WHITE PAPER

Value of Enhanced Service Coordination for American Association of Service Coordinators

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This white paper will provide documentation as to what members of the American Association of Service Coordinators (AASC) currently do and propose enhancements to Service Coordinator duties that will improve health and wellness among elder and disabled residents served, improve both the resident and property's experience, and reduce costs. Programs to enhance service coordination among AASC members that will be discussed are health prevention services, transitional care services, falls prevention, medication self-management, weight loss, brain health, chronic disease self-management, and advance planning.

The Service Coordinator, who typically has social work or human services education and experience, provides information and referrals to residents in low-income housing properties who need supportive services to maintain independence. According to AASC, there are approximately 218,000 residents who are actively tracked in the AASConline system out of the more than two million low-income seniors, individuals with special needs, and families residing in affordable housing (Donovan, S., HUD, 2013). They identify, locate, and assist the residents with acquiring the benefits and services necessary for them to age in place in their own community. Service Coordinators provide assistance and access to community-based supports, skills training, and resources for low-income elders and families to achieve self-sufficiency (HUD NOFA, 2013).

Over 1,430 AASC member Service Coordinators report agency/service referrals to their residents in the web-based AASConline documentation and case management system. According to the data in AASConline for the period of January 1, 2014 to June 30, 2014 (www.aasconline.org/miscellaneousreport/SuccessfulAging), approximately 14% of the residents being tracked are between ages 18 and 61, 57% are 62 – 80, 27% are 81-95, and the remaining 1.4% are over 96. Persons over 62 years old who need help with 1-2 activities of daily living (ADL's) such as eating, bathing, dressing, transferring or grooming are considered at-risk; and those who need assistance with 3+ ADL's are considered frail. AASConline indicates the numbers of at-risk and frail elder residents are 61,954 and 30,819, respectively. The top five health issues reported are: hypertension, arthritis, diabetes, high cholesterol, and heart disease. The majority of the service/agency referrals reported are typically one to one (one resident to one referral

service/agency); some exceptions are for referrals for services such as, but not limited to, personal care, and the referrals to meals and physical fitness/exercise classes which have significantly higher number of referrals. The AASConline database, at this time, does not contain data relating to referrals to falls prevention, medication management, or chronic disease self-management programs. However, the system does record the number of residents assisted by the Service Coordinator in these areas. A convenience survey administered by the Center for Healthy Aging in June 2014 for this white paper was a sample size of 3% of the total Service Coordinator membership of 3,200. Per the results, approximately 8% of the average resident population were referred to programs for common health and wellness prevention issues such as: falls prevention, medication management, and chronic disease self management. Given that 42% of the 218,000+ resident population are at-risk and frail, the numbers of residents receiving these preventive services should increase. These survey responses are of particular interest in our efforts to propose enhancements to service coordination (AASC Survey Results Attachment A). However, the sample survey is not meant to be a statistically scientific method for determining service coordination across all sites. The survey was designed to provide some general description of what the Service Coordinator currently does.

According to AASC, evidence supports what affordable housing practitioners have known for a long time; the provision of resident services through Service Coordinators result in dramatic benefits for both residents and properties. Elders experience better health outcomes and the ability to age in place as they become more functionally frail (AASC, 2013, HUD, 2013). Service Coordinators provide needs assessments, goal development, service planning, and follow up. One of the major goals is to increase safety as needs for assistance are more quickly recognized and addressed before they escalate to a crisis situation. Affordable housing properties that provide on-site service coordination see significantly lower operating costs through savings associated with lower vacancy rates (AASC, 2013). This paper addresses the enhancement of the Service Coordinator mission for the elder, the resident with disabilities, and the housing property management.

