Sixty and Better) to present the LIVE WELL initiative and its efforts to improve community based services for those with chronic conditions and their caregivers. A reporter from Dallas Morning News attended to the symposium. The LIVE WELL initiative obtains statewide and nationwide attention to community programs providing services to individuals at risk of poor health (Year 6).
  o Model for Alzheimer’s/Dementia Services: Partners (UWTC, AA, ES, MOW, SCS, BSWH) collaborated with James L. West Alzheimer’s Center and UNT Health Science Center established Model for Alzheimer’s/Dementia Services (MAS) to provide services to underserved groups who either have, or are at high risk of developing, Alzheimer’s Disease and related dementias (Years 7-9).
  o MOW HomeMeds implemented in SCS (now known as Sixty and Better): MOW hired a pharmacy technician to conduct HomeMeds in SCS (now known as Sixty and Better) senior centers throughout Tarrant County (Year 7).
  o SCS (now known as Sixty and Better) provided evidence based workshops in partnership with organizations including, but not limited to, Tarrant County Public Health, JPS Health Network, Texas Health Resources, Medical City Fort Worth, Scott & White Baylor Grapevine, and University of North Texas Health Science Center (Year 7).
  o Four hospitals incorporated evidence-based programs as part of their wellness outreach to the community (Year 7).
  o University of North Texas Health Science Center incorporated AMOB and CDSMP as part of their academic curriculum and community service (Year 7).
o AA collaborated with MOW and other agencies to work with Guardianship Services Inc.’s new Financial Exploitation Prevention Center (FEPC) of Tarrant County to prevent, recognize and report exploitation of a caregiver or their loved one (Year 8).

o UNTHSC residents received enhanced geriatric experiences at JPS and Medical City hospitals through MOW Nutrition-counseling program (Year 8).

o University of North Texas Health Science Center incorporated MOW HomeMeds for outpatient clinic on Geriatric Assessment and Planning Program (Year 8).

o Model for Alzheimer’s/Dementia Services for People Living Alone (MASPLA): An expansion of MAS established to provide services to prolong safe and independent living in the community for 6 additional months for people who are living alone with Alzheimer’s Disease/Related Dementia (ADRD) (Year 9).

o AA received additional funding and resources from Morris Foundation and WellMed Foundation to support the REACH program and referrals of clients (Year 9).

- Systems Change
  
o Underserved populations (e.g., minority, LGBT communities) were targeted to be engaged by LIVE WELL partners.

  o LIVE WELL partners were involved in events/presentations/meetings at local, state, and at the national level to advocate policy change for community-based services for people with chronic conditions and their caregivers
    ▪ AA: National Alzheimer’ Project Act, Spring Caregiver Seminar, Texas State Advocacy Day for Alzheimer’s
    ▪ MOWI: Meals on Wheels America Annual Conference, Meals on Wheels in Texas
    ▪ AAA: National Association of Area Agencies on Aging
    ▪ Evaluation team senior leader, Dr. Alan B. Stevens, served National Academies’ Institute of Medicine study committee on Family Caregiving for Older Adults. Their recommendations were published in a report in 2016.

  o Peer-reviewed manuscript publications & presentation: Evaluation team led and worked with LIVE WELL partners (MOW, AA) to publish several manuscripts, which resulted in national recognition of LIVE WELL Initiative.

**Evaluation Team**

As a partner and an independent evaluator, the evaluation team played the critical role of leading an unbiased, formal evaluation of implementation and outcomes of all projects. The evaluation team served as the interface between and among the UWTC and the CBOs charged with providing health services. The evaluation team was charged with designing and standardizing data collection at the CBOs, collecting data from CBOs and producing meaningful data reports to the CBOs and to UWTC.

The role of the evaluation team on the LIVE WELL Initiative were,

1) To provide evaluation consultation and data reports to support the efficiently and effectively of actions taken by the UWTC and its community partners to achieve milestones and BOLD Goal
2) To assess the degree to which the Initiative was achieving desired outcomes for adults with chronic conditions and their caregivers in particular as well as guide efforts to improve outcomes
3) To assess each service strategy independently, and as a collective initiative
4) To recommend course corrections and prepare periodic reports for partners and stakeholders
5) To disseminate LIVE WELL initiative findings in the academic community

The LIVE WELL Initiative evaluation process began with the creation of strategies and progressed through three stages, and the documentation of the programs' outreach, efforts, and impact.

I. Evaluation Process

1. Development of Evaluation Strategies

The LIVE WELL Initiative was evaluated based on the activities provided by the funded programs (outputs), the impact of services on the health and well-being of clients served (outcomes), and the programs' contribution to attaining UWTC’s health improvement goals linked to each health program (performance standards). The evaluation team developed strategies for measuring outputs, outcomes and performance standards and collated measures into a comprehensive report of the status individual programs as well as the initiative as a whole.

2. Understanding the individual programs

The evaluation team individually met with each of the partner organizations funded by the LIVE WELL Initiative to understand the organizations' culture, specific information on service delivery and existing data collection and management infrastructure. Conference calls and e-mail communication were important for eliciting feedback from partner organizations outside of regularly scheduled meetings. An annual meeting with all the Initiative partners and the UWTC leadership was held to discuss annual funding of projects, programmatic issues that impacted all of the partner organizations and significant changes to the evaluation model.

3. Monitoring program activities

Monitoring program activities, including conducting fidelity assessments of the evidence-based and/or informed programs was an ongoing activities of the evaluation team. This allowed the evaluation team to assess program implementation, and mechanisms of action that drove the desired outcomes of each program. For example, ongoing assessment would include the number of courses offered to the community, number of lay volunteers trained, number of courses led by lay volunteers, completion rate of enrolled clients, or the degree to which program providers' ability to deliver the essential elements of programs would contribute to success in service provision. These are a few examples of how the evaluation team monitored program implementation. The evaluation team reported these data in real time to the UWTC.
4. Executing the evaluation plan

The core of evaluation model was the assessment service delivery to target populations (outputs) and client status on standardized outcome measures (outcomes) prior to service delivery (baseline) and at meaningful time points after services (follow-up) were delivered. Outputs were defined as annual goals for the number of individuals served by each program and set by UWTC and each organization, whereas outcomes were defined as standard measures that showed the impact of services on the health and well-being of clients. As reflective of changes in health status among clients served, performance standards were used to progress toward meeting the Bold Goal (Tables 2-4).

On data collection, the evaluation team created data collection protocols for each program. Trained staff guided by the data collection protocols conducted data collection. The designated staff in partner organizations generated quarterly data reports and sent to the evaluation team. The evaluation team was charged with data cleaning, data management and data reporting.

Furthermore, UWTC and all LIVE WELL Initiative partners worked together to achieve collective impact and systems change. To assess this impact, the evaluation team conducted qualitative interviews with LIVE WELL Initiative partners that focused on all components of collective impact, which included information on the common agenda, shared measurement system, accountability, ongoing communications, mutually reinforcing activities, and systems change at local and national levels (See V. Collective Impact and Systems Change).

5. Documenting the Impact of the LIVE WELL Initiative

Reports included the UWTC-set targets as well as program’s achievement for each output and outcome. Demonstrating outputs, outcomes, and performance standards provided how the programs met their target goals throughout the year and guidance about how to make informed decisions about funding for the upcoming year. Following the initial year, three reports were provided annually—at six months, nine months, and at the fiscal year’s end (annual report). In addition to written reports, evaluators presented oral findings to partners for the current funding year, accomplishments, areas for improvement, and changes for the upcoming year.

