PRACTICE CHANGE FELLOWS
LEADERS IN GERIATRIC CARE

Practice Change Bulletin

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Changing Practice

Changing Practice: Designing a Comprehensive Approach to Delirium

The prevalence of delirium in people with dementia is quite high, estimated at nearly one-quarter of community-dwelling individuals and almost 90% of inpatients. Yet delirium is often underdiagnosed in this patient population. "Acute care nurses may not differentiate between dementia and delirium," says Ellen Barrington, MSN, RN, BC, a nurse manager with Ocean Medical Center in Brick, New Jersey. "Because our county population has a high proportion of individuals over age 65 – approximately 21%, compared to a national average of 12.4% -- it is critical that we help our clinicians accurately identify delirium along with other diseases of aging so that we can offer appropriate treatment to the patients we serve."

> "Acute care nurses may not differentiate between dementia and delirium."
>
> ~Ellen Barrington

Barrington's multi-component approach prompts improved delirium identification and treatment, with the goal of reducing morbidity, mortality, and extended lengths of stay. The intervention begins with the Confusion Assessment Method (CAM), an evidence-based practice for assessing and identifying delirium. For targeted patients, the program incorporates the Inouye Hospital Elderly Life Program (HELP), which uses trained volunteers to provide daily therapeutic activities and companionship to inpatients to help them maintain their cognitive and functional ability, orientation, and mobilization. Educational programs target clinicians, caregivers, patients and the community. The project has been piloted on an acute care unit; as a result of positive preliminary outcomes -- including reductions in delirium incidence, length of stay and costs of care -- the program is being expanded to the hospital's orthopedic unit in September 2009.

Changing Practice: Improving Heart Failure Care for Seniors in Rural Areas

Congestive heart failure (CHF) is one of the most common discharge diagnoses in the senior population. Appropriate follow-up care and monitoring can prevent emergency room visits,

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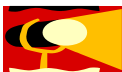

Spotlight On: The Campaign for Better Care

Individuals with multiple chronic illnesses are the heaviest users of health care resources – and a majority of these individuals are older adults. Clearly, older adults with chronic conditions comprise a highly vulnerable population, experiencing fragmentation of care; polypharmacy; insufficient or ineffective discharge education and support and high complication rates, leading to frequent rehospitalizations; and lack of support in coordinating the necessary home care and non-medical services that will enable them to live at home safely.

The Campaign for Better Care, created by the National Partnership for Women & Families with support from The Atlantic Philanthropies, is giving these vulnerable individuals a voice. "We need to harness the collective strength of geriatric providers, advocates, older adults and families to be advocates for better care," says Lynn Feinberg, campaign director.

The multi-year campaign incorporates a number of components, including the development of a broad-based national consumer coalition that will serve as the consumer voice for better care; grassroots mobilization of older adults and their families who can be activists for care improvement; building a policy agenda for a sustained consumer voice for change on topics such as care quality, care coordination, patient-centered care, and team-based care; creating partnerships and alliances with other advocacy organizations and stakeholder groups; and a focused communication strategy that will mobilize advocacy efforts.

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hospitalization, and readmission, yet CHF hospitalizations are escalating. Underlying causes of insufficient follow-up care include care fragmentation, lack of adequate patient education, and/or lack of access to services, particularly in rural areas.

> "Integrated, targeted interventions will help us improve care for our seniors by identifying gaps in CHF care."
>
> ~Lee Greer

"We are predicting an 8% rise in CHF discharges between 2007 and 2012," says Lee Greer, MD, a geriatrician with North Mississippi Medical Center, which serves Tupelo and the surrounding rural areas. "Integrated, targeted interventions will help us improve care for our seniors by identifying gaps in CHF care and addressing them effectively in the outpatient setting so that our patients experience fewer hospitalizations."

Greer's project has involved the development of a CHF registry, which helps clinicians track care so that appropriate preventive measures – such as ACE inhibitors, beta blockers, blood pressure medications, and smoking cessation advice -- can be provided to all patients. Rural CHF patients with gaps in care or who have experienced multiple rehospitalizations are invited to attend "Heart Failure Days" at their local physician's office; during Heart Failure Days, patients meet with their own physician and a multidisciplinary team of medical center providers who assess the patient and make care recommendations. Patient education is another critical component of Greer's project. Preliminary results suggest that this project has led to declines in CHF hospitalizations and fewer gaps in care.

Changing Practice: Designing a Geriatric Care Service Line

Optimal care for seniors requires a multidisciplinary approach, given the myriad of complex health issues faced by this patient population. Yet in large health systems, clinicians in different care areas tend to work in isolation – a shortcoming obvious to Amy Minnich, RN, BSN, Executive Director for LIFE Geisinger. "While our clinicians are very effective within their individual silos of responsibility, there is great opportunity to pool geriatric expertise across the system," she states. "A geriatric service line will enable multidisciplinary experts to collaborate and to develop system-wide program initiatives that will meet the vision of our organization." Minnich's project builds on the success of Geisinger's ProvenCare programs, which align evidence-based care initiatives and provider incentives within service lines such as surgery, kidney disease, diabetes, and pregnancy.

> "A geriatric service line will enable multidisciplinary experts to collaborate and to develop system-wide program initiatives."
>
> ~Amy Minnich

Program initiatives include development of best-practice protocols, including geriatric surgery evaluation protocols; creation of a system-wide end-of-life initiative; development of an educational resource center; development of a geriatric fellowship program to expand the number of board-certified geriatricians in the health system; improvement of referral processes; and creation of a community-wide coalition to coordinate services for seniors. The program will track outcomes such as fall rates, medication compliance, and readmission rates.