According to the Lewin Group, the Department of Housing and Urban Development's (HUD) FY 2010-2015 Strategic Plan (HUD, 2010) and the Department of Health and Human Services' (HHS) Vision and Strategic Framework on Multiple Chronic Conditions (The Lewin Group, Sept. 2013) both embrace person-centered, holistic and cost-effective approaches to addressing the needs of vulnerable low- and moderate-income older adults. These approaches include a person-centered philosophy that focuses on the elder as central to the health and social service system and recognizes that the quality of the larger physical and social environment within which an individual lives (including shelter) significantly influence one's health and quality of life (The Lewin Group, Sept. 2013). Building on over two decades of efforts to increase access to home and community based services and supports, the Patient Protection and Affordable Care Act (ACA) further expands Medicare and Medicaid-funded options, providing unique opportunities for exploring how housing with services models may provide efficient ways of serving large numbers of low-income elders (HUD, 2013).

Acknowledging the lack of service coordination and integration for Medicare and Medicaid beneficiaries, particularly those with multiple chronic conditions and functional limitations, the ACA established several new offices within the Centers for Medicare and Medicaid Services (CMS) to develop and oversee a range of payment and service reform demonstrations and programs that test new approaches to reducing fragmentation and costs. These policy changes offer unique opportunities to explore the role of affordable housing with services in achieving the goals and objectives of these initiatives (DHHS, 2013). Programs of interest to enhance service coordination among AASC members are health prevention services, transitional care services, falls prevention, medication self-management, and chronic disease self-management.

Many problems of elders and the disabled deal with chronic health conditions that if not attended to, will exacerbate into costly emergency or other medical services. Preventive services and education around brain health, medications, falls, nutrition, exercise, socialization, emergency advanced planning, chronic disease self-management, and transitional care after a hospitalization are critical to improving

quality of life for the elders and disabled, as well as improving both the residents' and properties' experience for aging in place, and reducing costs.

In the Lewin Group and LeadingAge document entitled "Demonstration Design Options for Coordinated Housing, Health, and Long-term Services and Supports for Low Income Older Adults" (The Lewin Group, Sept. 2013), they propose three designs for demonstrating "enhanced service coordination": *Option 1: Enhanced Service and Support Coordination Model; Option 2: Added Onsite/Clustered Home Care Services Strategy; Option 3: Added Engagement with Health Care Entities Strategy.* These three designs for enhanced service coordination incorporate the following elements: 1) Assessing residents for health and social needs; 2) Helping to identify, access and coordinate services (i.e. personal care), including communicating with service providers; 3) Monitoring receipt and follow through of services, including encouraging and motivating residents to engage with providers and participate in their own management; 4) Building partnerships and communicating with service providers; and 5) Serving as a member of an interdisciplinary team.

All options serve the whole resident population, but allow for targeted attention to specific resident populations, such as those with multiple chronic illnesses or functional limitations. It is important to serve the whole resident population because all residents may benefit from some level of services and support. All three models recognize the value of an integrated approach to address housing, health and long-term services and support needs. All rely upon the inclusion of innovative person-centered, holistic and cost-effective interventions to coordinate care. All include a strong health promotion and disease prevention focus, with an emphasis on health education, physical and cognitive fitness, and self-care management.

In the first option, the Service Coordinator acts more proactively, assuming tasks, such as conducting assessments, developing and monitoring care plans, encouraging resident engagement in programs and activities, motivating resident engagement in their own health and supports management, and collaborating with other community services, especially a public health or community nurse to address resident issues. The second option takes option one enhanced services and support coordination model and adds the support of home care or personal care services through a clustered care

strategy. The third option takes the first option of enhanced services and support coordination model and adds linkages with primary and behavioral health providers. Of particular interest for enhanced service coordination is to link Service Coordinators with hospital staff (discharge planners, nurses, etc.) to improve resident transitions between care settings, e.g.: from hospital to home.