II. Contribution and Dissemination Efforts

The Evaluation team has worked with the LIVE WELL partners to disseminate finding to the academic audience. This includes original research manuscripts on LIVE WELL Initiative that have been published, or are under review in scientific journals. In addition, the evaluation team presented at multiple state and national conferences.

1. Publications


2. Manuscripts (under review)


3. Conference presentations


o Cho, J. (2014). What is the Value of Home-Delivered Meals for Older Adults? Meals on Wheels Association of Texas Conference, Dallas, TX


o Powell, S. & Robinson, K. (2014). Healthy at Home... Surely Its Not This Simple. Presented at the Academy of Nutrition and Dietetics Food and Nutrition Conference and Expo. Atlanta, GA.


o Cho, J., Throud, J. L., & Stevens, A. B. (2016). Impact of a community-based implementation of a caregiver support program and respite care program on quality of
III. Lessons Learned from the LIVE WELL Initiative

1. Achieving Collaboration with Multiple Stakeholders
The LIVE WELL Initiative encompasses numerous stakeholders, including partner organizations, United Way, evaluation team, and clients receiving services. Trust, cooperation of the community partner organizations and their service providers, the United Way, day-to-day communications including conference calls and emails allowed all stakeholders to be on the same page and time to review changes, ask questions, and initiate discussions before changes were made. As a result, all of the organizations supported each other and helped promote the value of each other’s work.

2. Overcoming Challenges
The biggest challenge in working with community organizations is associated with different emphases on tasks and processes. The LIVE WELL Initiative partnered with community organizations to complete an evaluation that required a collective, strategic approach. The primary objective of partner organizations is service delivery to their target clients instead of data collection. To overcome the gap between two ends (i.e., evaluation vs. community organizations), the LIVE WELL Initiative partners were required to find reasonable compromises that would work for both sides and accommodate clients’ needs by emphasizing the impact of the evaluation (e.g., more funding opportunities).

3. Achieving Sustainability
From the beginning, sustainability has been a focus over the course of the Initiative and is needed for capacity building for those who are responsible for implementing the intervention in the
future. The LIVE WELL Initiative partners have reached out and created new partnerships with other community partners, such as local hospital systems and county public health departments in order to keep serving clients. In addition, some partners have applied for funding through grant submissions and private funding to continue with their services.

**Future Plans for Sustainability**

**Moving to next step**

The LIVE WELL Initiative funding from United Way of Tarrant County achieved many successes and made a clear impact on the health of over 17,000 citizens of Tarrant County. Partner organizations have worked with UWTC and the evaluation team to both embed LIVE WELL Initiative funded programs into the culture of the organization as well as seek other community partners and funders who are stakeholders in the programs. This has led to the submission and funding of numerous grant applications to extend the work funded by the LIVE WELL Initiative.

**Grant Applications that Support the Sustainability of LIVE WELL Initiative**

- Model for Alzheimer’s/Dementia Services (PI: Donald Smith, United Way of Tarrant County), Administration for Community Living, 2016-2019.
- Model for Alzheimer’s/Dementia Services focused on People Living Alone (MASPLA) (PI: Donald Smith, United Way of Tarrant County), Administration for Community Living. **Active grant.** 2019-2020.
- Evaluation of Home-delivered Evidence-based programs project (PI: Donald Smith, United Way of Tarrant County), Administration for Community Living. 2018 Submitted
- Evaluation of Nutrition Education for Independent Living (NEIL) Project (PI: Donald Smith, United Way of Tarrant County), Administration for Community Living. 2017 Submitted.

**Ongoing efforts aimed towards the sustainability of LIVE WELL Initiative** include:

- Dissemination with a “community friendly” format which could be used in traditional and social media outlets
- National exposure for the Initiative which would be used to develop evaluation strategies to promote successful partnerships in community settings
- Archiving central data repository would make the data available to others who are working to improve the health of adults with chronic disease and improve health services in communities across the United States.
Conclusion

In response to the United Way of Tarrant County’s 2020 Bold Goal, the LIVE WELL Initiative (formerly, Healthy Aging and Independent Living Initiative) identified a Bold Goal of having improved the lives of 17,000 adults with ongoing health concerns by the year 2020. Strategies to improve health outcomes for adults with ongoing health concerns were established.

Partnered with seven organizations supporting 10 programs, the Live Well Initiative provided proven strategies woven into a comprehensive set of health programs that target individuals at high risk of placement into a nursing facility and other poor outcomes such as preventable admissions and readmissions to hospitals, as well as services that promote healthy lifestyles in the management of chronic conditions.

With nine year of efforts, the LIVE WELL Initiative successfully achieved and exceeded its Bold Goal of having improved the lives of adults with ongoing health concerns:

- 63,102 cumulative adults served and/or received home-based care and evidence-based programs.
- 18,149 adults maintained and improved health status.

The impact of services on the health and well-being of clients who served are also shown in outcome measures. Overall, the LIVE WELL Initiative showed improved changes in standardized outcome measures prior to service delivery and at after service delivery. Each program collected standardized outcomes also showed improved in program specific outcomes and achievements from baseline to follow-up. Details are on Appendices A to J.

- The overall percent of participants who rated their health good, very good, and excellent improved from 52.1% at baseline to 66.6% at follow-up assessment (CDC Healthy Days Module).
- The average healthy days for clients improved from 16.0 days at baseline to 20.7 days follow-up assessment (CDC Healthy Days Module).
- The overall percent of clients who had hospitalized overnights declined from 15.9% at baseline to 8.9% at follow-up assessment (NHIS Health Care Utilization).
- The overall percent of clients who had emergency room visits declined from 22.4% at baseline to 16.0% at follow-up assessment (NHIS Health Care Utilization).

Under common agenda for improve health and well-being among adults with chronic conditions and their caregivers, over nine year efforts of The LIVE WELL Initiative partners also achieved successful impact on the community. Below are factors contributed to the success of the LIVE WELL Initiative:

- Collecting data with common measures
- Providing leadership and guidance to support the Initiative programs
- Active communication among partners on a regular basis in servicing clients and for outreach purpose
- Dissemination with multiple outlets to advocate policy change for caregivers and older adults with chronic conditions (e.g., attending meetings at local and national conferences, manuscript and grant application submissions)

The LIVE Well Initiative provided further insight into the direction of community-based health programs and strategies for how these partnerships can be successful in addressing the needs of individuals at risk of poor health outcomes and overall, reducing healthcare costs.
Appendices

Appendix A. A Matter of Balance
Appendix B. Chronic Disease Self-Management Program
Appendix C. SCS (now known as Sixty and Better) HomeMeds
Appendix D. MOW HomeMeds
Appendix E. Community Health Navigation
Appendix F. DiabetesSalud!
Appendix G. REACH-TX
Appendix H. Respite Care
Appendix I. Nutrition-Counseling Program
Appendix J. Health Literacy
A Matter of Balance (AMOB)

Findings as of NOVEMBER 2019

United Way of Tarrant County
LIVE WELL Initiative

Jennifer Severance
Christina Bartha
Jerry Mosman
Monique Barber
A Matter of Balance (AMOB)

- Helps older adults reduce the fear of falling and encourages physical activity
- Evidence-based intervention facilitated by trained lay leaders
- Eight 2-hour sessions

Desired Outcomes
- View falls and fear of falling as controllable
- Set realistic goals for increasing activity
- Change participants’ environment to prevent falls
- Increase strength and balance through exercise

Why is Falls Prevention important?

