Hartford Change AGEnt's Policy Institute
2015 Participants

Name: Nikola R. Alenkin
Location: Los Angeles, CA
Home Institution: Department of Veterans Affairs (Greater Los Angeles Healthcare System)

Proposal Title: "Improving Access to Evidence Base Practice Treatments: A Focus on Aging Veterans with PTSD"

PTSD is a chronic condition that can impact someone over a lifetime. For aging Veterans especially, the natural course of life events (e.g., health problems, loss of a spouse) may trigger PTSD symptoms from earlier trauma(s) particularly from war experience (Landau & Litwin, 2000). The lifetime exposure rate for older male Veterans of traumatic events is approximately 85% (Hankin et al, 1999). Current evidence base practice treatments for PTSD such as Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) have been proven to be effective; however, there exists scant literature on effectiveness of these treatments for aging Veterans. With medical and technological advances, Veterans are living longer and will likely present with PTSD and in need of effective treatment. Finding and testing potential effective treatments for PTSD and aging Veteran has implications on the allocation of funds for future disability claims, treatment providers, and medical centers, etc… Veterans' costs comprise the fourth largest category of expenditures in the United States budget, with the cost for disability claims estimated between $355 billion to $534 billion over the next 40 years (Bilmes, 2011). The proposed practice change addresses the intersection of not only effective treatment but also the associated increased access to care and costs that come with it. It asks policy makers to develop legislation that providers at V.A. medical centers utilize effective research based treatments **specific** to the needs of aging Veterans. It also asks policy makers to increase awareness of the **increase of access** to services for aging Veterans and resulting fiscal impacts. This practice change requires policy makers in conjunction with researchers to work together to avoid an unexpected war on the fiscal security of our nation.

Name: David Dorr
Location: Portland, OR
Home Institution: Oregon Health & Science University

Proposal Title: "Patient Centered Medical Home Network**"**

The Patient-Centered Medical Home (PCMH) Network will transform PCMH and similar initiatives to recognize, facilitate, encourage, and ultimately reward doing the right thing for older adults and their caregivers. The vision of the Network is to transform PCMHs to recognize, facilitate, encourage, and ultimately improve the care of older adults and their caregivers. We also propose to enhance their connection to relevant resources, including family caregivers and community based resources. By advocating for and promoting the thoughtful insertion of geriatrics into the PCMH model and the eventual implementation of two to three geriatrics-specific pilot projects in PCMH settings, the Network seeks to improve outcomes for older adults in the Comprehensive Primary Care (CPC) initiative and other PCMH sites. A large thrust of the Network will be to identify ways to improve the skills of PCMH clinicians who may not have formal geriatric training, at both the

patient and population level. These efforts may include evidence based geriatrics education on specific topics, appropriate risk identification and stratification, and more geriatric sensitive care management. It is the goal of the Network to support better policy and implementation by reframing the PCMH model to establish the value of caring for older adults and defining a set of PCMH models and policy changes that increase the likelihood of better outcomes for older adults.

Name: Nancy Dudley
Location: Los Altos, CA
Home Institution: University of California, San Francisco

Proposal Title: "Integrating Community-based Palliative Care in Primary Care"

Community-dwelling older adults living longer with advanced illness, not in hospice, experience high symptom burden, fragmentation of care, frequent hospital readmissions, overuse of health care services, and poor quality of life. Community-based palliative care (CBPC) is an opportunity to deliver ongoing symptom focused, coordinated care, yet access is limited and processes of care are ill-defined. The passage of California SB 1004 will require Medi-Cal managed care plans to ensure the delivery of palliative care services. However, primary care as the coordinator of community services lacks the clinical leadership in the specialty of geriatrics and palliative care to 1) understand complexities of providing primary and specialty palliative care, 2) design system-wide evidence-based practice protocols and process to deliver care, 3) effectively communicate and negotiate change to successfully implement a co-management model of primary care and specialty palliative care, 4) teach primary providers, nurses, and staff, and 5) monitor, evaluate and sustain practice change.