PROPOSAL TO AASC

Our proposal to AASC and its members is to incorporate options 1 and 3 and develop a demonstration that provides training and tools to the Service Coordinator to enhance and standardize their role. The enhanced Service Coordinator role will assist residents with preventive health and wellness services and the linkages for transitional care programming. This white paper will introduce the concept by presenting the following health prevention and wellness services: transitional care; falls prevention; medication self-management; weight loss – nutrition and exercise; brain health; chronic disease self-management; and advance planning. This enhancement will improve health and wellness among elder and residents with disabilities served, improve both the residents' and properties' experience, and reduce costs.

TRANSITIONAL CARE

In 2011, CMS documented that approximately 2.6 million seniors, or one in five, are readmitted within 30 days of discharge from a hospital at a cost of over $26 billion every year. These readmissions or failed transitions in care lead to substantial increases in costs, morbidity, and mortality (http://innovation.cms.gov/initiatives/CCTP /index.html). As a result, the Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, began testing models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. According to the CMS Innovation Center (2010), the goals of the CCTP were to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.

Avoidable readmissions and patient dissatisfaction with discharge care are growing problems nationwide. Of those Medicare beneficiaries who are readmitted within 30

days, 64% received no post-acute care between discharge and readmission. Combine that with mismanagement of medications and other causes for re-hospitalization, the leading experts believe that a total of 76% of readmissions may be preventable (MedPac, 2007). Furthermore, research from the CMS shows beneficiaries report greater dissatisfaction in discharge-related care than any other aspect of care CMS measures. Additional research shows that the majority of readmissions were medication related (66%) and 50% had lab results that were still pending at discharge (Roy, et.al, 2005). Clearly, returning to an acute care hospital is a major Medicare healthcare problem, but it is solvable.

A challenge frequently raised is assisting residents with their return from a hospital stay. Results from the survey of select Service Coordinators indicate that they are mindful of following residents when they return from a hospital stay to ensure they have all the supports in place they need to have a successful transition back home. They face challenges, however. Because the properties the Service Coordinators serve are independent settings, they do not track residents on a consistent basis and the Service Coordinators are not always notified when residents have gone to the emergency department or been admitted to the hospital. (AASC Survey Results Attachment A).

The fundamentals of the proposed demonstration include utilizing the Service Coordinators in a 'Transitional Health Coach' model built on the work of Coleman, et.al., Care Transitions Intervention Program, (2004). Care Transitions Intervention is an evidence-based model that helps older adults and family caregivers become more comfortable and competent in participating in the patient's care needs during transitions between sites of services, and ultimately assists in keeping the frail, chronically ill elder out of the acute care setting within the first 30 days after an acute hospital discharge. The survey of the AASC Service Coordinators indicated that, although not consistent, Service Coordinators do perform tasks that are fundamental to transitional care (AASC Survey Results as they relate to Transitional Care Attachment B). Although the Coleman Care Transitions Intervention Program promotes the use of a nurse as the Transitional Health Coach, we propose utilizing trained Service Coordinators in a Transitional Coach role to address Coleman's '4-Pillars', which are: Medication Self-Management, Primary Care Follow-up, Recognizing Red Flags, and creation and/or

maintenance of a Personal Health Record. In this role, the Service Coordinator will act as a 'coach', and as such, will promote self-management. The AASC member Service Coordinators will provide tools, such as forms to list medications, forms that relate to the residents' personal health (e.g.: in case of emergency, primary care physician, personal health issues, questions to ask the doctor, etc.), and health information sheets (to help in recognizing red flags). The Service Coordinator will assist the resident in making an appointment to see their primary care physician and securing transportation, as needed. When questions arise regarding medications, red flags, or other health issues, the Service Coordinator will encourage the resident to document their questions and speak to their healthcare provider (physician, pharmacist, or home health nurse) to gain understanding.