Falls and fall-related injuries are a public health issue; they often have serious consequences for older adults and can lead to loss of independence.

Every year, approximately 40% of adults aged 65 or older fall at least once\(^1,2\); falls are the leading cause of unintentional injuries and injury deaths among adults aged 65 or older.

In 2000, the total direct cost of fall-related nonfatal injuries for this population in the United States was approximately $19 billion\(^3\).

---

PARTICIPANT’S CHARACTERISTICS

Female (2,888) 79.4%
Male (748) 20.6%

N=3,636

Average Age: 76.6 years old
Participants ranged from age 29-100

Geographic Region of Tarrant County | N | %
--- | --- | ---
Northeast | 1,049 | 28.9%
Northwest | 493 | 28.9%
Southeast | 1,010 | 27.8%
Southwest | 969 | 26.7%
Outside of Tarrant County | 115 | 3.2%

Ethnicity
- Not Hispanic or Latino, 90.6%
- Hispanic or Latino, 5.9%
- Ethnicity Not Reported, 3.5%
- Asian, 2.6%
- Black/African American, 16.5%
- Hawaiian/Pacific Islander, 1.3%
- Not Reported, 1.7%
- Other Race, 0.5%

White/Caucasian, 77.4%
AMOB IN TARRANT COUNTY

From September 2012 to December 2018,
- A total of 239 classes delivered
- Completion rate: 72.8%

PROGRAM CAPACITY

- 7 AMOB Master Trainers trained
- A total of 501 Lay Leaders trained

FALLS EFFICACY SCORE CHANGES FROM ENROLLMENT TO GRADUATION

- Clients who enrolled in AMOB program showed significant improvements in five items of falls efficacy score from enrollment to graduation.

Note. Percentage indicates proportion of clients who answered as 'somewhat sure' and 'absolutely sure'.
• **Glad to impact participant’s life.** We know clients enrolled in the programs were positively impacted because they tell us so! For example, Mrs. S hoped enrolling in an AMOB program would help her balance. She reported that after participating in the classes, her balance and strength improved. Even after the class completed, she continues to exercise, using the AMOB workbook as a guide. She is more aware of safety, especially while stepping out of the shower.

• **Strengthen partnership with other organizations.** Not only were clients directly served through AMOB, they also benefitted from having multiple local partners collaborating to deliver the program. LIVE WELL helped make it possible for cross-sector partners, including hospitals, community based organizations, academic institutions, first responders, and faith based organizations, to work together toward the common goal of healthy and independent living among older adults in Tarrant County.

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**SUCCESSES**

- Maximize capacity from volunteers/interns
- Ongoing program promotion and local awareness
- Outreach to different populations and communities
- Improvement in tracking referrals
- Established partnerships with other organizations

---

**CHALLENGES**

- Recruiting and retaining clients
- Keeping up with the demand of the program
- Managing a large group of volunteers
“I enjoyed this class. It was informative as well as very helpful in doing exercises for balance and flexibility. We should have these classes more often.”

“This is one of the most valuable and informational experiences that I have participated in this year. Our instructor was excellent and a great motivator.”

“I have become lots more aware of how falls happen if one is not careful of behavior and surroundings. I like having the notebook – the course is a very positive approach to the problem of elderly falls. It has been very helpful to become aware of how a person can avoid serious injury in falling.”

What participants are saying…
(2012-2018)

“I am very conscious of fall hazards both at home and away. Very aware of concrete parking strips in the many parking lots. This was a great class.”

“I have learned to improve safety measures in my home and understand exercise need to be a way of life.”
Chronic Disease Self-Management Program (CDSMP)

Findings as of
NOVEMBER 2019

United Way of Tarrant County
LIVE WELL INITIATIVE

Jennifer Severance
Christina Bartha
Jerry Moseman
Monique Barber
Chronic Disease Self-Management Program (CDSMP)

• A self-management education workshop facilitated by trained lay leaders
• Build participants' confidence in managing their health and keep them active and engaged in their lives
• Six 2.5-hour sessions
• Discussion and problem-solving to manage chronic disease

Exercise and Nutrition

Stress-Management

Medication Usage

Talking with your doctor

Dealing with emotions and depression

Why is CDSMP important?

• More than 50% of older Americans have two or more chronic diseases, including heart disease, stroke, diabetes, cancer, and arthritis (1, 2).

• The increasing prevalence of multiple chronic conditions places enormous strain on the American economy with more than $2 trillion in health care costs, which could be substantially reduced through greater attention to disease prevention efforts (3-5).

• A greater emphasis on self-management strategies is an essential strategy for avoiding the onset of chronic conditions and helping those with diseases to manage their conditions more effectively in terms of slowing disease progression, reducing complications, and lowering costs (4, 5).

PARTICIPANT’S CHARACTERISTICS

**Gender Distribution**
- Female: 1,564 (78.7%)
- Male: 423 (21.3%)

**Average Age:** 68.7 years old
Participants ranged from ages 30-100

**Geographic Region of Tarrant County**

<table>
<thead>
<tr>
<th>Geographic Region of Tarrant County</th>
<th>N</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Northeast</td>
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<tr>
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<tr>
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<tr>
<td>Southwest</td>
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</tr>
<tr>
<td>Outside of Tarrant County</td>
<td>94</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

**Ethnicity Distribution**

- White/Caucasian: 1,852 (65.2%)
- Black/African American: 670 (23.3%)
- Hispanic/Latino: 430 (14.9%)
- Asian: 46 (1.6%)
- Other: 75 (2.6%)
- Not Reported: 106 (3.8%)

**Other**
- Gender: Female: 78.7%, Male: 21.3%
- Average Age: 68.7 years old
- Participants ranged from ages 30-100

**Map of Tarrant County**

- Geographic areas showing enrollment numbers
- Color-coded areas indicating enrollment rates

**Pie Chart**

- White/Caucasian: 65.2%
- Black/African American: 23.3%
- Hispanic/Latino: 14.9%
- Asian: 1.6%
- Other: 2.6%
- Not Reported: 3.8%
How confident are you that you can… | Enrollment Mean | Graduation Mean | % Improvement
--- | --- | --- | ---
Control the fatigue caused by your disease | 7.15 | 7.96 | 11.33%↑
Manage the physical discomfort or pain of your disease | 7.09 | 7.96 | 12.27%↑
Handle the emotional distress caused by your disease | 7.55 | 8.25 | 9.27%↑
Manage any other symptoms or health problems you have | 7.34 | 8.19 | 11.58%↑
Do the different tasks and activities needed to manage your health condition so as to reduce you need to see a doctor | 7.63 | 8.25 | 8.13%↑
Do things other than just taking medication to reduce how much your illness affects your everyday life | 7.72 | 8.45 | 9.46%↑

Note. 1 = Not at all confident; 10 = Totally confident

Clients who enrolled in CDSMP showed significant improvements in managing their health from enrollment to graduation.

Desired Outcomes
- Decreased pain and health distress
- Increased energy & less fatigue
- Increased physical activity
- Decreased depression
- Better communication with physicians
- Decreased social role limitations
- Increased confidence in managing chronic disease

PROGRAM CAPACITY
- 8 CDSMP Master Trainers trained
- A total of 253 Lay Leaders trained

CDSMP IN TARRANT COUNTY
- A total of 239 classes delivered
- Completion rate: 77.5%
STAFF TESTIMONY

Strengthen partnerships with other organizations. Working with multiple partners requires constant collaboration, effective communication, and the ability to be adaptive and flexible when course correction is needed.