Name: Jennifer C. Greenfield, PhD, MSW
Location: Denver, CO
Home Institution: University of Denver, Graduate School of Social Work

Proposal Title: "Building Momentum to Pass a Paid Family Leave Policy in Colorado"

More than 62 million Americans will care for a family member with a serious health concern or functional limitation this year, and while most of these caregivers are also employed, less than 12% of them will have access to paid leave. Caregivers in the U.S. are increasingly responsible for multiple aspects of their loved ones' care, including making and attending medical appointments, assisting with activities of daily living such as eating and bathing, and managing complex medical tasks. Juggling these caregiving responsibilities while working takes a toll on caregivers' health and finances. Three states, California, New Jersey, and Rhode Island, have now implemented paid family leave policies that allow workers to take partially paid leave in order to care for an ill family member. Although a proposal to implement a similar program in Colorado was introduced in the Colorado Senate last year, it did not move out of committee. Similarly, paid family leave has been mentioned by some national policy leaders as a goal at the federal level, but there is currently very little political will to move such a proposal forward. My proposed policy project has two parts: 1) to

help pass a paid family leave policy in Colorado during the 2016 legislative session; and 2) to help build political will for a national paid family leave insurance program.

Name: Shawn Halls & Karen Reynolds
Location: Sarasota, FL
Home Institution: Sarasota Memorial Health Care System

Proposal Title: "PEACE: Improving Patient Experience for Acute Care Elders through Policy Change and Innovation"

When the Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare/Medicaid (CMS) implemented their three-state pilot study of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in 2003, the unprecedented over 80 population was not represented in this sample. This population is predicted to triple over the next twenty years. With greater than three fourths of older adults having more than one chronic condition, these individuals with multiple conditions utilize a vast majority of health care services (Page, Kowlowitz, & Alden, 2010). Sarasota County, FL has one of the oldest populations in the country, the third-highest percentage of residents aged 65 and over, the second-highest percentage of residents aged 75 and over and the highest percentage of residents aged 85 and over. Sarasota Memorial (SMH) is an 819 bed public, not-for-profit health system and is considered one of the 20 largest public hospitals in the United States. With our depth and breadth of services and our area's concentration of senior citizens, SMH is uniquely positioned to lead the nation in the care of this vulnerable population. Initial SMH HCAHPS data analysis shows that inpatient experience drops sharply for patients 80 years and older. The current trends suggest this is not only unique to this population at SMH but also, nationally. The issue we are framing is the 80+ HCAHPS policy impact on Value Based Purchasing (VBP) for the future of health care systems. It is the right thing to do for the patients and also the government's fiscal responsibility to health care financing to focus on the needs of the over 80 population. Two questions exist: Are we meeting the unique needs of this population and are we adequately measuring the right areas of experiential need for this population?

Name: Teri Kennedy, PhD, MSW, LCSW, ACSW
Location: Phoenix, AZ
Home Institution: Arizona State University, College of Public Service & Community Solutions; School of Social Work

Proposal Title: "Integrating Social Work across National Center for Interprofessional Practice & Education (Nexus) Incubator Sites"

The National Center for Interprofessional Practice and Education (Nexus) was designated in October 2012 by the Health Resources and Services Administration of the U.S. Department of Health and Human Services as the sole center to advance interprofessional education and practice as a viable and efficient health care delivery model. Interprofessional team-based care is a key

feature of new models of healthcare delivery and aligned with the national strategy to create a better health system through the Affordable Care Act. While recognizing that health professionals must work together with their patients and families to achieve better care, more value, and healthier communities (the Triple Aim), the Nexus leadership has exhibited a lack of understanding of the role of social workers and failed to integrate social workers as essential members of the interprofessional team in projects across all incubator sites, leading to marginalization of the profession. I propose to offer my services to work collaboratively with the Nexus leadership (Dr. Barbara Brandt, Director; Dr. Frank Cerra, MD, Senior Advisor) with the goal of developing a white paper outlining the role of social work in interprofessional practice and providing strategies facilitating full inclusion of social workers across all projects and incubator sites. In addition to the pledged support of the organizational representatives noted in 2 below, I plan to reach out for support from HRSA and the three private foundations that comprise this public-private partnership: the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation, and the Gordon and Betty Moore Foundation

Name: Nancy Kusmaul
Location: Baltimore, MD
Home Institution: University of Maryland, Baltimore County

