Hartford Change AGEnts Action Awards Recipients

January 2015 – December 2015

A Hidden Safety Resource: Family Caregiver Participation in Medication Reconciliation Across Care Transitions

Mary Dolansky, PhD, RN, Case Western Reserve University, Francis Payne Bolton School of Nursing, Cleveland, OH
Stefan Gravenstein, MD, University Hospitals Case Medical Center, Cleveland, OH

Domain of Practice Change: Transforming practice, care and services

Summary:

The purpose of this project is to implement, evaluate and disseminate a program to help educate patients and informal caregivers to be engaged in medication safety during transitions of care when medication errors are most common. The project utilizes the **M**edication **E**rror **D**iscovery and **Rec**onciliation (MED Rec) bundle, which includes: (1) a video to educate patients, families and informal caregivers about the importance of being involved in medication reconciliation and steps to take; (2) a process to engage patient, family, and staff; and (3) a process to monitor implementation. The expectation is that patient and informal caregiver engagement in medication management will bridge the gap across care transitions and will greatly reduce discharge medication errors leading to fewer re-hospitalizations, increased patient satisfaction, improved quality of life, and reduced cost of care for elderly hospitalized patients.

Assessing and Addressing Caregiver Needs in the Caregivers of Homebound Elders

Stephanie Bruce, MD, Washington Hospital Center, Washington, DC
Ruth Shea, LICSW, Washington Hospital Center, Washington, DC

Domain of Practice Change: Transforming practice, care and services

Summary:

This project focuses on addressing the needs and stresses of the families and other non-paid caregivers who provide the bulk of care to elderly patients served by the Medical House Call Program in Washington, DC. The patients are frail, often with multiple co-morbid medical conditions, with dependencies in one or more activities of daily living. Studies have revealed that this type of patient population results in high levels of stress and high levels of unmet social work needs for caregivers. The project will assess the current level of caregiver stress and implement a formal program to mitigate these stresses and support families, in order to improve the health and quality of life of the patients and their caregivers.

Hampton Roads Care Transition Program

Fran Anderson, MS, Senior Services of Southeastern Virginia, Norfolk, VA

Domain of Practice Change: Transforming practice, care and services

Summary:

Senior Services of Southeastern Virginia, in partnership with Sentara Healthcare and Hampton University School of Pharmacy, has been conducting a pilot program that utilizes two evidence based programs (Care Transitions Intervention and HomeMeds), to address preventable hospitalizations and medications issues for adults age 60 and older with chronic conditions. The Action Award project will expand the current pilot from one hospital to a second, larger hospital in order to have a greater impact by engaging more older adults in the management of their chronic conditions, and gathering outcomes and cost savings data that will be instrumental in pursing sustainable funding streams to support the program.

Implementation of an Innovative lntergenerational, Trauma Informed Kinship Care Practice Model

Amy Astle-Raaen, MSW, University of Washington School of Social Work, Seattle, WA
Wendy Lustbader, MSW, University of Washington School of Social Work, Seattle, WA

Domain of Practice Change: Transforming practice, care and services

Summary:

This project aims to fundamentally transform the ways in which individual and family needs are assessed and services are delivered by implementing an innovative intergenerational, trauma-informed kinship care practice model that will break down systemic barriers contributing to fragmented age-based services. The project includes conducting a capacity building training program for front line workers, leaders and students in training with staff from child protective services, adult protective services, and other aging and adult service providers with a goal of reaching over 100 workers across systems. The project will conclude with a community wide "practice to policy" spotlight forum to present and disseminate this practice model, plus the establishment of principles from lessons learned during implementation to guide the development of other cross systems training opportunities.

Improving Access, Communication, and Efficiency of Care: Implementation of Telemedicine Capabilities between a Hospital and Skilled Nursing Facility

Winnie Suen, MD, MSc, Inova Fairfax Hospital, Falls Church, VA
Steven Dean, MS, Inova Health System, Falls Church, VA
Amanda Gannon, Burke Health and Rehabilitation Center, Burke, VA

Domain of Practice Change: Transforming practice, care and services

Summary:

The project will address communication issues between Inova hospital and skilled nursing facilities (SNF) providers who care for patients after leaving the hospital. Inova will deploy a geriatrics trained SNF team to care for patients discharged to SNFs and educate SNF staff on geriatrics care. As part of this program, telemedicine tools, which have been shown to be beneficial in other specialties, will be utilized. The goals of this project are to: 1) improve SNF patient satisfaction with care coordination and communication and 2) decrease readmissions from the SNF to the hospital. The results of this project will serve as a model for how other health systems and programs can incorporate telemedicine capabilities to support caring for older adults and serve as fertile ground for future innovation.