FALLS PREVENTION

One in three adults aged 65 and older falls each year (Sterling, DA, O'Connor, JA, Bonadies, J., 2001). Of those who fall, 20% to 30% suffer moderate to severe injuries that make it hard for them to get around or live independently, and increase their risk of early death (Alexander BH, Rivara, FP, Wolf, ME, 1992). Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes (Centers for Disease Control and Prevention, 2010). In 2011, emergency departments treated 2.4 million nonfatal fall injuries among older adults; more than 689,000 of these patients had to be hospitalized (Sterling, DA, O'Connor, JA, Bonadies, J., 2001). Fortunately, falls are a public health problem that is largely preventable.

Per the Centers of Disease Control and Prevention (CDC), older adults can stay independent and reduce their chances of falling (Gillespie, LD, Robertson, MC, Gillespie, WH, Sherrington, C, Gates, S, Clemson, LM, Lamb, SE, 2012 and Moyer, VA, 2012). They can: 1) Exercise regularly. It is important that the exercises focus on increasing leg strength and improving balance, and that they get more challenging over time. Tai Chi programs are especially good. 2) Ask their doctor or pharmacist to review their medicines—both prescription and over-the counter—to identify medicines that may cause side effects or interactions such as dizziness or drowsiness. 3) Have their eyes checked by an eye doctor at least once a year and update their eyeglasses to maximize their vision. They can also consider getting a pair with single vision distance

lenses for some activities such as walking outside. 4) Make their homes safer by reducing tripping hazards, adding grab bars inside and outside the tub or shower and next to the toilet, adding railings on both sides of stairways, and improving the lighting in their homes.

Per the survey of AASC member Service Coordinators, 70% of the respondents indicated they refer residents to a Falls Prevention program. A structured and standardized Falls Prevention program such as "A Matter of Balance" (MOB) offered to the residents would have multiple benefits for the residents and the properties. "A Matter of Balance: Managing Concerns about Falls" is an award-winning program designed to reduce the fear of falling and increase activity levels among older adults who manifest this concern. The program was developed and formally evaluated by The Roybal Center for Enhancement of Late-Life Function at Boston University with a grant from the National Institute on Aging (Tang, F., Choi, E., and Morrow-Howell, N., 2010). It has since been translated into a program that uses volunteer lay leaders as facilitators instead of health care professionals and serves as a national model for addressing falls prevention.

Classes help participants to view falls and fear of falling as controllable, set realistic goals for increasing activity, change their environment to reduce fall risk factors, and promote exercise to increase strength and balance. Matter of Balance is designed to benefit community-dwelling older adults 60+ who are concerned about falls, have sustained a fall in the past, have restricted their activities because of concerns about falling, and are interested in improving their flexibility, balance and strength.

The Lewin Group reported that when there is a high incidence of resident falls, there are perceived limitations of the housing property to respond. Many properties have a policy not to assist a resident in any way when they fall and to call 911. The concern is the potential liability. Nonetheless, several housing providers recognize that many residents probably do not need to go to the emergency department and that there is a high cost connected to these unnecessary trips. (The Lewin Group, 2013). This challenge can be mitigated by utilizing a Personal Emergency Response System (PERS) that gives the resident the choice of who to call as their responder when they need help. A signed agreement between the resident and the PERS provider listing the names of

persons the resident chooses as their responder can mitigate liability. Another benefit of utilizing a PERS with residents who are at high-risk for falls is to minimize the amount of lay time. About half of older people who fall cannot get up without help. Remaining on the floor for more than 2 hours after a fall increases risk of dehydration, pressure ulcers, hypothermia, and pneumonia (Rubenstein, L.Z., 2013).These complications can have a negative impact on the person's quality of life, by increasing the chance of a visit to the emergency department/hospital, increasing the risk of losing independence, and also adding greatly to the cost of their healthcare. In addition, there is a negative impact to the property/community since many times, residents end up not returning to their residence.

