## PARTICIPANTS & THEIR PRACTICE/POLICY CHANGE EFFORTS

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**Practice Change Description:** Senior Housing Preservation — Detroit was established to advocate on behalf of preserving apartments for low-income housing, organizing and relocating tenants if necessary, and promoting development of new housing for low-income seniors. This effort is partnering with Tam Perry, PhD, at Wayne State University, who is collecting and relaying the stories of 100 older adults in Detroit who have recently experienced involuntary relocation out of the downtown area. This Action Award project will explore and assess the social and health effects of relocation upon these adults, and then use the information to demonstrate the need to balance growth and revitalization concerns with the costs of supporting older adults through relocation and resettlement.

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**Practice Change Description:** Honoring Choices Idaho is a major collaborative initiative to achieve universal adoption of best practice in advance care planning throughout Idaho. We promote opportunities for conversations in the context of one's values, empower individuals to make and document decisions, and help ensure health care choices are honored.

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**Practice Change Description:** Our change project, "Connecting the Dots: Behavioral Health Integration in an Accountable Care Organization (ACO)," is a multi-pronged approach to increasing depression screening and intervention in primary care practices throughout our ACO.

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**Practice Change Description:** Downtown Women's Center is piloting an 18-month, diabetes self-management treatment and prevention program for adult women experiencing homelessness. To support the work at a systems level, the coalition also began a Diabetes Self-Management Learning Collaborative for health care providers in the Skid Row community providing diabetes treatment programs to homeless populations. The aim of the project is to sustain collaborative efforts around Skid Row health coordination by improving the health of at least 250 older women with or at risk for diabetes in the Skid Row community in Los Angeles.

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**Practice Change Description:** Working within the Financial Alignment Initiative, our project seeks to improve practice within health plans by systematically increasing identification of members with dementia; identifying, assessing and supporting family caregivers; and increasing referrals to home and community-based services including MLTSS and services of Alzheimer's support organizations.

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**Practice Change Description:** Our goal is to move the Utah State Legislature away from one-time funding for the Utah Caregiver Support Program into ongoing financial support. We are using the research-based play, *Portrait of a Caregiver*, as a tool in these efforts.

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**Practice Change Description:** In partnership with Weill Cornell Medical College, two community-based elder service agencies, and an established community advisory board, we are developing and piloting a screening tool to identify palliative care needs in community-dwelling older adults in traditionally underserved neighborhoods in New York City.

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**Practice Change Description:** Our team has a Change AGEnts Action Award to pilot test a curriculum to enhance Adult Protective Service (APS) workers' engagement skills around elder abuse. The ultimate goal of this work is to enhance detection and reporting of elder abuse by APS.

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**Practice Change Description:** Northwest Life Passages© is the organizational community partnership of the Whatcom Alliance for Health Advancement (WAHA), Western Washington University's Palliative Care Institute, and PeaceHealth Medical Center Palliative Care service to transform the culture of palliative and end-of-life care. Northwest Life Passages© strives to improve advance care planning, provide outpatient palliative care services, improve opportunities for healthcare provider training, and support a shift in community culture to achieve becoming a Palliative Community of Excellence.

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**Practice Change Description:** Our project involves working with the Athens Neighborhood Health Center (ANHC), a federally qualified health center. In this area of Georgia, there is a relatively large Medicare population served by ANHC. The key issue for our project is creating a patient-centered approach to polypharmacy by implementing a policy that supports a Pharmacist-led Annual Medicare Wellness visit.

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**Practice Change Description:** A major initiative of the John A. Hartford Foundation's Dementia Caregiving Network is to create an online, user-friendly tool to allow service providers, family caregivers, and individuals with early-stage dementia to search for evidence-based programs. The online tool will facilitate decision-making about which evidence-based programs service organizations will choose for implementation; families will find and use in their communities; and policymakers will advocate for changing regulations in order to establish sustainable funding options.

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**Practice Change Description:** Our practice change effort involves disseminating the white paper developed by the The John A. Hartford Foundation Change AGEnts Patient Centered Medical Home (PCMH) Network. Our efforts will be focused on translation of this paper into a variety of public media and social media forums that target key decision makers involved in the PCMH practice in their organizations, including clinical leaders, C-suite leaders, policy developers and analysts, professional societies, and other trade organizations, including AGS and GSA.

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**Practice Change Description:** We are starting a new effort, which we are calling the Geriatrics Advanced Illness Program (for now). This will encompass a skilled nursing facility program, house calls program, a geriatrics consult clinic, and an advance care clinic. We will be marketing this program to patients and providers.

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**Practice Change Description:** The purpose of our project is to: 1) identify the barriers to and facilitators of the dissemination and implementation (D/I) of evidence-based psychological interventions to older adults with cancer, 2) develop strategies for D/I of these interventions, and 3) foster ongoing collaboration between oncology providers, older adults with cancer and their families, academic researchers, and government staff to improve the psychological care and well-being of older adult cancer patients.

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**Practice Change Description:** Emerging trends indicate that a growing number of adults ages 55 and over will live longer with symptoms and functional limitations due to both head and neck cancer and its treatment. Current valid instruments to assess symptom and function exist, but do not fully capture the symptom experience and function impairments of older adults with head and neck cancer during and after treatment completion. As such, the goal of our Action Award project is to develop and implement a pragmatic 15-minute valid and reliable electronic patient visit questionnaire (ePVQ) for symptom and function assessment that older adults with head and neck cancer can easily use during clinic visits.