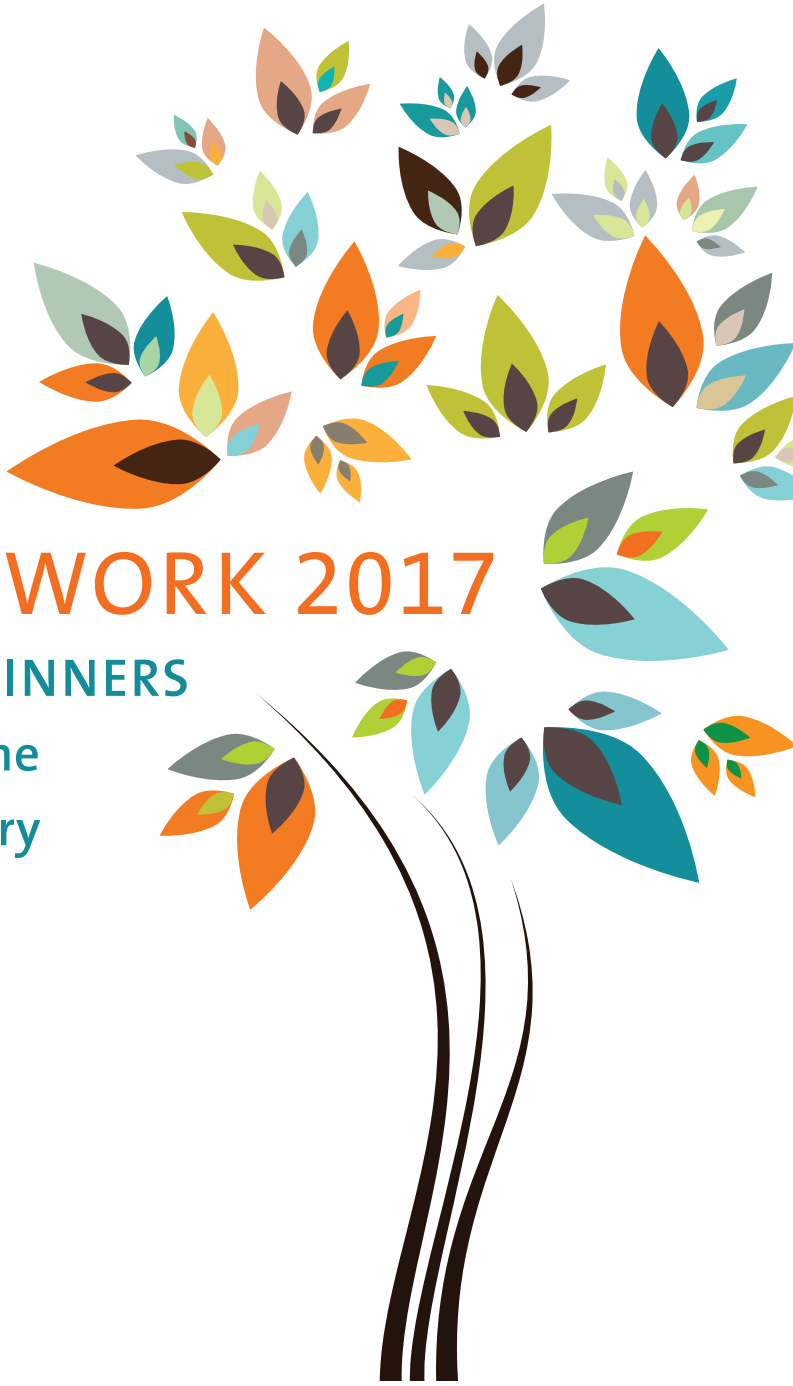

INNOVATION AT WORK 2017

PROMISING PRACTICES WINNERS

That Are Reshaping the Aging Services Industry

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Institute on Aging

In many areas of aging services, organizations are restricted by guidelines, protocols, and mandates. Yet those with vision and insight can find plenty of room for innovation and evolution in how we serve older adults. Mather LifeWays Institute on Aging recognizes several exciting innovations every year with the Promising Practices Awards, designed to honor organizations working with older adults in a variety of settings that are moving away from conventional practices by developing and implementing groundbreaking approaches.

Award recipients are selected based on one or more of the following:

- **innovation**
- **outcomes presented**
- **replicability of the practice**

By sharing these promising practices each year, the Institute encourages innovations that improve programs and services for older adults. We hope other organizations will adapt the ideas here, transform them into best practices, and ultimately improve areas within aging services.

