Change AGEnts Action Awards

The 34 projects funded through the Action Awards grants program showcased the improvements that interprofessional teams can bring to light by implementing evidence-based programs into targeted care settings in local environments. These one-year grants for up to $10,000 were available to interprofessional teams led by Change AGEnts for the purpose of achieving meaningful change to practice or policy that will improve the health and wellbeing of older adults and/or their families.

Cycle 1
August 2014 – July 2015

Community Engagement to Better Manage Ischemic Vascular Disease

Suzanne Landis, MD, MPH, Mountain Area Health Education Center and U of North Carolina and 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 and 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; Lisa Mailliard, MS, APN; Megan Huisingh-Scheetz, MD, MPH; and 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; and 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; Deborah J. Culley, MD; Houman Javedan, MD; and 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.

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Change AGEnts Action Awards

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

Sandra L. Spoelstra, PhD, RN, Michigan State University and 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 and 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 and 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.

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Change AGEnts Action Awards

Cycle 2
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 Frances Payne Bolton School of Nursing, Cleveland, OH and 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 and 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.

Hidden Strengths: An Innovative Intergenerational, Trauma Informed Kinship Care Practice Model

Amy Astle-Raaen, MSW, Wendy Lustbader, MSW, and Karen I. Fredriksen-Goldsen, PhD, Hartford Center of Excellence and 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; and 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.

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Change AGEnts Action Awards

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; and 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, and 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.

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Change AGEnts Action Awards

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, Frances Payne Bolton School of Nursing, Cleveland, OH and 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.

Cycle 3
June 2015 – May 2016

Perioperative Geriatrics 101

Sheila Ryan Barnett, MD, and Marianne Mcauliffe, MSN, RN, Beth Israel Deaconess Medical Center, Boston, MA

Domain of Practice Change: Connecting health professions education and practice

Summary: The focus of this project is to develop a geriatric educational series to address the lack of training in perioperative geriatric principles amongst the nursing staff in the preanesthesia holding area and post anesthesia recovery units. The course will include lectures, case discussions, and a simulation session, plus the team will engage patients and caregivers in focus group discussions on the surgical experience and use the data to direct educational objectives. Advanced geriatric risk assessment will be taught through a series of tutorials provided in parallel. Retention of the basic geriatric principles will be reinforced through the use of a web based spaced-learning tool (Qstream) following the lectures and seminars.

Early Intervention for Informal Caregivers using High Fidelity Simulation via Community-Based Participatory Ethnodrama

Jacqueline Eaton, PhD, University of Utah, Salt Lake City, UT and Nancy Madsen, MS, SSW, Utah Division of Aging & Adult Services, Salt Lake City, UT

Domain of Practice Change: Transforming practice, care and services

Summary: This project will bring together 12 experienced and 12 new caregivers to develop an ethnodrama targeting the needs of early caregivers. Ethnodrama is the process of turning verbatim nonfictionalized personal accounts into a performance with the goal of making research findings accessible to the general public. The participants will meet four times over a four month period and the resulting ethnodrama will be performed for them and family members by professional performers. Small group discussion and simulation will follow the performance. The performance will be conducted for the wider caregiving community at three other time

points: during caregiver month in November; a caregiver conference held in Utah in November; and during the legislative session held in February 2016.

Transforming Practice: Innovative Care Delivery Redesign at the Hospital Unit Level to Improve Patient-Centered Outcomes in Vulnerable Elders

Kellie Flood, MD, University of Alabama at Birmingham, Birmingham, AL and Emily Simmons, MSN, RN-BC, CNL, University of Alabama at Birmingham Hospital, Birmingham, AL

Domain of Practice Change: Transforming practice, care and services

Summary: This project addresses the need to disseminate the Acute Care for Elders (ACE) interprofessional team model of care to all hospital units via the implementation and evaluation of a Virtual ACE Intervention. The Virtual ACE Intervention utilizes unit-based provider training on geriatric conditions, proactive identification of at-risk patients, and collaborative interprofessional team management of geriatric syndromes. The project team has already conducted a successful pilot test of the Virtual ACE Intervention on an orthopedic surgery unit, and will use the Action Awards year to evaluate the effectiveness of this practice change on both a medical and surgical unit.

