

## *In This Issue* Changing Practice

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### *Developing Care Management Protocols Aimed at Persons with Dementia and Their Family Caregivers*

Experts  
Corner

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Because seniors in Medicaid waiver programs have complex and chronic needs, the family members who care for them at home are also often in need of support. “Effectively providing in-home services to both Medicaid waiver program participants and their caregivers is essential to helping them remain in the community,” says Sharon Foerster, LCSW, Director of Elder Independence of Maine (EIM) in Lewiston. “Medicaid waiver services typically focus on in-home service coordination but do not actively address the client’s particular health conditions or systematically provide evidence-based assistance to caregivers.”

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Foerster’s project includes developing protocols to guide EIM care managers in providing caregiver risk screening, education, and links to community resources; care managers then create an action plan with goals for follow-up. Care

managers use a risk assessment tool to evaluate

caregivers along six domains (depression, burden, self-care and health behaviors, social support, safety, and patient problem behaviors) and then offer targeted interventions.

The project is initially focusing on clients with dementia, who comprise nearly 35% of EIM’s Medicaid waiver population. “People with dementia are among those at highest risk of nursing home entry; by supporting their caregivers, we can delay nursing home placement,” Foerster points out.

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~Sharon Foerster

### *Ensuring Safe Discharge Home*

Observation care enables Medicare patients to remain in the hospital for up to 48 hours pending a decision regarding whether the patient requires further inpatient treatment. Although most patients prefer to receive subsequent care at home, some patients require a higher intensity of care available in a short-term rehabilitation

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## *Expert’s Corner: Direct Care Workforce: Issues and Implications*

The availability of direct-care workers – certified nurse aides, home health aides, and personal care attendants – has critical implications for senior care and service quality. “Direct-care workers account for 7 out of 10 long-term care staff members and provide 8 out of 10 hours of direct health services to eldercare consumers,” noted Steven L. Dawson, President of PHI (Paraprofessional Healthcare Institute), located in the South Bronx, NY. “More than 1 million new direct-care paraprofessional positions are expected to be added by the year 2018, driven in part by the shift from facility-based care to home- and community-care settings.” PHI’s mission is to improve the quality of care for seniors and people with disabilities, by improving the jobs of direct-care workers.

Dawson notes that unless these jobs are made more attractive, recruiting and retaining direct-care workers will remain a challenge – a significant issue, given the growth of the elder population and the reduction in the traditional labor supply of direct-care workers (women aged 25-54). “There is very little public policy attention to this issue,” he said, adding that between 1999 and 2007, real wages for health professionals increased by 16% but fell by 3% for home care workers. Furthermore, annual earnings for direct-care workers average approximately \$17,000 – less than half of the median for all US workers; 41% rely on public benefits; and roughly 25% have no health insurance. “While there is a social justice argument that direct-care workers deserve better salaries and benefits, the only argument that will prompt fundamental policy change is if the roles of these workers are re-structured—adding value by providing more efficient, cost-effective care.” PHI is promoting several initiatives to policymakers, including development of an “advanced aide” position, improvements in training, and access to health coverage for health care workers.

## Practice Strategy: Practical Strategies for Conflict Engagement



Because Practice Change Fellows must foster collaboration among different decision-makers across settings and disciplines, effectively managing the conflicts that inevitably arise is a critical skill that is key to successful project implementation.

Conflict can be viewed as a barrier to progress or embraced as a learning opportunity. “Much of the conflict in health care stems from natural paradoxes inherent in the system, such as the tension between cost and quality and between individual and group needs,” noted Debra Gerardi, RN, MPH, JD, President and

Chief Executive Officer of Emerging Health Care Communities (EHCCO) in Half Moon Bay, California. “The question becomes, how do we engage in conflict productively? We can learn to modify both assertiveness and cooperativeness during a conflict and use constructive behaviors.”

Gerardi noted that we must reflect on our own mindset about conflict, which develops over time through experience. It can shape how we respond. “Understanding how you view conflict and our own default styles – competitive, avoidant, compromising, collaborative or accommodating – as well as the styles of those we work with is the first step in learning how to adapt our conflict responses to a particular situation,” she said. Gerardi led the Practice Change Fellows and Advisory Board members in experiential learning activities that highlighted the following lessons about conflict engagement :

- ✧ *View conflict as an opportunity for contribution and learning*
- ✧ *Ask others what they hope the outcome of discussions will be, rather than making assumptions*
- ✧ *Connect with the other person by first deescalating and then trying to understand the situation; building a connection involves: focusing on the person, expressing empathy, acknowledging the person’s perspective, reframing the issue, actively listening, and asking clarifying questions (PEARLA)*
- ✧ *Encourage integrative thinking (“me and you” rather than “me versus you”)*
- ✧ *Describe the impact of difficult behavior on others, and seek alternatives*
- ✧ *Build on small agreements in the process of working toward a larger goal in order to cultivate trust and show respect*

## Welcome 2010 Fellows!

PCF is pleased to congratulate the Fellows who will join the program in September 2010:

**Andrea R. Fox MD, MPH** from Squirrel Hill Health Center

**Denise L. Lyons CNS**, from Christiana Hospital

**Hermia Parks MACP, BSN** from Riverside County Community Health Agency

**Jennifer B. Porth MSW**, from Palmetto Health

**Melissa A. Frey MSW**, from Rush University Medical Center, Johnston R. Bowman Center

**Shirley F. Jones MD**, from Scott and White Memorial Hospital/ Texas A&M Health science Center

**Thomas Price MD**, from Emory University School of Medicine

**Ursula McClymont MD**, from Baltimore Medical Systems

## Implications for Health Reform on Practice Change

With new health care reform legislation as a backdrop, five Advisory Board Members provided updates on various activities and programs that will influence the way care for seniors is financed and delivered.