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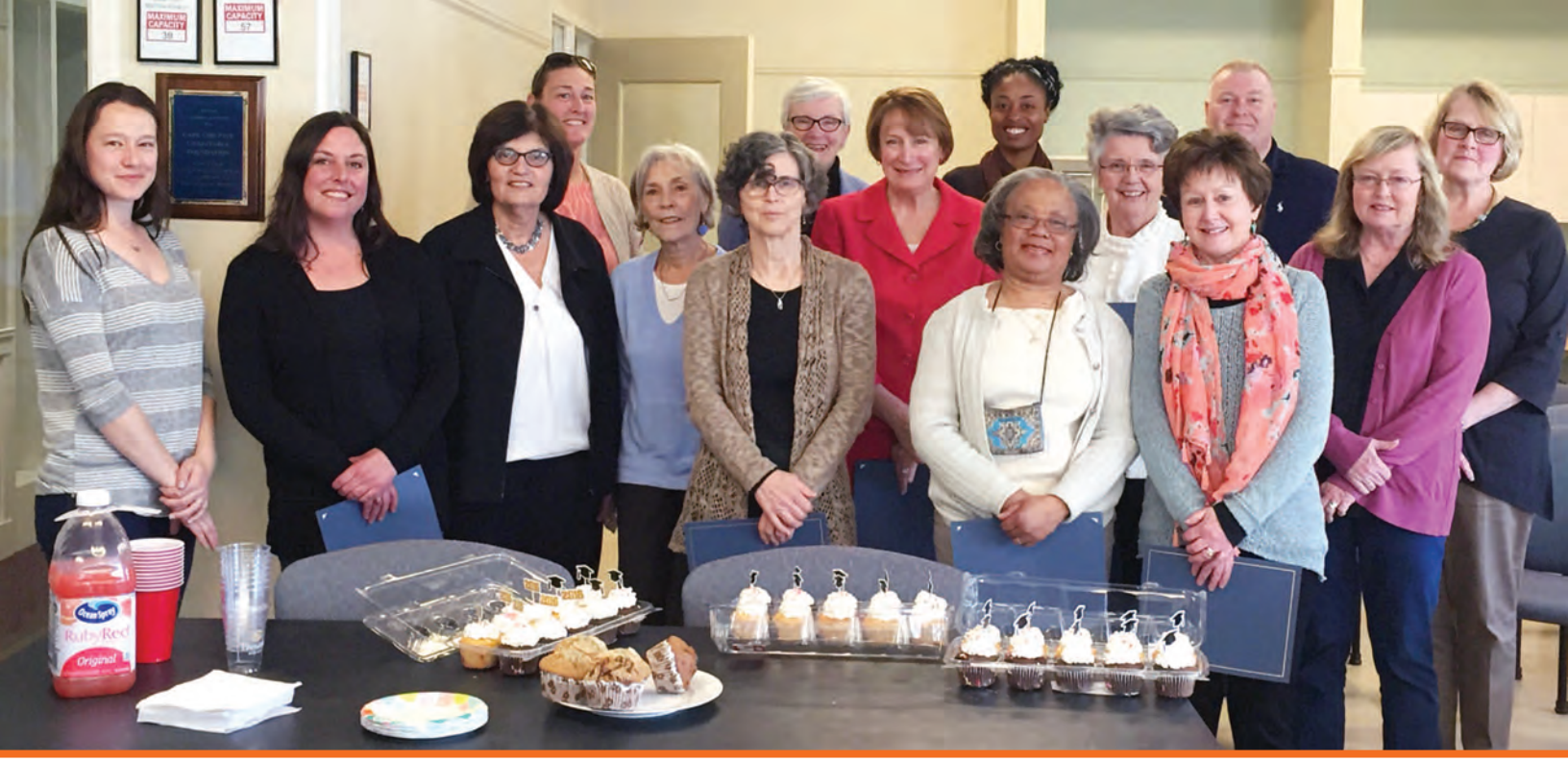
AWARD RECIPIENTS

HONORABLE MENTIONS

All photos supplied by the recognized organizations.



Part of CADER's Behavioral Health and Aging training is two in-person sessions, taught on-site for all staff involved at a centrally located senior center.