Proposal Title: "Policy Advocacy for changes in Nursing Home Regulation that support Person Centered Nursing Home Culture Change"

The nursing home industry is one of the most regulated industries in the nation. While these regulations address various elements of care, and were enacted to improve care, they represent minimum standards, and in practice they do little to address quality of life and individualized care (Stone, Bryant, & Barbarotta, 2009). Various nursing home culture change models, such as Eden, Green Houses, Planetree, and Wellspring return the focus of care to the individual care recipient and emphasize choice and quality of life (White-Chu et al., 2009). Regulatory enforcement has been slow to catch up to these changes and facilities have been concerned about the regulatory risks that come with implementing culture change practices (Kapp, 2013). Additionally, there are few overt incentives for facilities to adopt these practices.

I envision changing practice in nursing homes by modifying regulations to support culture change. First, instructions to surveyors could be expanded so current practices are evaluated for their ability to engender real choice for residents, families, and direct care staff. Second, the regulations should be changed to promote structural changes that reduce disciplinary silos and encourage cross training of staff. This will allow individual staff members to meet more of a resident's needs and choices.

Name: Gina M. McCaskill
Location: Birmingham, AL
Home Institution: Birmingham VAMC

Proposal Title: "The Development of an Indoor Walking Trail for Public Senior Housing: Project STEPS!"

Physical activity levels decrease with age. Although there are numerous health benefits associated with regular physical activity, most older adults fail to achieve the recommended level of physical activity established by the Federal government. However, physical activity is especially low among older adults who live in urban impoverished neighborhoods. Project Seniors Taking Exercise Promotion Seriously! (STEPS!) will take a community-based participatory approach to remove some of the environmental challenges reported in the research literature as barriers to physical activity for low income seniors, such as dilapidated sidewalks, inadequate lighting, and crime, by developing an indoor walking trail for older adults who live in public senior housing in an urban area in the Deep South.

Name: Shyvonne Noboa
Location: Sunnyside, NY
Home Institution: Sunnyside Community Services

Proposal Title: "Strengthening Workplace Leave for Caregivers"

Family caregiving for an older adult relative proves to be a stressful juggling act having a direct impact on finances, relationships, careers and mental health. All too often, an employed family caregiver eventually reaches a difficult cross roads, faced with the challenging decision between choosing career or responsibilities of being a family caregiver. This should not be a burdensome choice given the toll caregiving already entails.

Do policy makers know the impact family caregiving has? How often do state level policy makers have the opportunity hear real life accounts of the impact family caregiving has on a family caregiver? As a Social Worker advocating for family caregivers in NYC, I can bring these accounts to the table. I aim to educate the media, Members of Congress, and public on the importance of paid family leave. I envision public awareness campaigns in bi-lingual efforts to reach isolated family caregivers so they are better educated on existing employer related leave policies. These movements would ultimately impact workplace flexibility and have a trickle-down effect impacting family caregivers and advocates.

Family caregivers encounter wage loss and loss of other work related benefits, such as vacation, sick time due fluctuating and often unpredictable work patterns to meet the demands of caregiving and loss of retirement contribution to Social Security; my proposed change would examine policies to strengthen state level employer paid leave benefits.

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Name: Carolyn E Ziminski Pickering, PhD, RN
Location: Tecumseh, MI
Home Institution: Michigan State University
Proposal Title: Temporary Safe Housing

A major barrier to progress in addressing elder abuse/neglect is a lack of temporary safe housing for victims, particularly older adults who are no longer independent but also not dependent enough for nursing home care. Sometimes a practitioner (i.e. police or APS) will identify a victim of elder abuse/neglect and feel in their professional judgement that it is not safe for the older adult to remain at home until further interventions are delivered. However, the victim is not independent enough to go to a shelter or a hotel but they also do not meet nursing home level of care so there is no safe place to send them. The practice change I envision would be allowing temporary "safe housing" nursing home stays for older adult victims of abuse/neglect. Two possible ways to address this include: 1. modifying the Medicaid Level of Care Determination Form to include an item that would allow temporary shelter for older adults victims of abuse/neglect 2. Allowing for temporary stays in nursing homes for victims to be compensated by the Crime Victims Compensation Fund. Temporary safe housing would not only increase safety and prevent potential serious outcomes for older adult victims, it would also allow practitioners to focus their time and efforts on addressing the abusive situation and coordinating services. By achieving this practice change we will redesign service delivery for older adult victims of elder abuse/neglect.