SUCCESSSES
- Dedication from volunteers/lay leaders
- Outreach to bilingual populations
- External Sponsorship
- Program Promotion/Awareness
- Expanded partnerships

CHALLENGES
- Standardizing data sharing processes
- Management in manpower
- Oversight of program fidelity
- Achieving Follow-up/graduation response rate
"As a result of this class I am reading food labels, creating action plans, increase exercise, and communication improvements; blood glucose in A.M. was 107 without medicine."

"I learned how to eat healthier, to eat every four hours, and exercise every day."

"I read more labels. I have more confidence in my choices of foods and my exercise."

What participants are saying…
(2012-2018)

"The course gave me tools to work within myself to help solve or alleviate chronic health problems."

"I have learned to manage my diet, medications, exercise, and myself in a positive way that improves my health and well-
HomeMeds

Findings as of
NOVEMBER 2019

United Way of Tarrant County
LIVE WELL INITIATIVE

Jennifer Severance
Jerry Mosman
HomeMeds

What HomeMeds is:
- An evidence-based, in-home, medication review and intervention that includes a computerized risk assessment and alert process, plus a pharmacist review and recommendation for improvement
- A complement to other evidence-based programs that address patient readmission reduction, health self-management, care transitions or caregiver support

HomeMeds helps patients to:
- Facilitate medication reconciliation after hospitalization
- Monitor adherence to medications for chronic illnesses
- Achieve an ROI similar to medication therapy management by decreasing adverse drug events such as falls and gastrointestinal bleeding

How HomeMeds works:
- Community-based organizations arrange for a pharmacist (or geriatric nurse practitioner) to review and respond to potential medication problems identified at an in-home screening
- Partners in Care trains staff and assists with implementation planning
- Partners’ contracted pharmacists can support HomeMeds in most states
- Special arrangements are available for shared training and statewide or regional licensing
- Partners offers an affordable fee for planning and training, setup, technical assistance and the license to use the online medication risk assessment software

Why medication adherence is important?
- Among adults with chronic illness, 30% - 50% of medications are not taken as prescribed.
- Poor adherence is associated with increased morbidity and mortality
- Nonadherence is also a significant contributor to US health care costs
PARTICIPANT’S CHARACTERISTICS
A total of 913 clients enrolled (Sept. 2012 – Dec. 2014)

Average Age: 73.41 years old
Participants ranged ages from 35 to 101

Geographic Region of Tarrant County

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<thead>
<tr>
<th>Region</th>
<th>N</th>
<th>%</th>
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<tbody>
<tr>
<td>Northeast</td>
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<tr>
<td>Northwest</td>
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<tr>
<td>Southeast</td>
<td>192</td>
<td>21.3%</td>
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<tr>
<td>Southwest</td>
<td>169</td>
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<tr>
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<table>
<thead>
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<th>Race/Ethnicity</th>
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<tr>
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<td>85.0%</td>
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<td>Not reported</td>
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</table>
HOMEMEDS IMPLEMENTATION

56.6% of clients received alerts on their medication list.
88.9% of clients resolved alerts within 30 days.

MEDICATION ADHERENCE LEVEL

The level of high medication adherence increased from baseline and follow-up assessments among clients who had medication reviews.

<table>
<thead>
<tr>
<th></th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
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<tbody>
<tr>
<td>Initial</td>
<td>14.50%</td>
<td>41.60%</td>
<td>43.90%</td>
</tr>
<tr>
<td>Follow-up</td>
<td>23.6%</td>
<td>45.3%</td>
<td>31.1%</td>
</tr>
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SUCCESES

- Increased demand for program due to new marketing and outreach strategies
- Expanded outreach and partnerships with other organizations
- Assist from interns and volunteers
- Enhanced capacity building through a variety of sources (calls, webinars, symposiums)

CHALLENGES

- Low local awareness of the program
- Low follow-up survey rate
- Limited funding sources
- Technical challenges and heavy workload for care coordinator
Care Coordinator (CC) traveled to an individual’s home after receiving a referred by a doctor. While discussing what medications the individual was taking, it was found that this senior had not been taking his daily 81 mg aspirin as prescribed by his heart specialist for his previous heart attack. CC encouraged the individual to call his doctor to discuss this issue, but reinforced that he should not stop taking medications without talking to his doctor. Upon further discussion, CC also discovered that the senior was waiting to take his pain medications until he was in severe pain. In fact, on one occasion he had waited so long to take his medication that he took 2 tabs instead of his usual 1 and ended up having an adverse reaction. CC advised the individual to discuss with his doctor the proper timing of his medication to optimize its effectiveness. Participant indicated he would call his doctor. CC made a follow-up call to him and found out he was taking his aspirin again and was being more careful with his pain medication.

“An individual met with Care Coordinator under some distress because she had made an impulsive and imprudent decision and blamed it on her medication regimen. She wanted her medications reviewed to see what could be done. Senior reported experiencing various symptoms including memory loss from a stroke which she did not know had happened until her doctor informed her. She was in possession of several bottles of medication which she was not sure how often to take. Several of her medications she admitted taking less than prescribed because she felt she was “taking too many meds”. Her medication regimen totaled 22 over-the-counter, prescription, and supplements. After processing, results indicated that individual was taking medications with duplicate therapies, duplicate ingredients, and possible side effects of confusion, especially in seniors. Care Coordinator consulted with pharmacist for recommendations on how to proceed.
HomeMeds

Findings as of
NOVEMBER 2019

United Way of Tarrant County
LIVE WELL INITIATIVE

Steven Wilson
Bill May
Allison Feather
Lilly Frawly
Older adults tend to have multiple illnesses and therefore take more drugs, and polypharmacy increases the risk of poor outcomes. Combination of prescribed medications and over-the-counter medications and dietary supplements can increase the risk for adverse drug reactions, nonadherence, financial burden, drug interactions, and worse outcomes among older adults.

PARTICIPANT’S CHARACTERISTICS

Average Age: 72.9 years old
Participants ranged from ages 21 to 105

Geographic Region of Tarrant County

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<thead>
<tr>
<th>Region</th>
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<tbody>
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<td>24.8%</td>
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<tr>
<td>Northwest</td>
<td>18.4%</td>
<td></td>
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<tr>
<td>Southeast</td>
<td>28.3%</td>
<td></td>
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<tr>
<td>Southwest</td>
<td>26.2%</td>
<td></td>
</tr>
<tr>
<td>Outside of Tarrant County</td>
<td>2.2%</td>
<td></td>
</tr>
</tbody>
</table>

Male    Female

34.7%    65.3%

0% 20% 40% 60% 80% 100%

Male  Female

8.60%  88.80%  2.60%

0.00%  10.00%  20.00%  30.00%  40.00%  50.00%  60.00%  70.00%  80.00%  90.00%  100.00%

Hispanic  Non-Hispanic  Not-reported
Many clients at the senior centers seem genuinely concerned about medication interactions. I feel we are able to give them a peace-of-mind with the information we provide to them.” – Emily Ledwig, CPhT

“Just in the last few weeks, I had a client tell me during a follow-up call that our program has helped her reduce the number of medications she takes by three.” – Susan Munoz, CPhT

Number of alerts ranged from 1 to 22.
- 64.7% of participants received alerts after medication list review.
- 62.6% of participants who received alerts resolved issues on their medication list within 30 days.