- **Lynn Friss Feinberg, MSW**, Director of the Campaign for Better Care at the National Partnership for Women & Families, noted that the campaign officially launched in April and is positioned to become a strong consumer voice in setting the national health care policy agenda.
- **Joanne Handy, RN, MS**, President and CEO of Aging Services of California, discussed the Community Living Assistance Services and Supports Act, (CLASS) which creates the first national long-term care insurance program.
- **David Labby, MD**, Medical Director for CareOregon, described how health care reform will impact Medicaid patients; he noted that hospitals will attempt to control resources, quality and costs - thereby gaining market strength - by creating integrated delivery systems.
- **Cheryl Phillips, MD, AGSF**, Chief Medical Officer of OnLok Lifeways and Board Chair of the American Geriatric Society (AGS), discussed recent AGS activities to support geriatrics professionals; she noted that the AGS supported the inclusion of non-physicians in the Geriatric Academic Career Awards sponsored by HRSA and lobbied to include geriatrician care in the primary care evaluation and management (E&M) codes, which recently increased by 10%.
- **Cheryl Schraeder, RN, PhD, FAAN**, Director of Policy & Practice Initiatives, Institute for Healthcare Innovation, UIC College of Nursing, described the Center for Medicare and Medicaid Innovation, which will test new payment and care delivery models that could improve quality while reducing expenditures.



## Changing Practice

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facility. “Returning home is typically the only discharge option for older adult observation patients, since Medicare only covers short-term rehabilitation care for patients who remain in the hospital for three consecutive nights,” notes Caroline Ryan, MA (SW), Manager at Aging Care Connections in La Grange, Illinois. Unfortunately, the aging services network in most communities is not well equipped to respond to the needs of observation patients immediately upon discharge—it may take up to 30 days before community services can be arranged.”

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~ Caroline Ryan

The goal of Ryan’s project, Safe Discharge Home, is to improve the community’s ability to rapidly respond to the needs of observations patients as they transition from hospital to home. Safe Discharge Home establishes an expedited referral process between Adventist La Grange Memorial Hospital and Aging Care Connections, the local senior service agency. Hospital social workers refer patients to an Aging Care Connections care coordinator located on-site; the care

coordinator reviews community care options and completes service assessments in a face-to-face meeting with the patient and family prior to discharge. The care coordinator then contacts home health and community providers to coordinate a care plan and expedite services.

### Creating a Diabetes Care for Seniors

Community-dwelling seniors with diabetes are at elevated risk

Poor clinical outcomes, extended hospital lengths of stay and high readmission rates. “Our hospitalized Medicare patients with diabetes are 72% more likely to be readmitted within 30 days than non-diabetics,” notes Eileen Koons, MSW, ACSW, Manager of Government Programs — Senior Care Network at Huntington Memorial Hospital in Pasadena. “Furthermore, this group’s length of stay is 5.4 days longer on average than the Medicare mean length of stay, costing the hospital \$3.4 million annually.”

To improve outcomes and reduce readmissions, Koons is creating a one-month hospital-to-home transition intervention that includes a process for targeting eligible patients and then applies Coleman Care Transition Intervention™ protocols. The program provides transition coaching for four weeks, with a social worker making contact at the bedside and then visiting the patient at home within four days of discharge. At the home visit, the social worker conducts a medication reconciliation; teaches self-management and Personal Health Record use; confirms patient knowledge of diabetes “red flags”; and ensures that the patient schedules and keeps a follow-up physician visit. The social worker then follows up with weekly telephone contact for three weeks to monitor the patient’s well-being. The program also involves referral to community-based resources, such as group or in-home diabetes educators, the hospital’s Stanford Chronic Disease Self-Management program, and healthy eating and lifestyle education activities.

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~ Eileen Koons

## Quick Study: Designing Truly Patient-Centered Care

Health care industry experts tout “patient-centered care” as an important goal of institutional initiatives as well as wider health care reform. However, program developers have not typically incorporated consumers into the design of new programs; as a result, assumptions about what constitutes “patient-centered care” have not yielded program components that reflect what truly matters to patients.

In an article entitled, “If You Build It, Will They Come? Designing Truly Patient-Centered Health Care,” published in the May 2010 issue of *Health Affairs*, authors Christine Bechtel and Debra L. Ness argue that consumers should have input into the design, ongoing operations, and evaluation of new models of care such as medical homes and accountable care organizations. Based on consumer surveys and focus groups conducted by the National Partnership for Women and Families, Bechtel and Ness describe what patients report they want from their health care delivery model. These components, listed below, serve as a good framework for Practice Change Fellows to consider as they create their initiatives:

- **“Whole person” care:** Patients want to be viewed as a whole person rather than as a collection of body parts or conditions; understanding the patient’s life situation, home environment, and personal preferences is vital to providing patient-centered care.
- **Comprehensive communication and coordination:** Patients prefer team-based care, which requires thorough communication among providers and between providers and patients/families.
- **Patient support and empowerment:** Patients wish to partner with clinicians in making care decisions, and thus want meaningful education about their conditions and support for self-management.
- **Ready access to care:** This includes the ability to schedule appointments quickly, brief office wait times, and availability of care team members by phone or email.

## The Practice Change Fellows Program

The Practice Change Fellows program is a two-year fellowship program designed to build leadership capacity among nurses, physicians, and social workers who have operations level responsibility for aging programs and geriatric service lines. The application period for the 2011 Class will run from January 2011 through April 2011. To learn more about the program please visit [www.practicechangefellows.org](http://www.practicechangefellows.org).



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