

Issue Brief

Evidence-Based Programs

WHAT ARE EVIDENCE-BASED PROGRAMS?¹

Evidence-based programs are based on research, usually conducted in a clinical or academic setting, where researchers evaluate the effects or outcomes of specific interventions. These outcomes are reliable and consistent, even when translated from a clinical setting to the real world. They are found to make positive difference in the lives of participants.



Health care organizations have been practicing EBPs for years. Since 2003, the Administration on Community Living (formerly the Administration on Aging) has encouraged community-based organizations to implement EBPs, which are found to make a positive difference in the lives of participants.

ADVANTAGES OF EVIDENCE-BASED PROGRAMS:²

- Better probability that the program will work
- Ready to implement, reducing strain on resources needed to develop a new program
- Easy to use and comes with implementation instructions and evaluation materials (surveys, knowledge assessments, etc.)
- Demonstrable results and positive outcomes that help:
 - Secure funding
 - Create community buy-in and partnership formation
 - Provide participants with knowledge and options for choosing further evidence-based health promotion programs

DISADVANTAGES OF EVIDENCE-BASED PROGRAMS:³

- Limited target audience — Many EBPs are developed with a specific population in mind (e.g., low-income seniors, women with diabetes). While these particular groups may benefit from the program, others may not see the same results.
- Limited adaptability — EBPs are meant to be replicated as they were designed. This is called fidelity, and it means these programs cannot easily adapted or customized.
- Cost-restrictive — Copyrighted EBPs require permission or licensing from developers to implement. Staff may need to attend trainings or purchase materials. Additional expenses can include food for program participants and incentives (e.g., gift cards, coffee mugs).

- Unknown long-term outcomes — Many existing EBPs lack research on their long-term effects, so their benefits five or 10 years after implementation are unknown.

THE NEED FOR EVIDENCE-BASED PROGRAMS

Chronic Disease

- In Texas, six of the seven top causes of death are linked to chronic disease.⁴
- Among older adults, around 80 percent have one chronic disease, and 77 percent have at least two. Almost two-thirds of all deaths are caused by four diseases: heart disease, cancer, stroke and diabetes.⁵
- Around 75 percent of health care spending in the United States is for treating chronic diseases, yet public efforts to improve health receive only one percent.
- Over 12 million adults aged 60 and older have diabetes; 57 million Americans aged 20 and older are pre-diabetic and at risk of developing type 2 diabetes, stroke and heart disease.
- Only one-third of older adults with mental health problems receive needed treatment. In addition, preventative services are limited.

Falls

- Every 15 seconds, an older adult is treated in the emergency room for a fall; every hour, two older adults die as a result of a fall.⁵
- Falls are the top reason for hospital admissions for trauma, fractures and injury deaths among older adults. Additionally, falls are the leading cause of traumatic brain injuries in older adults, accounting for more than 46 percent of fatal falls.
- In the U.S., \$30 billion a year goes towards treating older adults for falls and by 2020, fall treatment costs are projected to reach \$59.6 billion. About 25 percent of patients with hip fractures will need nursing facility care for at least one year following a fall, which adds to Medicaid costs.

Mental and Behavioral Health

- Among older adults, one in four experiences a mental health problem — such as depression, anxiety or dementia — and this number is expected to reach 15 million by 2030.⁵
- In Texas, mental health disorders affect both health and productivity; about 25 percent of productivity lost can be attributed to mental health disorders.
- Older adults with substance abuse problems will double, reaching five million by 2020.
- In the U.S., seven million older adults have depression and many do not receive treatment.
- Untreated mental and behavioral health problems among older adults can lead to poorer health outcomes, more health complications, higher

use of health care services, and increased risk of disability, mortality and suicide.

- People aged 85 and older have a higher suicide rate than any other age group, six times higher than the general population for older white men.

CAREGIVING

- In Texas, approximately 2.1 million caregivers provide services estimated to be worth \$22 billion.⁶
- Almost 10 percent of caregivers are 75 or older.⁷
- Caregiving hours average 44.6 hours a week for those caring for a partner.
- Nearly 40 million Americans provide unpaid care to an adult. In 2016, caregivers of people with Alzheimer's disease provided an estimated 18.2 billion hours of care valued at \$230 billion.⁸
- Among caregivers for someone with Alzheimer's disease or related dementia, 35 percent say their own health has gotten worse due to caregiving, compared to 19 percent of those caring for someone without Alzheimer's.
- Around 40 percent of caregivers have a high burden of care, and 18 percent have a moderate burden of care.
- Over half of all caregivers say they do not have a choice in taking on caregiving responsibilities.

OLDER ADULTS IN RURAL AREAS

Health care in rural America is limited by lack of access to primary and preventive health services.⁹ Texas has the largest rural and second largest urban population of any state in the United States.¹⁰ While the state's rural population accounts for only 11 percent of the overall population, the rural population is more likely to be older and sicker, have higher poverty rates, and have less access to healthcare.¹¹

A shortage in the health care workforce limits health access in rural areas, with fewer than 10 percent of physicians trained in the U.S. choosing to practice in these areas. Older adults in rural communities may have to travel long distances to access limited health services.¹²

EBPs may be able to bridge some of the gaps, especially for rural older adults, by providing a local, low-cost source of information and self-care interventions. EBPs can be disseminated on a large scale in the absence of health professionals. They generally have less development and start-up costs for agencies, because of the rigorous research that goes into establishing the programs.¹³

RESOURCES

Participants in EBPs have the advantage of enrolling in a program with proven outcomes.¹ The benefits depend on the intent of the program. Examples include:

- **Stanford's Chronic Disease Self-Management Program** increases self-efficacy in managing one's health.¹⁴
- **A Matter of Balance** addresses the fear of falling and encourages falls prevention through improved balance.¹⁵
- **Healthy Ideas** helps people manage depression.¹⁶
- **Stress-busting Program for Family Caregivers** teaches stress reduction techniques to caregivers of people with dementia or chronic illness.¹⁷
- **Texercise Select** provides participants with healthy behavior change methods such as regular exercise and healthy eating to improve overall quality of life. Select employs easy-to-use, practical change methods, thereby making the healthy choice the easy choice.

EBPs translated for community settings are practical and effective and are usually packaged with supporting materials. If the program is delivered with fidelity to its core principles, the results will be consistent. The Community Research Center for Senior Health provides comprehensive information on how to select EBPs and a toolkit to help community-based organizations assess their readiness to implement them.¹⁸

The National Council on Aging has been a leader in EBPs since 2003, and its Center for Healthy Aging provides information on a variety of the programs. It also lists EBPs that meet the Administration for Community Living's criteria for highest-level evidence-based programs under Title IIID of the Older Americans Act. This list includes program descriptions, costs, contact information, program goals, target audiences and training requirements. While it has not been updated since 2012, new EBPs that meet the highest criteria are scheduled to be eligible to attain this status in 2018.¹⁹

Texas has been a leader in EBPs since 2003. Several Area Agencies on Aging were awarded some of the first grants issued by the Administration on Aging to translate and replicate EBPs. The Texas Association of Area Agencies on Aging (T4A) pooled their resources to bring master training to the state for several EBPs: the Stanford Chronic Disease Self-Management Program, Stanford Diabetes Self-Management Training, Matter of Balance and HomeMeds for medication management. The programs helped connect health care partners for the first time and diversify their funding sources with new payers such as insurance plans. T4A allocated funding to each AAA to ensure each region had the opportunity to select an evidence-based program that fit their needs. In 2015, the Evidence-based Leadership Council reported that 86 organizations were licensed to offer programs in Texas.²⁰

CITATIONS

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