88.7% of participants have a better understanding of their medication list.
- 88.8% of participants are confident to take care of their medication list.
- 88.8% of participants are used or plan to use the revised medication list at an appointment with their primary care provider.
- 91.9% of participants found the educational information useful.
- 92.6% of participants are glad that the medication review was completed.

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- 91.9% of participants found the educational information useful.
- 92.6% of participants are glad that the medication review was completed.

**STAFF TESTIMONY**

- “Many clients at the senior centers seem genuinely concerned about medication interactions. I feel we are able to give them a peace-of-mind with the information we provide to them.” – Emily Ledwig, CPhT
- “Just in the last few weeks, I had a client tell me during a follow-up call that our program has helped her reduce the number of medications she takes by three.” – Susan Munoz, CPhT

**SUCCESSES**
- Streamlined process of collecting client’s information
- Increased outside contracts
- Structured policies and process manual for new staff

**CHALLENGES**
- Client’s burden for new questionnaire (Medication adherence scale)
- Client’s less recognition of the program and its benefits
M. was taking 29 medications and was constantly dizzy. After consulting with the pharmacist it was determined that the timing of the medications was too close, the client was taking a majority of them at the same time. After speaking with the client, the Pharmacy Tech was able to advise that they spread the medications out. We were able to reduce the dizziness from the medications as well as remove two medications from the list.

Mrs. P seemed very ill and overwhelmed. She smiled and said “I am so glad to see you; I am a mess with my meds.” Mrs. P’s Homemeds report had 10 alerts including, drug dosage, drug regimen, duplicate therapy, and duplicate ingredients. Mrs. P does have a history of falls and she had 5 alerts alone for falls. When we finally found all of her medications in her room, she had three full grocery bags of pill bottles. She looked overwhelmed and just looking at the bags. She had several expired medications and empty pill bottles mixed with her daily meds. We talked to her about how to discard those bottles for her safety. Mrs. P was very grateful to me for coming by and helping her sort her medications.
Community Health Navigation

The Community Health Navigation program engages clients to improve or maintain their health through in-home counseling. Trained community health professionals are able to help clients get connected with services in the community.

Flow of Program

Referral of Clients → Client assigned a CHN → Initial Visit: Collect Baseline PAM score → Weekly calls & Monthly visits

Follow up Data Collection at 6 months → Data Collection at 3 months → CHN supports based on client’s needs

CHN: Community Health Navigator
PAM: Patient Activation Measure

Source: Insignia
PARTICIPANT CHARACTERISTICS

<table>
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<tr>
<th>Geographic Region of Tarrant County</th>
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<th>%</th>
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<tr>
<td>Outside of Tarrant County</td>
<td>30</td>
<td>3.2%</td>
</tr>
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</table>

Average Age: 73.6 years old
Participants ranged ages from 36 to 111
COMMUNITY HEALTH NAVIGATION

- Completion rate: 50.1% (466/930)
- 63.2% of participants (294/465) showed improvement in Patient Activation Management (PAM) level from initial assessment to follow-up assessment.

CHANGES IN PATIENT ACTIVATION LEVELS

![Initial vs. Follow-up Activation Levels]

Reporting No Problem in Health status

<table>
<thead>
<tr>
<th>I have</th>
<th>Initial</th>
<th>Follow-up</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>No problems in walking about</td>
<td>15.5%</td>
<td>20.9%</td>
<td>38.8% ↑</td>
</tr>
<tr>
<td>No pain or discomfort</td>
<td>23.1%</td>
<td>26.3%</td>
<td>13.9% ↑</td>
</tr>
<tr>
<td>No problems with self-care</td>
<td>26.1%</td>
<td>28.0%</td>
<td>7.3% ↑</td>
</tr>
<tr>
<td>No problems with performing my usual activities</td>
<td>36.7%</td>
<td>44.6%</td>
<td>21.5% ↑</td>
</tr>
<tr>
<td>(e.g., work, study, housework, family or leisure activities)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am not anxious or depressed</td>
<td>33.6%</td>
<td>41.6%</td>
<td>23.5% ↑</td>
</tr>
</tbody>
</table>
STAFF TESTIMONY

**SUCCESSES**
- Building trust between Community Health Navigators (CHN)s and clients over time
- Great performance of Certified CHNs
- National recognition through nationwide dissemination efforts

**CHALLENGES**
- Staff turnover
- Burden of collecting data and providing services together
- Client’s less recognition of program and its benefits

- I just love Mr. J. I wish I had time to just be a personal motivator and go walk with him and help him get moving. That is his biggest wish. …seems to be the wish for everyone. "I just wish I could get out and exercise" they say.-DB
- “Sometimes we can’t keep our clients from going to the hospital, but I know I am making a difference in their lives”- BS
- “This program has opened my eyes to the way people live. It has changed my life and I am glad to be a part of it”.- KD
- I wish I could say everyone has had such success but it is a journey and not a destination. We keep working at it. - KJ
“The problem cannot be fixed in a hospital or clinic, it can only be fixed in the home.”

“The home is where people trust you and let their guard down”

---

**What participants are saying…**

(2012-2015)

Upon completion of the program, Mrs. C increased 2 PAM levels from 45.2 to 63.2. She has had medication changes, has realized (as her doctor has) that her issues are more about depression than dementia. She is now dealing better with her depression. She is in better spirits, her demeanor has improved, and she seems happier than in past. She has had no falls or hospitalizations since the medication changes. She is thankful for program and appreciates our visits more than she thought she would.

“I am grateful for the time and counseling offered by the PAM program. It has changed my life for the better.”
DiabetesSalud!

North Texas Area Community Health Center

Findings as of
NOVEMBER 2019

United Way of Tarrant County
Live Well Initiative

Liz Trevino
Derrick Villa
Jessica Allen
DiabetesSalud!

• **Goal of program:** to provide access to quality diabetes care management and improve the health outcomes of diabetics residing in Tarrant County

• **Program features:**
  - One-on-one educational-case management
  - Structured by trained Diabetes Health Promoter
  - Composed of six 60-90 minute-Diabetes Health Education Classes

• **Program contents:**
  - Basics of diabetes
  - Healthy eating
  - Diabetes complications
  - Physical activity
  - Foot care
  - Healthy coping
  - Medication review & compliance
  - Smoking cessation

**Why is DiabetesSalud! important?**

More than 30 MILLION AMERICANS have diabetes

Health care costs for Americans with diabetes are **2.3X GREATER** than those without diabetes

Diabetes
- 7th leading cause of death in the U.S.
- Increases all-cause mortality rate 1.8 times
- Increases the risk of heart attack by 1.8 times
- Leading cause of other chronic conditions.

Source: American Diabetes Association
PARTICIPANT’S CHARACTERISTICS
A total of 2,642 participants enrolled (Sept. 2011 – Dec. 2018)

Average Age: 47.2 years old
Participants ranged from 11-88

<table>
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<tr>
<td>Outside of Tarrant County</td>
<td>94</td>
<td>4.1%</td>
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</table>

Male 25%
Female 75%

Not reported, 1.6%
Other, 1.6%
Black/African American, 0.5%
White, 96.3%

Not reported, 3.0%
Hispanic, 96.4%
Non-Hispanic, 0.7%
Change of HgA1c Level from Initial to 6 Month Follow-up Assessment

Overall percent of participants with diabetes* decreased from 82.0% at initial assessment to 57.9% at 6 month follow-up assessment.

