Hartford Change AGEnts Action Award Recipients

August 2014 – July 2015

Community Engagement to Better Manage Ischemic Vascular Disease

Suzanne Landis, MD, MPH, Mountain Area Health Education Center and University of North Carolina
Sarah Thach, MPH, Mountain Area Health Education Center

Domain of Practice Change: Transforming practice, care and services

Summary:

The project plans to utilize a "Boot Camp Translation" process to teach 15 community members of rural Enka Candler, NC about the various practices for managing Ischemic Vascular Disease risk factors; members will identify, develop, and disseminate key messages to the community. The process seeks to: 1) help a new safety-net medical practice build relationships in its surrounding community, and 2) transform primary care practice by engaging the community in a collaborative effort to educate individuals and to improve population health.

Designing a New System-wide Geriatric Medicine Program for Care New England

Nancy Roberts, MSN, RN, Kent County Visiting Nurse Association d/b/a VNA of Care New England
Ana Tuya Fulton, MD, FACP, Butler Hospital

Domain of Practice Change: Redesigning delivery systems

Summary:

The project will seek to develop systems, specifically dementia services, that provide effective population management for geriatric patients by better managing the inpatient experience and developing cross-continuum models of care. The goals are threefold: 1) complete a 90-day system needs assessment to define the patient populations, staffing needs and challenges faced by Care New England (CNE) partners to carry out the desired changes; 2) disseminate knowledge to the CNE partners and provide basic principles of evidence-based geriatric care; and 3) to roll out the first of several clinical programs, the Advanced Dementia Consultative Service.

Development of a Patient-Centered Care Planning Tool for Multimorbid Patients

Katherine Thompson, MD, The University of Chicago
Lisa Mailliard, MS, APN, The University of Chicago
Megan Huisingh-Scheetz, MD, MPH, The University of Chicago
Mariko Wong, MD, The University of Chicago

Domain of Practice Change: Strengthening quality measures and tools

Summary:

The aim of this project is to develop a patient-centered care planning and communication tool for interdisciplinary providers with multimorbid patients – the tool is based on the American Geriatrics Society's Principles of Care for Older Adults with Multimorbidity. The model will

use patient goals and preferences as the foundation for complex care decision-making, thereby shifting the focus of care away from disease-specific benchmarks and towards patient-centered goals.

Health Home Connect (HHC)
Amy Turk, LCSW, Downtown Women's Center
Domain of Practice Change: Advancing public policy
Summary:
The project will primarily focus on advancing public policy as it relates to improving access to healthcare services for Medicaid-eligible older adults experiencing homelessness. DCW and its partners will strive to: 1) maximize Medi-Cal expansion by furthering efforts to coordinate enrollment for homeless residents; 2) create partnerships with Medi-Cal contracted health plans to identify homeless and formerly homeless enrollees, link those enrollees to permanent housing, and fund services in housing; and 3) support the development of the Health Homes Bill state plan amendment to ensure Medi-Cal funding for "health home" services that promote housing stability.

Honoring the Care Wishes of Nursing Home Residents
Mercedes Bern-Klug, PhD, MSW, MA, University of Iowa
Nicole Peterson, DNP, ARNP, University of Iowa
Jane Dohrmann, MSW, Honoring Your Wishes, Iowa City Hospice
Domain of Practice Change: Connecting health professions education & practice
Summary:
The project will build the capacity of nursing home social workers and nurses to work together to enhance how their facility identifies, documents, and addresses medical care preferences of residents in an emergency situation. The model will utilize the Respecting Choices evidence based best practice model to train staff on how to engage in advance care planning conversations with residents and family members as well as how to make system changes in support of person-centered care.

Implementing Routine Cognitive Assessment for Older Elective Surgery Patients in a Busy Preoperative Testing Center
Zara Cooper, MD, MSC, FACS, Brigham and Women's Hospital
Deborah J. Culley, MD, Brigham and Women's Hospital
Houman Javedan, MD, Brigham and Women's Hospital
Angela Bader, MD, MPH, Brigham and Women's Hospital
Domain of Practice Change: Strengthening quality measures and tools
Summary:
The overarching goal of this project is to implement routine cognitive assessment for older adults undergoing elective surgery and transform the practice and care for these older adults by: 1) better identifying at-risk patients and ultimately allowing personalized targeted interventions to mitigate these risks and to set expectations for patients, clinicians and caregivers; 2) demonstrating that implementing routine cognitive testing is feasible without specialized staff and useful for identifying those at greatest risk for potentially preventable perioperative morbidity; 3) identifying older patients who are at risk for unrecognized decisional deficits

because they may be too impaired to fully understand the implications of the surgical procedure for which they will have already consented.

MiCAPABLE-Community Aging in Place, Advancing Better Living for Elders in the Michigan Medicaid Waiver Program

Sandra L. Spoelstra, PhD, RN, Michigan State University
Sarah Szanton, PhD, ANP, Johns Hopkins University

Domain of Practice Change: Transforming practice, care and services

Summary:

The project aims to reduce disability, lower cost-of-care, and improve quality-of-life for people receiving services through Michigan's home and community based services Medicaid waiver program. MiCAPABLE addresses the needs of the vulnerable aging population with chronic conditions by integrating evidence-based strategies in a comprehensive, patient-centered, self-directed, home-based program to enhance function by engaging patients in self-care to improve mobility. MiCAPABLE is based on the CAPABLE model, a Hartford Foundation funded model championed by Dr. Szanton. One modification to the model is the incorporation of social work visits to address family dynamics, mental health and benefits access beyond what RNs provide.

New Strategies for Community Fall Prevention - Linking Emergency Care Providers with Home Health, Patients and their Providers

Kate T. Queen, MD, Mountain Area Health Education Center
Mark Johnson, RN, CCEMT-P, BSN, Mission Health

Domain of Practice Change: Redesigning delivery systems

Summary:

Studies have identified tools to prevent falls but there is a lack of real world examples of well-coordinated systems of care that consistently identify older adults at high risk and then connect them with providers who can further assess and address the risk factors. This project intends to demonstrate that Emergency Medical Service (EMS) and Emergency Department (ED) providers can identify elders who have fallen, and help link them to a voluntary Home Health visit for fall risk assessment.

Testing and Refinement of Interprofessional Geriatric Rounds (TRIGR) Practice Change

Susan M. Lee, PhD, RN, NP-C, Brigham and Women's Hospital
Heidi Doucette, MS, RN, Brigham and Women's Hospital

Domain of Practice Change: Developing model programs

Summary:

The purpose of this proposed practice change is to test and refine a model of team-based, acute geriatric care which has the potential to improve health, lower costs, improve the patient/family experience of care, and be easily implemented. The project aims to increase the rate of discharge to home by 20% annually as well as improve patient and family satisfaction by 20%. To achieve the second aim, this nurse-driven interprofessional model will actively engage patients and families in daily rounds and provide anticipatory guidance to patients and families related to promoting physical function.