TRAINING

Senior Center Staff on a Taboo Topic

THE CENTER FOR AGING & DISABILITY EDUCATION & RESEARCH (CADER) AT BOSTON UNIVERSITY'S SCHOOL OF SOCIAL WORK
Boston, MA
bu.edu/cader/

The Center for Aging & Disability Education & Research (CADER) at Boston University's School of Social Work answered a training need among those who work with older adults in the community: these professionals could enhance their roles by learning to recognize and respond to older individuals with behavioral health concerns—an area of focus often left unaddressed in aging services.

"One of the greatest barriers to the provision of mental health services is the lack of a sufficiently trained workforce," points out Bronwyn Keefe, research assistant professor at BU SSW and director at CADER.

"One of the greatest barriers to the provision of mental health services is the lack of a sufficiently trained workforce."

So CADER, part of Boston University School of Social Work, has designed and delivered a Behavioral Health and Aging training program built around key competencies in geriatric behavioral health.

CADER standardized the program's curriculum so it can be provided online to employees of any of the 11,000 Councils on Aging (COAs), across the country. Nationally, COAs are often the community focal point for social and support services for older adults, families, and caregivers. "Given the lack of training in aging and mental health, we believe that providing an online, competency-based curriculum to [COAs] can have significant impact on this problem," says Keefe.

The program uses an innovative blended training model, combining two two-hour, in-person sessions with 15 hours of online coursework from CADER's Behavioral Health and Aging online certificate. Online coursework focuses on:

- Mental Health and Aging
- Mental Wellness and Resilience among Older Immigrants and Refugees
- Suicide Prevention among Older Adults
- Substance Use among Older Adults

To date, CADER has trained 100 workers in 56 COAs in Massachusetts. Of those, the majority were directors and outreach workers; other learners included program coordinators, administrative assistants, and case managers.

Pre- and post-program evaluations show statistically significant improvements in all competencies. For example, participants averaged the following:

- 363% increase in the competency "Utilize information about depression in your work with older immigrants and refugees"
- 340% increase in the competency "Describe interventions you can utilize to promote mental wellness with older immigrants and refugees"
- 235% increase in the competency "Identify standardized screening and assessment tools that are appropriate for use with older adults"
- 280% increase in the competency "Utilize evidence-based models for addressing substance use"

In addition to COAs, the program is being used by over 700 staff members at Area Agencies on Aging across the country and clergy members in Massachusetts.

"This program has proven to be a cost-effective way to provide a significant amount of training, and constitutes a great step forward in addressing this workforce need," says Keefe.

CADER'S PROGRAM BY THE NUMBERS

OVER 230% increase in competencies

700 aging service providers have completed training

56 Councils on Aging trained in Massachusetts

Insights into CADER's Training

This program—and programs like it—have the potential to change the aging services industry. By working through the existing statewide structure of the COAs, it can have a significant impact on helping older adults with behavioral or mental health challenges.

CADER sought and received funding from the Massachusetts Department of Public Health, Suicide Prevention programs to cover the cost of the delivering their training to COAs. Other organizations could seek funds from private and public funders such as their state departments of elder affairs, mental health, and public health to address this growing public crisis.

For more information from CADER, contact Bronwyn Keefe at bronwyn@bu.edu.

Team members trained on serving those living with dementia get a hands-on experience on the resident's perspective.

TRANSFORMING
Care Transitions for Persons Living with Dementia

PRESBYTERIAN SENIORCARE NETWORK
Oakmont, PA
srcare.org/index

Presbyterian SeniorCare Network is training key health care professionals in care transitions to better serve people with dementia.