- Initial: 8.5% Normal, 9.5% Prediabetes, 82.0% Diabetes
- 6 Month Follow-up: 16.8% Normal, 25.2% Prediabetes, 57.9% Diabetes

* Diabetes is defined as HgA1c level; Normal: Below 5.7%; Prediabetes: 5.7 to 6.4%; Diabetes: 6.5% or higher

**SUCCESES**
- Expanded partnerships with other organizations
- Increase in internal referrals
- Integrating the program with other classes (e.g., cooking classes, exercise classes)
- Clinic expansion
- Staff increase
- Community health worker's continuing education
- Ongoing efforts for program outreach in local events

**CHALLENGES**
- Retaining patients due to changes in client's information and schedule
- Limited time and resources for increased referrals
- Limited funding sources
“The patient was diagnosed with diabetes at 34 years old. The patient’s only symptoms were fatigue and decreased sex drive. His A1c was 13.4, and he drank two liters of soda every day, and ate an excess of unhealthy foods. He began the DiabetesSalud! program, decreased his soda intake by 90%, and began eating healthier. His A1C is now down to 6.3, and he is now walking for exercise to decrease stress. Because of his success, he has recommended the program to his friends and family.”

“A 44-year-old patient with a 10-year history of diabetes has always had high sugar levels, and her A1C has always been over 10. In her consults with her primary doctor, the doctor had only prescribed her medicine and recommended her not to eat carbohydrates and to exercise. By coming to DiabetesSalud!, she states that she is happy because she has finally been able to understand carbohydrates. She also mentioned liking the class because of the individual care the classes offer. It has given her more confidence to ask questions. She learned about proteins, grains, vegetables, fruits, the importance of eating healthy, and exercising. In addition to lowering her stress levels, her A1C was lowered to 7.

“A 32 year old male was diagnosed with Type 2 diabetes 4 years ago. Over the past 4 years, his A1c has held constant around 10.3. After consulting his physician, he was referred to the DiabetesSalud! program. After completing three sessions, his A1c was lowered to 6.5. The patient, as well as his physician is very pleased with the outcome of his participation in DiabetesSalud!. DiabetesSalud! taught him how to eat healthy to control his diabetes. He also learned the importance of exercising regularly and minimizing stress. As a result, he got his diabetes under control without increasing his medication.”

Participants & Staff Stories (2012-2018)

“A 32 year old male was diagnosed with Type 2 diabetes 4 years ago. Over the past 4 years, his A1c has held constant around 10.3. After consulting his physician, he was referred to the DiabetesSalud! program. After completing three sessions, his A1c was lowered to 6.5. The patient, as well as his physician is very pleased with the outcome of his participation in DiabetesSalud!. DiabetesSalud! taught him how to eat healthy to control his diabetes. He also learned the importance of exercising regularly and minimizing stress. As a result, he got his diabetes under control without increasing his medication.”
REACH-TX

Alzheimer’s Association
North Central Texas
Chapter

Findings as of
NOVEMBER 2019

United Way of Tarrant County
LIVE WELL INITIATIVE

Susanna Luke-Jones
Laura McEntire
Theresa Hocker
REACH-TX

Resources for Enhancing Alzheimer’s Caregiver Health (REACH)-Texas

- Helps Alzheimer’s and dementia caregivers reduce stress and depression and improves their capacity for self-care
- Multicomponent skills-based family caregiving intervention
- Evidence-based intervention adapted for the community setting
- 6 months; English and Spanish versions

Why is REACH-TX important?

5.5 million Americans are living with Alzheimer’s.

An estimated 16 million Americans provided a total of 18.5 billion hours of unpaid care for family members or close friends with Alzheimer’s disease and other dementias in 2019.

Compared with caregivers of people without dementia, twice as many caregivers of those with dementia indicate substantial emotional, financial and physical difficulties.

(Alzheimer’s Association, 2019)
CAREGIVER CHARACTERISTICS
Total caregivers enrolled: 2,381 (2011 – 2018)

Average Age: 63.3 years old
Participants ranged from 20-94

Geographic Region of Tarrant County

<table>
<thead>
<tr>
<th>Region</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>471</td>
<td>26.4%</td>
</tr>
<tr>
<td>Northwest</td>
<td>265</td>
<td>14.9%</td>
</tr>
<tr>
<td>Southeast</td>
<td>459</td>
<td>25.7%</td>
</tr>
<tr>
<td>Southwest</td>
<td>422</td>
<td>23.7%</td>
</tr>
<tr>
<td>Outside of Tarrant County</td>
<td>166</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

Female (1,397)
78.4%

Male (386)
21.6%

N = 1783

Black/African American 17%
White 81%
Hispanic/Latino 11.7%
Non-Hispanic/Latino 88.3%
EFFECTIVENESS OF REACH-TX

59.1% (899) of caregivers completed all 6 months of the program.

Caregivers who completed REACH-TX showed significant improvements over 6 months in all five domains of quality of life.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Baseline</th>
<th>Follow-up</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>9.57</td>
<td>7.34</td>
<td>2.23</td>
</tr>
<tr>
<td>Caregiver Burden</td>
<td>21.02</td>
<td>16.55</td>
<td>4.47</td>
</tr>
<tr>
<td>Self-care</td>
<td>6.41</td>
<td>6.53</td>
<td>0.12</td>
</tr>
<tr>
<td>Social Support</td>
<td>18.52</td>
<td>20.26</td>
<td>1.74</td>
</tr>
<tr>
<td>Behavioral Problems</td>
<td>0.54</td>
<td>0.69</td>
<td>0.15</td>
</tr>
</tbody>
</table>

STAFF TESTIMONY

- **Eye opening experience.** I have been involved with Alzheimer’s in my family but did not realize how huge the number of affected was. I was under the impression that I was alone. I have not only learned that there are resources now but there are others struggling and I can use my experience and knowledge to relieve some of the pressure they are feeling.

- **Expanding services for caregivers.** The Alzheimer’s Association has provided in more clients and broader area, not only Tarrant but surrounding counties. Alzheimer’s Association has opened doors for Caregivers to walk through and receive help and support.
**REACH-TX**

**SUCCESSES & CHALLENGES**

**SUCCESSES**

- Ongoing training and continuing education opportunities
- Increased awareness through broader referral base
- Educating the public through local and nationwide presentations
- Development of written protocols and improvement in data collection
- Commitment to caregiver care and educational outreach to healthcare providers and community organizations
- Connecting with underrepresented communities, such as Hispanic, African American, and LGBTQ communities

**CHALLENGES**

- Staff turnover and increased responsibilities
- Meeting enrollment goals
- Decreased referral numbers and appropriate referrals from outside agencies
- Retaining caregiver engagement over 6 months
- Language barriers, especially for Spanish speaking clients
- Helping families deal with a progressive and terminal disease
“If I hadn’t gotten the support from the REACH program I do not feel I could have continued care for [my mother] at home. Having the tools to help a caregiver improve the quality of life for a person with this dreadful disease is life-changing.

“The support I received and the coping skills I learned are invaluable.”

“You gave me new tools and resources to help me be a better caregiver…I would strongly recommend your services to anyone in my situation.”

What participants are saying…
(2012-2018)

“I thank God for Alzheimer’s [Association] and REACH. They helped me at my weakest point. Thank you guys for all the support and help you have provided for me.”

“Just when I need some encouragement, you’re there to talk to. It’s so nice knowing that I have someone who I can talk to and share my story with…it helps me so much and it has helped my family as I care for my loved ones.”
Respite Care

Easter Seals of North Texas

Findings as of
NOVEMBER 2019

United Way of Tarrant County
LIVE WELL INITIATIVE

Lynn Boyd
Donna Runion
Donna Dempsey
Respite Care

The Respite Care program provides in-home care services by experienced providers to individuals with Alzheimer’s disease or dementia.