Graduation: 2007 Practice Change Fellows

Amid laugher, a few tears, and much applause, the Practice Change Fellows Program proudly celebrated the graduation of our first class of Fellows. The remarkable achievements of our graduating class reveal that with intelligence, hard work, dedication and a little help from professional friends, geriatrics professionals can have a wide-reaching impact on the lives of the seniors they serve. Congratulations to our 2007 Practice Change Fellows – we look forward to celebrating your future successes!

Expert's Corner:Creating Organizational Abundance

In an environment characterized by financial constraints, clinicians may find it difficult to win senior management support for new projects. According to James Firman, President and CEO of the National Council on Aging, those who believe in abundance can identify and creatively leverage previously untapped resources in ways that pave the way for success. "Needs are growing, and available funds are declining – yet resource scarcity is essentially an illusion," asserts Firman.

Firman emphasizes that doomsday scenarios discussed during economic crises are eventually countered by innovation. "Those of us who provide services and programming to senior populations need to identify resources that may not have been considered previously," he says.

Firman identified a number of largely untapped sources of funding for aging services and programming. For example, many older adults have considerable disposable income, meaning that organizations can cultivate a private-pay market for aging services rather than relying on traditional notions of providing free services to economically disadvantaged individuals. "Another source is planned giving," says Firman. "Older people currently give away about $40 billion annually in bequests, largely to hospitals, universities, and religious organizations. We need to overcome our discomfort and ask individuals to consider senior services organizations as donation recipients." Senior organizations can also more aggressively seek grants from corporations, foundations, and government agencies, and create effective alliances with other community organizations.

Finally, Firman notes that older adults themselves constitute a huge untapped resource. "Seniors are looking for a way to remain active and meaningfully contribute to the community beyond participating in typical volunteer activities," he notes. "Retirees have energy, ideas, opinions, and sophisticated business acumen – all of which can be leveraged to help an organization thrive."

Firman also highlighted strategies for achieving organizational abundance. "First, we have to believe that there is an abundance of resources, and then we have to figure out how to identify and tap into them," he says. A second strategy is to carefully define the organization's mission, core competencies and economic drivers, and then target resources (money, time, and branding) toward focused objectives. Third, organizations should divest themselves of unnecessary and/or unsuccessful programs that may have been perpetuated due to habit or nostalgia. Fourth, organizations should shift their focus away from providing services and programs and toward producing and selling outcomes. "The current economic crisis is also a rare opportunity to spur transformational change," he adds.

Practice Strategy: Practical Tips for Project Success

Geriatrics professionals are experts in care provision, yet often do not have practical experience applying the business strategies that can help them develop projects successfully. Practice Change Fellows program mentors moderated sessions on a wide array of topics, including building high performing teams; disseminating best practices within and between organizations; performance measurement and pay for performance; selectively leveraging national leadership roles; strategic fundraising; and business plan development.

Program mentors and the Practice Change Fellows themselves shared practical advice based on their own varied experiences. For example, participants offered the following suggestions for effectively disseminating best practices: leverage networking opportunities, especially with hospital leadership; make formal presentations to a variety of groups so that interested parties learn about innovations; demonstrate how best practices can fulfill the audience's particular needs; build flexibility into new processes so they can be more easily adopted; and provide tools to facilitate adoption.

Suggestions for strategic fundraising for geriatric initiatives included: develop a strategy and vision for identifying potential funders and define the clinician's role in this strategy; obtain coaching (for example, from the hospital's director of business development) regarding how to develop relationships with potential donors and how to ask for money; ask satisfied patients to express support for geriatric services directly to the board via letters or phone calls; and ensure that donors feel connected to the program, for example by allowing them to help name the program or to meet patients who will benefit from program services.

Participants in the session on building high performance teams agreed that team builders must typically overcome a number of challenges in order to ultimately achieve success. Practical strategies suggested included: clarifying the mission of the group and maintaining a focus on this mission rather than on participant personalities; understanding how group members communicate and work most effectively; recruiting outside process facilitators to coach the team; and clarifying accountability by defining action steps and responsible parties.

Welcome New Fellows!

PCF is pleased to congratulate the Fellows who will join the program in September 2009:

Randi Berkowitz, MD, Hebrew Senior Life

Alice Bonner, PhD, RN, Massachusetts Senior Care Foundation

Audrey Chun, MD, Mount Sinai School of Medicine

Sandra Ferguson, RN, BBA, MS Area Agency on Aging, 10B Inc.

Sharon Foerster, LCSW, Elder Independence of Maine/SeniorsPlus

Eileen M. Koons, MSW, Huntington Memorial Hospital

Janis McGillick, MA(SW), LNHA, Alzheimer's Association,

St. Louis Chapter

Kate T. Queen, MD, Haywood Regional Medical Center

Caroline Ryan, MA(SW), Southwest Suburban Center on Aging

Gail Sarli, RN, NP, Visiting Nurse Service of New York

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 2010 Class will run from January 2010 through April 2010. To learn more about the program please visit www.practicechangefellows.org.

The Practice Change Fellows Program would like to express our sincere gratitude to our sponsors for their support:
The Atlantic Philanthropies ▪ The John A. Hartford Foundation

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