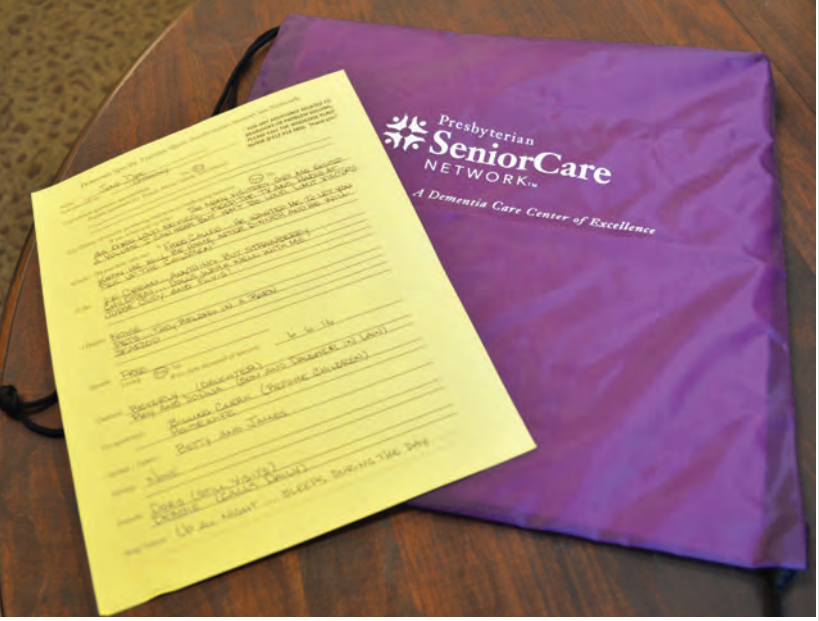
A not-for-profit network that serves older adults through senior living residences, affordable housing, and home health in western Pennsylvania, Presbyterian SeniorCare Network is grounded in expertise in dementia care. "That expertise positioned us to share our knowledge about dementia and improved continuity of care for our residents living with dementia, as they transition across care settings—particularly to the hospital," says Carrie Chiusano, executive director of the network's Dementia Care Center of Excellence.

The network developed training modules for a lunch-and-learn series offered to hospital workers, covering topics such as

- Dementia . . . What's It All About?
- Finding the Right Words . . . How to Communicate
- Behaviors . . . Finding a Creative Path
- Family Dynamics

The first participants in the sessions were RNs from emergency departments and nursing units; staff from quality improvement teams also attended.

In addition to these trainings, Presbyterian SeniorCare Network has developed a system to share important information about persons living with dementia upon transfer to a hospital. The individual is accompanied by a purple cinch bag that hospital staff have been trained



A person living with dementia who is transported to the hospital travels with an easily recognizable bag with important information.

100% of participants improved their comfort level and/or competency when interacting with individuals living with dementia.

to recognize. In the bag are forms with information, including a bright yellow cover sheet outlining the individual's history of anxiety-producing situations or challenging behaviors, and techniques on how to de-escalate situations. The resident's likes and dislikes are included, as well as phrases that prove calming to them or topics of conversation that are comforting for them. Per the hospitals' request, a phone number is also included in case more details are needed.

Pre- and post-tests tailored to each lunch-and-learn presentation indicated that 100% of participants improved their comfort level and/or competency when interacting with individuals living with dementia. This improvement impacts the likelihood of a better care experience for these residents when a transition in care is necessary. The effectiveness of this model has been replicated with several other hospitals across the Network's region.

Adapt Your Own Training for Transitions

The dementia training modules and cinch bag of vital information can be replicated easily. The most important step will be identifying the hospitals or other entities you partner with. "After the initial success, we expanded the concept further," says Chiusano. "We're educating first responders, local fire departments, police departments, and EMS teams."

Tips:

- Form your partnership(s) first, and ask your contacts what they need to know about interacting with persons living with dementia.
- Work with a training expert as well as your in-house experts to create modules on dementia.
- Work with your partner organization(s) to determine the frequency, time, and place of the trainings.
- If you want to include the cinch bags of information, you'll need to follow HIPAA and privacy rules regarding creating and storing the information sheets.
- For each training module you deliver, include a pre- and post-session test on the topic area so you can monitor your success.

For more information from Presbyterian SeniorCare Network, contact Carrie Chiusano at cchiusano@srcare.org.

The Community Care Connections program enables an older adult's health care professionals, social worker, and other providers to collaborate on care.

BRIDGING CARE GAPS
for Older Adults in the Community

LIFESPAN OF GREATER ROCHESTER
Rochester, NY
lifespan-roch.org

Lifespan of Greater Rochester saw a need to coordinate medical care and community-based social services for older adults with multiple chronic illnesses and other risk factors.

The organization spearheaded a program called Community Care Connections (CCC), which serves those age 60 and better living with multiple chronic illnesses, nonadherence, low health literacy, or lack of financial, caregiver, or transportation resources.

"As a provider of community-based aging services, we know that what occurs in people's homes and lives affects their health outcomes," says Ann Marie Cook, president/CEO of Lifespan of Greater Rochester. "Yet organizations like ours traditionally function outside of medical systems." The result is siloed medical care and social services for older adults.