Emergency Department Transitions with Nursing Homes: Improving and Standardizing Communication

Sharon Foerster, LCSW, MSW, MaineHealth, Portland, ME

Domain of Practice Change: Redesigning delivery systems

Summary: In response to the challenge of communicating essential information between a nursing home and a hospital emergency department during a patient transfer, a group from the MaineHealth system of hospitals and nursing homes/skilled nursing facilities came together to find a solution. The group, which included representatives from each part of the care continuum during a resident transfer, developed a standardized process for what information is communicated verbally and in writing. Based on the success of the pilot, this project focuses on further dissemination of the standardized process to other hospitals in the MaineHealth system with the goal of embedding more widespread process standardization.

Improving Access to Palliative Care in Underserved Communities: Developing a Community-Based Screening Tool for Older Adults

Daniel S. Gardner, PhD, LCSW, Silberman School of Social Work at Hunter College, New York, NY, Elizabeth Capezuti, PhD, RN, FAAN, Hunter College School of Nursing, New York, NY, M. Carrington Reid, MD, PhD, Weill Cornell Medical College, New York, NY, and Angela Ghesquiere, PhD, MSW, Brookdale Center for Health Aging, New York, NY

Domain of Practice Change: Strengthening quality measures and tools

Summary: This project will develop and test a multi-domain Palliative Care (PC) screening tool, specifically for use in community-dwelling, chronically ill elders in the East and Central Harlem communities of New York City. Currently no screening tool exists for community-dwelling chronically-ill populations. Once the new tool is created, the team will partner with four sites to

implement it: a case management agency and senior center will act as pilot testing sites, while two outpatient PC clinics will act as referral sites for positive screens. If the tool is found to be feasible, acceptable, and effective, the project team anticipates widespread implementation at both pilot sites, with eventual dissemination to senior centers and case management centers and case management agencies throughout the New York area and beyond.

Opening the Door: A Training for Engaging in Attuned Adult Protective Services Work

Caroline Gelman, PhD, LCSW, Silberman School of Social Work at Hunter College, New York, NY and Geoff Rogers, BA, Brookdale Center for Healthy Aging, New York, NY

Domain of Practice Change: Connecting health professions education and practice

Summary: This project will evaluate the feasibility of training Adult Protective Services (APS) workers in a person-centered approach designed to develop trust and facilitate a collaborative worker-elder relationship to help with detection, disclosure/reporting and intervention in cases of elder abuse. The project team will implement and evaluate an interactive 8-hour, 2-unit training developed with extensive input from APS workers and supervisors. The NYC Human Resources Administration's (HRA) APS program has committed to providing two cohorts of 20 APS workers each to participate in the training. HRA has committed to system-wide implementation if the training is found to be effective.

Calhoun County Coordinated Community Response: Redesigning Service Delivery for Victims of Elder Abuse and Neglect

Carolyn E.Z. Pickering, PhD, RN, Michigan State University College of Nursing, East Lansing, MI

Domain of Practice Change: Redesigning delivery systems

Summary: This project focuses on redesigning the service delivery system for victims of elder abuse and neglect by using a Coordinated Community Response (CCR) model. CCRs provide a single-point-of-entry system in which the victim only has to tell their story once, coordination of service planning occurs between the agencies, and the victim is connected with the appropriate service providers. The project aims to strengthen service coordination and collaborations among community agencies through creation and adoption of a uniform intake form and case management system; successfully implement the CCR model as evidenced by an increase in services available to older adults who have experienced elder abuse and/or neglect and service coordination among agencies; and collect data for further program planning aimed at addressing elder abuse and/or neglect in the community.