Name: Robert J. Schreiber
Location: Andvoer, MA
Home Institution: Hebrew SeniorLife

Project Title: "Reaching the Triple Aim Through the Use of Evidenced based Self-Management Programs"

My policy challenge is making evidence based programs for self management a patient covered benefit for individuals with chronic disease. The goal is to have these programs become a patient benefit for those individuals and that they will be accessible and integrated into the care delivery and care plans for individuals. This will become a standard approach for management and control of chronic conditions. These programs are presently across being done across the country in most states. However, the funding has been through grants from the Administration on Community Living and other foundations. There has been slow uptake on giving patients and caregivers some of the tools and training essential in helping them better manage their chronic conditions and become an activated member of their own health care team.
The theoretical framework of how these programs support better outcomes is shown in the Chronic Care Model developed by Ed Wagner. A national outcome study published in 2013 involving the Stanford Chronic Disease Self-Management Program showed that implementation of this program in over 900 individuals with chronic illness resulted in statistically significant better health, healthcare and lower cost in one year.

My policy initiative is to advocate for the inclusion of these programs as a patient benefit in by all insurance plans. In addition, a payment mechanism for these programs is needed to ensure they can be sustained, replicated and scaled in a standardized approach.

Name: Casey R. Shillam, PhD, RN-BC
Location: Bellingham, WA
Home Institution: Western Washington University

Proposal Title: "Creating a Palliative Community: Changing Policy to Meet Community Demands"

Background: The Institute of Medicine's Dying in America recommends person-centered, family-oriented approaches to end-of-life care honoring individual preferences and promoting quality of life. The Palliative Care Initiative (PCI), a partnership of community members, educational and non-profit organizations, and health institutions in Northwest Washington, promotes excellence in palliative and end-of-life (P/EOL) care.

Description of the problem: Although a large-scale palliative care center and multiple initiatives exist in Washington State, two issues impact effective implementation of IOM recommendations: 1) the major focus of policy work takes place in Seattle, addressing needs for the urban area, but neglecting ¾ of the state's rural area; and 2) the center and initiatives are housed in academic health institutions, founded in the role of physicians in a medical model and limiting participation from patients and families.

A community-based solution: PCI community events, focus groups, and professional conferences have been held over 18 months in a rural area in far northwest Washington. Engaging over 600 stakeholders, partners identified important components of P/EOL care, and convened stakeholders to develop the "Blueprint for Community Excellence at End of Life." Five key elements for success were identified: 1) advanced care planning; 2) community-based palliative care services; 3) shifting the community culture; 4) improved provider training; and 5) sustainable financing. A collective framework for implementation and funding the work has been developed, with three organizations taking the lead responsibility for enacting these elements through ongoing community engagement.

Proposed change: A framework created by community members in partnership with health care providers can inform the current movement in the state's policy implementation for changes to palliative care reimbursement.

Name: Winnie Suen, MD, MSc, AGSF
Location: Falls Church, VA
Home Institution: Inova Fairfax Hospital

Proposal Title: "Advocating for provider reimbursement for telemedicine services to improve care access"

The Affordable Care Act has helped to create many more health care consumers. Meanwhile, available health care providers have not been able to keep up with demands for in-person visits in

the tradition manner. Technology has advanced to the point where it can be leveraged as a useful tool to compliment the care in many settings other than the traditional office visits. However, due to lack of a payer reimbursement scheme, providers are reluctant to be involved in this type of care.