- Assisting families in keeping their loved ones in their own home and community versus seeking institutional care,
- Providing in-home respite care so the caregiver could have a break in their day/week to relax, handle their own needs, meet their own appointments, get refreshed without worrying about their loved ones,
- Being a safe place for people to express themselves, learn practical skills from our direct care providers that made it easier to provide the necessary day-to-day care and learn to cope and adapt with the ever-changing, and sometimes ever-declining, needs of their loved one, and
- Benefiting the community by not having to fund, via taxes, nursing facility/memory care center costs, 24/7, for the subset of individuals we served.

PARTICIPANT’S CHARACTERISTICS
A total of 1,208 families served (Sept. 2010 – Dec. 2018)

Care Recipients

Average Age: 80.5 years old
Participants ranged from ages 39 to 101

<table>
<thead>
<tr>
<th>Geographic Region of Tarrant County</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>373</td>
<td>30.9%</td>
</tr>
<tr>
<td>Northwest</td>
<td>145</td>
<td>12.0%</td>
</tr>
<tr>
<td>Southeast</td>
<td>405</td>
<td>33.5%</td>
</tr>
<tr>
<td>Southwest</td>
<td>285</td>
<td>23.6%</td>
</tr>
</tbody>
</table>

American Indian, 0.1%
Asian, 1.2%
African American/Black, 23.4%
White/Caucasian, 75.3%

Hispanic, 14.5%
Non-Hispanic, 85.5%
PARTICIPANT’S CHARACTERISTICS
A total of 1,208 families served (Sept. 2010 – Dec. 2018)

Caregivers

Geographic Region of Tarrant County

<table>
<thead>
<tr>
<th>Region</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>237</td>
<td>26.5%</td>
</tr>
<tr>
<td>Northwest</td>
<td>126</td>
<td>14.1%</td>
</tr>
<tr>
<td>Southeast</td>
<td>282</td>
<td>31.5%</td>
</tr>
<tr>
<td>Southwest</td>
<td>194</td>
<td>21.7%</td>
</tr>
<tr>
<td>Outside of Tarrant County</td>
<td>56</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

Average Age: 67.7 years old
Participants ranged from ages 26 to 99

Relationship with Care Recipients

- Spouse, 40.9%
- Children, 57.2%
- Friend, 1.7%
- Neighbor, 0.2%
- Not reported, 25.8%
- Black/African American, 16.4%
- Not reported, 25.8%
- Asian, 1.2%
- White/Caucasian, 56.6%

25.8% 10.3% 63.9%
As I am the person who does the final assessments with caregivers, I am always profoundly moved by what they have to say and proud of the relief our services provide.

I know we can’t measure “still a 4 but...”, yet I consider myself privileged that I get to hear the feedback and gratitude in its entirety.

**SUCCESSES**
- Increase demands in monthly respite hours provided
- Strong relationships with other community organizations
- Local awareness of program
- Ongoing program promotion

**CHALLENGES**
- Shortage of bilingual providers
- Decrease in referrals from other organizations
- Limited funding sources

**RESPITE CARE IN TARRANT COUNTY**
- Average hours served monthly for completed program: 22.6 hours (2 to 54.4 hours)
- 59.8% of participants completed 6 months of service.
- Only 7.4% of care-recipients entered a nursing home.

Caregivers served by respite care showed significant improvement in Zarit burden score from 31.7 at initial assessment to 29.42 at final assessment.
Client is 69 years old with a diagnosis of dementia. Her primary caregiver is her husband. We provide respite care for them six hours a week. On a recent supervisory visit the husband told us that our provider had “worked miracles” with the client. He said that the client was less withdrawn now and her communications clearer. He credited our provider with the change in his wife. He said observing our provider with his wife has taught him to be more patient “as it gets better results.” He told us that his wife may no longer be able to find the bathroom by herself but thanks to our provider he has some of her back.
Nutrition-Counseling Program

Findings as of NOVEMBER 2019

United Way of Tarrant County
LIVE WELL INITIATIVE

Sherry Marishak-Simon
Denise Blevins
Carla Jutson
Nutrition-Counseling Program

GOAL OF PROGRAM
- To improve clinical outcomes and reduce hospitalizations for homebound seniors who are at nutritional risk, risk of diabetes/pre-diabetes, or risk of malnutrition.

PROGRAM FEATURES
- In-home, one-on-one nutrition and diabetes assessment, education and counseling
- Provided by registered/license dietitians (RDs)
- 6 month period of individualized in-home education and counseling
- Focuses on individual health concerns, nutrition, and medication

PROGRAM TOPICS
- Diabetes Risk Factors
- Diabetes Pathophysiology
- Diabetes Medicine
- Diabetes Insulin
- Hypoglycemia
- Hyperglycemia
- Chronic Complications
- Meal Planning
- Sharp Disposal
- Reading Labels
- Food Safety
- Fluid Intake
- Oral Health
- Low Sodium
- Foot Care
- Adequate Sleep

Why is Nutrition-Counseling Program important?

- **Food Insecurity**
  - Over 2.9 million household with elderly experience food insecurity.
  - Associated with poor physical and mental health
  - Impacts management of chronic health conditions

- **Diabetes**
  - Over 25% of 65+ population has diabetes.
  - Linked to high mortality, low functional status, increased risk of institutionalization
  - High health care costs
PARTICIPANT’S CHARACTERISTICS
A total of 9,779 participants enrolled (Jul. 2012 – Dec. 2018)

Average Age: 75.3 years old
Participants ranged from ages 23 to 104

Geographic Region of Tarrant County  |  N  |  %
-----------------------------|-----|-----
Northeast                    | 2,111 | 25.6%
Northwest                    | 1,476 | 17.9%
Southeast                    | 2,289 | 27.7%
Southwest                    | 2,248 | 27.2%
Outside of Tarrant County    | 133  | 1.6%

Average Age:
- Male: 34.0%
- Female: 66.0%

Race:
- White: 74.6%
- Black or African American: 23.7%
- Asian: 0.7%
- American Indian/Alaska Native: 0.2%
- Pacific Islander: 0.2%
- Hawaiian/Other Native: 0.2%
- Persons Reporting Some Other Race: 22.5%
- Race Not Reported: 0.9%

Nutrition Risk:
- No Risk: 37.7%
- Moderate Risk: 35.0%
- High Risk: 27.3%

Diabetes Risk:
- No Risk: 37.7%
- Moderate Risk: 35.0%
- High Risk: 27.3%
Clients who enrolled in Nutrition-Counseling program showed significant improvements in managing their health from enrollment to 6 month.