Change AGEnts Action Awards

Cycle 4
January 2016 – December 2016

Preventing Opioid prescription Theft and Ensuring seCure Transfer of Personal Health Information (PROTECT PHI) when Patients Transition from the Hospital and into a Nursing Home

Korey Kennelty, PharmD, PhD, MS, U of Wisconsin- Madison, William S. Middleton VA Hospital, Madison, WI and David Hager, PharmD, BCPS, University of Wisconsin Hospital and Clinics, Madison, WI

Domain of Practice Change: Redesigning delivery systems

Summary: The goal of this project is to disseminate and adapt the PROTECT PHI intervention to non-VA hospitals. PROTECT PHI, an acronym for Preventing Opiod prescription Theft and Ensuring seCure Transfer of Personal Health Information, is a low-cost, low resource intervention that ensures successful and secure delivery of opioid prescriptions and personal health information (PHI) during the hospital-to-nursing home transition. The intervention encompasses four modifications to the hospital discharge process: 1) replacement of traditional hospital discharge envelopes with tamper-proof envelopes, 2) an updated hospital discharge checklist, 3) patients and caregivers receiving in-depth counseling on medications and hospital discharge packet contents, and 4) follow up with nursing homes. PROTECT PHI was developed at the William S. Middleton VA Hospital in Madison, WI and has proved to be very successful in the VA setting. The PROTECT PHI Toolkit will be freely accessible online.

Where the Rubber Meets the Road: Using Interactive Theater to Promote Conversations about Driving Safety for Persons with Dementia

Diane Pastor, PhD, MBA, NP-C, RN, Andrea L. Jones, PhD, MSW, and Tamatha Arms, DNP, PMHNP-BC, NP-C, University of North Carolina Wilmington, Wilmington, NC

Domain of Practice Change: Transforming practice, care and services

Summary: This project focuses on driving safety for persons with dementia (PWD). The interprofessional team will implement an intervention using a live interactive theater performance and produce an educational DVD based on a videotape of the performance and evidence. The DVD will be shared with state-level community partners to educate and guide health care providers (nurse practitioners and social workers), family caregivers and PWD in beginning to have conversations about driving safety. The performance and DVD will be developed and implemented in collaboration with three community partners: 1) North Carolina Nurses Association; 2) Alzheimers North Carolina; 3) Theater Delta in North Carolina.

Developing the Vulnerable Elder Protection Team: An Emergency Department-Based Multi-Disciplinary Intervention to Improve Care for Potential Victims of Elder Abuse and Neglect

Tony Rosen, MD, MPH, Weill Cornell Medical College Division of Emergency Medicine / New York-Presbyterian Hospital, New York, NY

Domain of Practice Change: Developing model programs

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Change AGEnts Action Awards

Summary: Recognizing that an emergency department (ED) visit provides a unique opportunity to identify elder abuse, this project involves developing a first-ever ED-based, multi-disciplinary Vulnerable Elder Protection Team (VEPT) to improve identification, comprehensive medical and forensic assessment, and treatment for potential victims of elder abuse or neglect. Steps to accomplishing this includes: (1) conducting and analyzing focus groups with stakeholders from multiple disciplines to inform program development, (2) finalizing VEPT procedures and protocols among the leadership team and champions, (3) designing standardized informational/ educational materials for ED providers on elder abuse and neglect and how to work with the team, and (4) developing an implementation, evaluation, and sustainability plan for the VEPT.

Expansion of Health Information Technology for Hispanic Dementia Caregivers

Nicole Ruggiano, PhD, MSW, and Ellen Brown, EdD, MS, RN, FAAN, Florida International University, Miami, FL

Domain of Practice Change: Transforming practice, care and services

Summary: This project plans to enhance the Care Heroes health information technology to make it accessible and relevant to Hispanic caregivers of adults with Alzheimer's disease and other forms of dementia (AD). Care Heroes is a web-based and Android app with multiple functions that: assist and support the needs of AD caregivers; allow caregivers to self-assess their own symptoms of burden and depression; provide caregivers, Primary Care Providers, and home care case managers with the ability to share critical health-related information and updated AD patient information in real time; and offer access to vetted caregiving information and local resources. The findings from a recent pilot study of Care Heroes conducted in Miami, FL, demonstrated that the technology is valued, but that it should be translated into Spanish and include educational videos for caregivers to increase its potential impact before it is adopted for widespread use.