MAking Real Progress in Emotional Health (MARPEH)

Eran Metzger, MD, Hebrew Rehabilitation Center, Boston, MA

Domain of Practice Change: Transforming practice, care and services

Summary:

This project will integrate depression and cognitive support services into routine care for low income seniors living independently—improving coordination of depression and memory care with primary care treatment and eliminating barriers to care. The goals of the project are: 1) measurably reduce symptoms of depression in seniors living independently by increasing the capacity of supportive housing staff to detect residents exhibiting signs of depression and cognitive impairment; 2) provide short-term behavior activation, problem solving therapy, and cognitive adaptation strategies; and 3) when necessary, connect residents with appropriate community mental health services.

Relocation Amidst Revitalization: Recreating Social Worlds for Older Adults

Tam Perry, PhD, MSSW, MA, Wayne State University, Detroit, MI
Kathleen Ruth, MSN, RN, APHN-BC, St. Aloysius Parish, Neighborhood Services, Detroit, MI
Joann Adragna, St. Aloysius Parish, Detroit, MI
Deacon Donald E, Leach, MPA, MARS, St. Aloysius Parish, Detroit, MI
Claudia Sanford, BFA, United Community Housing Coalition, Detroit, MI

Domain of Practice Change: Advancing Public Policy

Summary:

This advocacy project will collect and relay the stories of 100 older adults in Detroit who have recently experienced involuntary relocation out of the downtown area. The stories will be compiled via open-ended interviews combined with validated stress and PTSD instruments. The project will explore and assess the effects of relocation upon these adults, and then use the information to demonstrate the need for advocates to balance growth and revitalization concerns with the costs of supporting older adults through relocation and resettlement. A summary report will be used as a tool when advocating on behalf of seniors being relocated.

SPRING: Screening PRogram for Identifying Needs due to Geriatric Syndromes in Homeless Veterans

Marcia Mecca, MD, VA Connecticut Healthcare System, Yale University, West Haven, CT
Theddeus Iheanacho, MD, VA Connecticut Healthcare System, Yale University; Errera Community Care Center, West Haven, CT

Domain of Practice Change: Transforming practice, care and services

Summary:

The project incorporates best practices of geriatric syndrome screening and referral to the appropriate supportive services into the standard care provided by the Homeless Services Team at the West Haven Veterans Affairs Homeless Clinic. Anticipated outcomes of this practice change include improvements in housing outcomes (e.g., latency to housing, evictions, etc.), health outcomes (e.g., hospitalizations, emergency department visits, engagement with care, etc.), and parity of resource referrals (e.g., home services, physical therapy, Meals on Wheels, etc.), as well as the opportunity for wider implementation at additional sites providing care to chronically homeless adults.

Transforming Chronic Disease Management Practice in the Skilled Nursing Facility through Patient and Family-Centered Clinical Decision Support

Evelyn Duffy, DNP, AGPCNP-BC, FAANP, Case Western Reserve University, Francis Payne Bolton School of Nursing, Cleveland, OH
Colleen Lavelle, MA, LNHA, Jennings Center for Older Adults, Garfield Heights, OH

Domain of Practice Change: Transforming practice, care and Services

Summary:

This project is intended to transform chronic disease management practice in a skilled nursing facility by placing the patient and their family at the center of an interprofessional team, utilizing the electronic clinical decision support tool Daylight IQ™ to inform patient centered plans of care. The software will guide nurses in assessing patients and identifying changes in condition while an interprofessional Patient Centered Care (PCC) team, that is expanded to include nursing assistants, housekeeping, dining services and maintenance staff, will work together to create individualized plans of care based on patient goals and preferences. The software will eventually be integrated into the facility's EMR system.