<table>
<thead>
<tr>
<th>I have</th>
<th>Enrollment</th>
<th>6 Month</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>No problems in walking about</td>
<td>18.2%</td>
<td>23.7%</td>
<td>30.2%</td>
</tr>
<tr>
<td>No pain or discomfort</td>
<td>38.8%</td>
<td>50.5%</td>
<td>30.2%</td>
</tr>
<tr>
<td>No problems with self-care</td>
<td>28.4%</td>
<td>35.2%</td>
<td>23.9%</td>
</tr>
<tr>
<td>No problems with performing my usual activities (e.g., work, study,</td>
<td>29.1%</td>
<td>34.0%</td>
<td>16.8%</td>
</tr>
<tr>
<td>housework, family or leisure activities)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am not anxious or depressed</td>
<td>49.0%</td>
<td>59.7%</td>
<td>21.8%</td>
</tr>
</tbody>
</table>
SUCCESSES

• Volunteers/Dietetic Interns’ Contribution
• Enhanced MOW client database increased RD’s productivity
• Medicare reimbursement for RD’s services
• Organization’s commitment and passion to provide assistance in keeping clients home safely in a healthy manner
• Support and resources from UTWC

CHALLENGES

• Data collection/Client Documentation
• Making follow-up calls (voluntary/involuntary termination, move out, changes of contract, etc.)
• Limited Bilingual staff
• Client’s lack of readiness for change

STAFF TESTIMONY

Understanding clients and their needs at where they are:

Nutrition-counseling program ultimately provides a much better picture of each client and how we, as staff, can educate them to make lasting changes based on their individualized needs and abilities at where they are.

We are able to assist our clients from making handouts with only pictures for those who cannot read, teaching someone the importance of hydration and how to actually increase their fluid intake, educating how to raise their blood sugar when it drops and the signs/symptoms of low blood sugar to look out for, and so on.
Mrs. J is 76 Year old female with recent weight loss and currently weighing 85# with a BMI of 14.5 (underweight). MOW Case manager conducted nutrition risk screen with a score of 15 and diabetes risk screen with a score of 9. RD verified weight and identified visible muscle wasting in the clavicular and temporal areas. RD educated client on tips for weight gain, reading nutrition labels, hydration and importance of physical activity and wrote Rx for nutrition supplement to be provided by MOW. RD provided nutrition handouts on tips for healthy snacking and importance of fluids handouts to reinforce information provided during visit. 6 month RD visit showed nutrition risk score of 7 (reduced). Client shows weight gain to 95#, an increase of 12%. Client presents with improved musculature, walking without assistive devices, and uses 2# weights for arms daily. Client now has adequate intake and no longer requires supplementation.

Client Stories (2012-2018)

GB is a 81 year old client with diabetes who was diagnosed with stage 4 lung cancer in September 2016. She was referred to the Diabetes and Nutrition Education program because she had lost 20 lbs in 3 months due to her chemo treatments. The Dietitian provided education to help her manage days of very poor appetite and nausea. Primary goals were to stabilize blood sugars and prevent further weight loss. After 6 months, 2 visits and 4 phone calls with the nutrition department at MOW, the client has maintained her weight and at her 6 month follow up she reported that she was cancer free.
Health Literacy in Tarrant County Adults: A Systems Approach

Findings as of
NOVEMBER 2019

United Way of Tarrant County
LIVE WELL INITIATIVE

Katie Cardarelli
Anissa Carbajal-Diaz
Kim Linnear
Erin Carlson
Teresa Wagner
Health Literacy in Tarrant County Adults: A Systems Approach

Goal:

To enhance connections between clinical and community-based institutions and United Way Tarrant County (UWTC)-funded evidence-based programs that enhance self-management of older adults with chronic disabling conditions.

Library Trainings

To Bridge community-based organizations with existing UWTC-funded evidence-based chronic disease program

Clinical Organization Engagement

Health Literacy Symposium

Health Literacy in Tarrant County Adults: A Systems Approach

Health Literacy!

Achieve self-empowerment

Feel understood

Be happy and able to talk to medical staff

Be able to make the right decisions

Be able to access the right information

Be well-informed

Source of images used in this report: https://dlpng.com/
Building the Bridge to Health: Library Trainings

- A total of 183 Librarians received trainings.
- Showed significant improved in knowledge of health literacy.

<table>
<thead>
<tr>
<th>Health Literacy Knowledge</th>
<th>Before Training</th>
<th>After Training</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I understand what it means to have low health literacy</td>
<td>3.98</td>
<td>4.69</td>
<td>17.8%↑</td>
</tr>
<tr>
<td>2. I know the proportion of adults in the US with low health literacy</td>
<td>2.45</td>
<td>4.34</td>
<td>77.1%↑</td>
</tr>
<tr>
<td>3. I know the groups that are more likely to have low health literacy</td>
<td>3.30</td>
<td>4.63</td>
<td>40.3%↑</td>
</tr>
<tr>
<td>4. I know the factors that contribute to low health literacy</td>
<td>3.37</td>
<td>4.60</td>
<td>36.5%↑</td>
</tr>
<tr>
<td>5. I understand the health outcomes associated with low health literacy</td>
<td>3.66</td>
<td>4.52</td>
<td>23.5%↑</td>
</tr>
<tr>
<td>6. I understand the roles of local librarians and library resources in addressing health literacy</td>
<td>3.66</td>
<td>4.61</td>
<td>26.0%↑</td>
</tr>
<tr>
<td>7. I am aware of the evidence-based programs and resources of the United Way of Tarrant County</td>
<td>2.36</td>
<td>4.53</td>
<td>91.9%↑</td>
</tr>
<tr>
<td>8. I understand how the evidence-based programs and resources of the United Ways of Tarrant County can help address keeping adults healthy at home</td>
<td>2.89</td>
<td>4.48</td>
<td>55.0%↑</td>
</tr>
</tbody>
</table>

Note. 1= Strongly Disagree, 5= Strongly Agree

HEALTH LITERACY SYMPOSIUM

- A total of 738 Community organization representatives attended annual Health Literacy Symposium Librarians from 2013 to 2016.
- Attendees showed significant improvement in knowledge of health literacy, practice of health literacy, and plan to implement what they learned from the symposium.

<table>
<thead>
<tr>
<th>Health Literacy</th>
<th>Before Symposium Score</th>
<th>After Symposium Score</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of Health Literacy</td>
<td>20.76</td>
<td>27.29</td>
<td>31.5%↑</td>
</tr>
<tr>
<td>Practice of Health Literacy</td>
<td>17.64</td>
<td>19.98</td>
<td>16.8%↑</td>
</tr>
<tr>
<td>Plan to implement what they learned from the symposium</td>
<td>15.66</td>
<td>18.29</td>
<td>13.2%↑</td>
</tr>
</tbody>
</table>

Clinical Organization Engagement

- A total of 128 participants from clinical sites received trainings.
- Showed significant improvement in knowledge of health literacy.

<table>
<thead>
<tr>
<th>Health Literacy Knowledge</th>
<th>Before Training</th>
<th>After Training</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I understand what it means to have low health literacy</td>
<td>4.05</td>
<td>4.58</td>
<td>11.1%↑</td>
</tr>
<tr>
<td>2. I know the proportion of adults in the US with low health literacy</td>
<td>2.58</td>
<td>4.47</td>
<td>73.3%↑</td>
</tr>
<tr>
<td>3. I know the groups that are more likely to have low health literacy</td>
<td>3.68</td>
<td>4.42</td>
<td>20.1%↑</td>
</tr>
<tr>
<td>4. I know the factors that contribute to low health literacy</td>
<td>3.82</td>
<td>4.53</td>
<td>18.6%↑</td>
</tr>
<tr>
<td>5. I understand the health outcomes associated with low health literacy</td>
<td>3.78</td>
<td>4.49</td>
<td>18.8%↑</td>
</tr>
<tr>
<td>6. I am aware of the evidence-based programs and resources of the United Way of Tarrant County</td>
<td>3.95</td>
<td>4.18</td>
<td>10.9%↑</td>
</tr>
</tbody>
</table>

Note. 1= Strongly Disagree, 5= Strongly Agree

Source of images used in this report: https://dlpng.com/