Funded by a $1.6 million three-year contract from the New York State Department of Health and guided by a committee of representatives from medical systems, Lifespan identified willing medical providers, then assigned—or hired—social workers and nurses to work within those provider organizations. "Our social workers are embedded in five physician practices with high geriatric populations, and we are aligned with 20 other physician practices, home care agencies, and outpatient clients," explains Cook. "In a new role for an aging service provider, we hired LPN nurses and an RN supervisor as health care coordinators, and they serve a subset of complex, high-need patients."

CCC RESULTS BY THE NUMBERS

72% of patients had fewer visits to the ED

65% had fewer hospitalizations

$3.2 MILLION in cost avoidance for 437 patients

CCC social workers link older adults to available services, while CCC nurses coordinate a range of care for complex, nonadherent patients, including arranging for transportation, attending medical appointments to ensure effective communication, conducting in-home medication reconciliations, and providing disease education and emotional support.

The results speak for themselves: The New York Academy of Medicine evaluated the program and found that 72% of patients had fewer visits to the emergency department, and 65% had fewer hospitalizations, compared to 180 days pre-service. "ROI estimates for the program are likely to be between $2.27 and $4.58 per dollar spent on the service," says Cook. "That translates to $3.2 million in cost avoidance for 437 patients."

Tips on Integrating Services in Your Community

"Most of the Area Agencies on Aging across the country could do this," says Cook. By focusing on the data regarding successful (and cost-effective) outcomes, aging services nonprofits and even senior centers could offer participation in this program to medical centers and funding agencies. "I believe the services we're providing could be provided using current dollars," Cook points out.

Here are some points to consider if you want to implement a similar service:

- The project began with an important six-month planning phase, during which Lifespan involved representatives from their two local health systems, the Medical Society, insurers, and home care agencies. This group still meets quarterly as an advisory committee.
- Data management is vital. Ensure the data pathway is set prior to start-up. To validate self-reported ED/hospital utilization, Lifespan uploads patient data to its Regional Health Information Organization (RHIO). Data is matched with utilization, then de-identified data is forwarded to the evaluator. Through RHIO, Lifespan social workers and nurses also are alerted to ED visits and hospitalizations among patients.
- Despite the ROI, employing LPN nurses is expensive. Lifespan is piloting a tiered intervention methodology using newly hired community health care workers, and they're using volunteers to make appointment reminder calls and help schedule transportation.

For more information about Community Care Connections, contact Ann Marie Cook at amcook@lifespanrochester.org.

JOINING FORCES
to Create a Virtual Agency

JEWISH ASSOCIATION ON AGING
Pittsburgh, PA
jaapgh.org

AgeWell Pittsburgh is a "virtual agency" that comprises three not-for-profit service agencies and is designed to help local older adults maintain their health and independence.

This unique collaboration of the Jewish Association on Aging, Jewish Family & Children's Service, and the Jewish Community Center of Greater Pittsburgh was conceived 12 years ago. At the time, the agencies each provided different but overlapping services for older adults.

AgeWell Pittsburgh has become an umbrella organization providing more than 25 unique services for older adults, including home-delivered meals, caregivers, transportation, information and referral services, and individual assessment services.

The organization is overseen by three program managers, each employed by a member agency, and staffed by a core group of employees from the agencies. Executive directors, coordinators, and providers from the three agencies meet regularly to discuss best practices, address service gaps, and respond to any challenges.

96% of the 8,000 older adults enrolled have stayed out of hospitals and skilled nursing facilities.

For AgeWell Pittsburgh, the agencies implemented a shared tool that quantifies risk factors and gathers data on clients' hospital or ED visits, so providers can be proactive on the next steps for care. An outcome measurement tool called the Protective Factors for Maintaining Independence (PFMI) is administered to participants to measure changes in risk factors associated with a loss of independence. The tool is flexible enough to accommodate the various services, and data is in a shared database.

As a result of the PFMI, 96% of the 8,000 older adults enrolled have stayed out of hospitals and skilled nursing facilities. AgeWell Pittsburgh clients fare well below the national and regional averages for ED utilization, hospitalizations, and skilled nursing admissions.

For details, contact Tinsy Labrie, marketing and public relations director, at tlabrie@jaapgh.org.

AgeWell Pittsburgh provides more than 25 different services for area older adults.