Bridging from Novice to Knowledge: Implementing a Geriatric Oncology Curriculum for Nurse Practitioner Students

Armin Shahrokni, MD, MPH, and Sincere McMillan, RN, MS, ANP-BC, Memorial Sloan Kettering Cancer Center New York, NY

Domain of Practice Change: Connecting health professions education and practice

Summary: The goal of this project is to increase the number of advanced practice nurses (APN) educated in geriatric-oncology by implementing a semester long intensive educational curriculum. Memorial Sloan Kettering Cancer Center (MSKCC) will serve as the primary training site and the Geriatric Service of MSKCC will provide the educational component. Each participant will complete a minimum of 100 clinical hours using this model. Once successfully implemented, the objective will be to expand the program and develop a year-long accredited fellowship for APNs that want expertise in the care of older cancer patients in the hospital and/or in the community.

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Change AGEnts Action Awards

Older Adults as Change Agents to Improve Mental Health Care in the Community

Juliette Shellman, PhD, APHN-BC, University of Connecticut School of Nursing, Storrs, CT and Karen Bailey-Addison, LCSW, Northend Senior Center, Hartford, CT

Domain of Practice Change: Developing model programs

Summary: This project addresses the specific need for culturally-tailored mental health programs designed to assist older Black adults to manage their depressive symptoms through a program based on integrative reminiscence. Integrative reminiscence is grounded in the Theory of Cognitive Adaptation and has been shown to be an effective method to decrease depressive symptoms in older adults. Older adults will be trained to facilitate integrative reminiscence with their peers, guided by the Reminiscence Resource Guide, a tool developed through an interactive process at the Northend Senior Center in collaboration with the University of Connecticut School of Nursing.

National Healthcare Decisions Day "Ramp Up" Event

Casey Shillam, PhD, RN-BC, University of Portland School of Nursing, Portland, OR and Catherine Bree Johnston, MD, MPH, FACP, PeaceHealth St. Joseph Medical Center, Bellingham, WA

Domain of Practice Change: Transforming practice, care and services

Summary: The purpose of this project is to engage the Whatcom County, Washington community in an advance care planning initiative to contribute to the "60 by 65 Campaign" to have 60% of those over 65 years of age in the region have an Advance Directive on file in the local hospital by 2017. The initiative was developed by Northwest Life Passages©, 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. A National Healthcare Decisions Day (NHDD) "Ramp Up" event is scheduled for March 16, 2016, 30 days prior to NHDD on April 16. The goal is for the 10 largest area employers to have 30% of their employees complete their advance directives by NHDD.

Medication Therapy Management (MTM) in a Home Based Program

Sandra Spoelstra, PhD, RN, and Evelyn Clingerman, PhD, RN, FNAP, Grand Valley State University Kirkhof College of Nursing, Grand Rapids, MI

Domain of Practice Change: Redesigning delivery systems

Summary: The goal of this project is to disseminate and implement a medication therapy management (MTM) program in home-based settings of older adults. The MTM program will be incorporated into the Tandem365 program, a pilot project comprised of nine organizations in the Grand Rapids, MI area that is designed to meet the needs of older adults, particularly those who are frail, multimorbid, and medically complex with many medications prescribed. The objective of this project is to improve medication management, thus, further reducing adverse events, hospitalizations, and/or Emergency Department visits, and ultimately, improving the quality-of-life of those who receive services in Tandem365. MTM, which is defined as care provided by

clinicians whose aim is to optimize drug therapy and improve therapeutic outcomes, has evolved as a complex, multi-modal intervention, which addresses issues of polypharmacy, preventable adverse drug events, medication adherence, and medication misuse.

Developing A Pragmatic Electronic Patient Visit Questionnaire (ePVQ) for Symptom and Function Assessment of Patients with Head and Neck Cancer

Janet Van Cleave, PhD, RN, New York University College of Nursing, New York, NY

Domain of Practice Change: Transforming practice, care and services

Summary: This project will focus on developing and implementing 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 clinical visits. The ePVQ will be a patient – centered questionnaire, composed of patient-reported outcomes of symptoms and function, based on existing valid and reliable instruments. The interdisciplinary team that will develop and implement the ePVQ is composed of physicians, nurses, speech pathology specialists, physical therapists, and a biostatistician. Of the 59,000 patients diagnosed with head and neck cancer each year in the United States, 73% are adults ages 55 and over and 43% are ages 65 and over. While current valid instruments to assess symptom and function exist, they do not fully capture the symptom experience and function impairments of older adults with this cancer during and after treatment completion.