My project involves advocating for provider reimbursement for telemedicine visits, as there is an absence of consistent, comprehensive reimbursement policies for telemedicine visits. Currently, Medicare reimburses for telemedicine services only when the originating site is in a Health Professional Shortage Area (HPSA) or in a county that is outside of any Metropolitan Statistical Area (MSA), defined by HRSA and the Census Bureau, respectively. In addition, in a skilled nursing facility, there is a limitation of one reimbursed telemedicine visit every 30 days. If the goal were to improve patient care and efficiencies and decrease costs, having access to more than one telemedicine reimbursement every 30 days would be beneficial for patients and providers in the skilled nursing facility. Medicare's current telemedicine reimbursement policy is a serious obstacle to integrating telemedicine into practice. If the policy can be broadened to include reimbursement for providers regardless of location, specialty, and number of visits, older adults could gain convenient access to geriatricians and other providers.

Name: Carin Tinney
Location: New York, NY
Home Institution: New York City Department for the Aging

Proposal Title: "Seeking Recognition of Aging Services as a Medicaid Plan Benefit"

Community-based socially oriented aging services providers attend to the health and social needs of older adults. Agencies serving in this capacity have been providing home delivered meal, senior center, case management and other services to frail elders for decades, and many have begun providing evidence-based health and wellness programming as well. It has become extremely clear that the services the NYC Department for the Aging (DFTA) provides are an essential part of maintaining the health and preventing decline amongst the older adult population, but adequate reimbursement for those services and recognition of the role they plan in the healthcare continuum has not kept pace.

For the Policy Institute, DFTA will continue on its course to formalize aging services' role related to Medicaid funding by exploring mechanisms at the federal/state levels to: 1) seek recognition for community and evidence-based health promotion and care transition programs as a plan benefit in Medicaid FFS and MC; 2) draw down Medicaid funds for those programs, including administrative fees; and 3) identify best practices for using those administrative fees to implement an effective back office function as well as operationalize a quality assurance arm for this work.

Name: Amy Turk, LCSW
Location: Los Angeles, CA
Home Institution: Downtown Women's Center

Project Title: "Health Home Connect"

The mission of the Downtown Women's Center (DWC) is to provide permanent supportive housing and a safe and healthy community fostering dignity, respect, and personal stability, and to advocate ending homelessness for women. DWC understands that homelessness cannot end unless proper supports are provided, including healthcare. To that end, DWC created the Health Home Connect Project. In 2014, Health Home Connect linked changes through Affordable Care Act (ACA) and the US Department of Housing and Urban Development (HUD)'s Coordinated Entry System (CES) housing system, to identify vulnerable women and enroll them into Medicaid while providing extensive patient navigation services. This effort resulted in a 41% decrease in unnecessarily emergency healthcare use for women 55 years old and above. Currently, the Health Home Connect Project is primarily focused on advancing public policy as it relates to improving access to healthcare services for Medicaid-eligible older adults experiencing homelessness. DCW and its partners (United Homeless Healthcare Partners and Corporation for Supportive Housing) are working to: 1) maximize Medicaid expansion by furthering efforts to coordinate enrollment for homeless residents; 2) create partnerships with Medicaid 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 and implementation of California's 1115 Waiver and the Health Homes Bill state plan amendment to ensure Medicaid funding for "health home" services that promote housing stability.

Name: Amy Vandenbroucke, JD
Location: Portland, OR
Home Institution: Oregon Health & Science University

Proposal Title: "Promoting Immediate Accessibility of Advance Care Planning documents in Electronic Health Records"

Too many health care facilities are not using electronic health records (EHRs) to ensure patient wishes are known and honored when patients lack the capacity to speak for themselves. Patient wishes are known through advance care planning documents, such as advance directives or living wills, and end of life medical orders, such as DNRs or physician orders for life-sustaining treatment (POLST). Given that these documents help ensure patient autonomy and improve the care being provided, particularly during medical emergencies, it should be a national priority to require all EHRs be created to store, show the presence or absence of such a document in the patient header, and allow one-click immediate access to such documents. [Note: EHRs are complicated systems and just because a document is "in the record" does not mean it can be easily located.]
Within EHR systems, patient headers provide a quick snapshot of, or access to, pertinent information such as identification, demographic and medically significant information like allergies. Although EHR builds are currently institutionally-specific, resulting in different patient header information, the Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible hospitals that adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology by meeting thresholds for a number of objectives. This program for Meaningful Use of EHRs is hoped to result in, among other things, empowerment of patients. Patient empowerment includes respecting their wishes for care.