Start Your Own Collaboration

- Creating this unique, intensive partnership involved a great deal of planning, cooperation, and buy-in from all levels of the organizations. AgeWell Pittsburgh was able to have a lasting impact on the community by working on culture change from the board level on down through the organization.
- AgeWell Pittsburgh combines the strength of member agencies by focusing solely on clients.
- AgeWell Pittsburgh credits success in responding to challenges while maintaining the collaboration to the high importance each agency places in this endeavor, as well as the structure of the program.

PROMOTING WELLNESS
through Resident Empowerment

FRIENDSHIP VILLAGE OF BLOOMINGTON
Bloomington, MN
lifespacecommunities.com/senior-living-bloomington

Every year, Friendship Village of Bloomington senior living community offers a WinterFit program for residents—a wellness program designed to keep them active January through March. In 2017, the fitness team chose the WinterFit theme of The Power of 1.

The Power of 1 encourages people to set one small, personal goal that could have a lasting and big impact on their health. To promote the program, the community took some unique steps:

- T-shirts were designed for residents and staff, who wore them on casual days and at special events
- Power of 1 posters were displayed
- handouts on effective goal-setting were shared with residents
- a "shared journal" was offered for anyone who wanted to write down their goal for public viewing
- support circles were formed to keep residents motivated

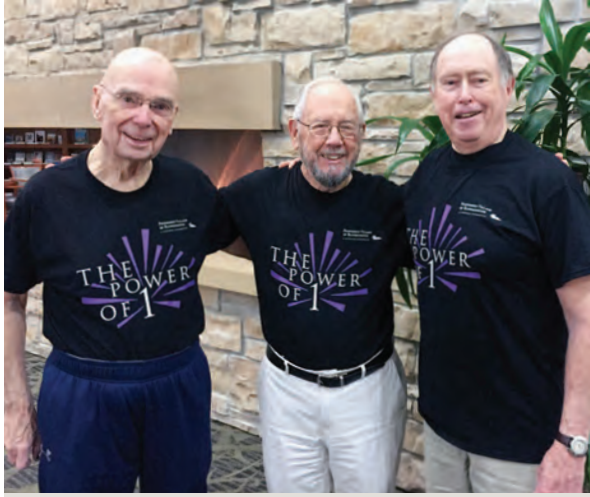
Residents reported various successes, including an ability to control blood sugar without insulin, increased endurance and energy, improved balance…

In March, WinterFit wrapped up with a party, complete with a resident-staff skit and a guest speaker.

The most innovative aspect of The Power of 1 was the support provided to residents to help them achieve their goals. Research indicates that talking about your goal in a social setting, as well as posting it in a public area, greatly increases the possibility of achieving and maintaining success.

The fitness team noted an increase in the use of the fitness center, and some of the support circles continued to meet for months after the event. Residents reported various successes, including an ability to control blood sugar without insulin, increased endurance and energy, improved balance, branching out to try new social opportunities, adding new brain challenging activities, and increasing volunteerism.

For details, contact Julie Schuster, fitness instructor, at julie.schuster@lifespacecommunities.com.



Participants focused on achieving a single goal that could have a major impact on their health.

Power Up for Your Own Goals Program

The Power of 1 could easily be replicated in any senior living community with the involvement of wellness professionals including fitness staff, chaplains, and even resident volunteers (with some guidance). Tips for leading goal-setting groups include:

- It is important that group leaders remind participants that anything shared in the group is confidential.
- It is also important to allow the individual who is speaking to do their own problem-solving. This is the most effective way for them to come up with their own steps to reaching their goal. The leader needs to remind the group of this at the start of each session.

A best practice would be to continue the support circles in some way for at least a few months.

Interested in Submitting for the 2018 PROMISING PRACTICES AWARDS?

Nominations will open in summer 2018.

For details, visit matherlifewaysinstituteonaging.com/promising.

Mather LifeWays Institute on Aging is a respected resource for research and information about wellness, aging, trends in senior living, and aging services innovations. In order to support senior living communities and others that serve older adults, the Institute shares its cutting-edge research in areas including effective approaches to brain health, ways to enhance resilience, and employee wellness programs. Mather LifeWays Institute on Aging is part of Mather LifeWays, a 75+-year-old not-for-profit organization dedicated to developing and implementing Ways to Age Well℠ by creating programs, places, and residences for today's young-at-heart older adults.

Learn more about the Institute at matherlifewaysinstituteonaging.com.

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