More Health Problems* = greater chance of falling this year

If your number of health problems is:	Your chance of falling is:
0	 (1 person in 10 will fall)
1	 (2 people in 10 will fall)
2	 (3 people in 10 will fall)
3	 (6 people in 10 will fall)
4 or More	 (8 people in 10 will fall)

*The common health problems for falling are:
Problems walking or moving around; 4 or more medications or medication interaction; Foot problems, unsafe footwear; Blood pressure drops too much on standing up/dizzy; Problems with seeing; Tripping hazards in your home.
SOURCE: http://www.fallprevention.org/pages/fallfacts.htm

MEDICATION SELF MANAGEMENT

If medication errors were counted as a disease, they would be the fifth leading cause of death for Americans over age 65. These medication errors among older people cost about $177 billion each year (Bates, DW, et. al., 1997). Falls are also a top health issue for older adults taking four or more medications (Tinetti, Mary E., 2005). In the United States, an estimated 3 million older adults are admitted to nursing homes due to drug-related problems at an estimated annual cost of more than $14 billion (Johnson, JA, Bootman, JL., 1995).

According to the Administration on Aging, U. S. Department of Health and Human Services, the combination of increased medication use paired with the normal body changes caused by aging can increase the chance of unwanted, and even harmful, drug interactions. According to a study of older adults taking five or more medications, 35% experienced an adverse effect from at least one, 63% required physician intervention, 10% required an emergency department visit, and 11% were hospitalized. Twenty-eight percent of all hospitalizations among older adults were found to be drug related; 11% for non-adherence. Non-adherence to medication regimens is also a major cause of nursing home placement of elders (AoA, 2013). Residents should learn as much as possible about their medications including dosage, potential side effects, and possible interactions with other drugs, food, or alcohol. To avoid potential medication problems, residents should have open discussions with their health care professionals (i.e., physician, pharmacist, home health nurse, etc.) about their medication.

Medications represent a significant problem for elder community residents due to the large numbers of medications taken, potential duplications and contraindications between prescribed medications, over-the-counter medications, vitamins/minerals, and administration mistakes (e.g., forgetting to take or doubling up as prescribed). Housing properties and Service Coordinators feel limited in their ability to aid residents in this area because it is “medical.” However, interventions that assist older adults in managing their medications can help prevent unnecessary costly nursing home

admissions, hospitalizations, and emergency department visits, as well as improves their quality of life.

To start, it is important that residents keep an updated list of all of the medicines they take, including over-the-counter medications, and nutraceuticals. This documentation will also help to reduce the risk of harmful drug interactions. The Service Coordinator can help the resident keep a list of medicines through a medicine record. In fact, in the AASC member survey 45% reported they assist some residents in developing or updating the medicine record as needed and/or when assistance is requested by the resident (AASC Survey Results Attachment A). This updating has to occur whenever there are new medicines or when medicines are stopped. The standard medicine record needs to include the following:

- Name of medicine
- What it is for
- Name of doctor who prescribed it
- How and when to take
- How much to take (dosage)
- Color/shape of medicine
- Any side effects or warnings

One can also take advantage of medication tracker software on a personal computer. See http://www.consumerreports.org/health/medicationtracker/index.htm for help organizing and tracking medicines, as well as other information to share with the physician.

In addition, residents who have compliance issues with taking multiple prescriptions according to a schedule can adopt the aid of technology. An example is the multi-function standalone technology, Philips Medication Dispensing (PMD) service, which organizes and dispenses up to a 40 day supply of medication (depending on the dose frequency) by individualized doses in plastic cups. Patients are reminded to take their medication based on verbal and auditory reminders. To safeguard against double dosing or missed doses the system will lock away the dispensed medication after 90 minutes if it has not been removed from the device. It will then alert up to four caregivers, including health care professionals, if requested, that a dose was missed. Alert and dispensing history are uploaded daily to a web-support system allowing caregivers and clinician review. In a study comparing Philips PMD use with plastic medication boxes like Mediset, the Philips device (PMD) was shown to reduce

hospitalization rates, emergency department visits, and (where appropriate) decrease the number of medications taken by the patient. Staff at the Johnston County Visiting Nurses Association (VNA) where the PMD machines were installed and where the study was conducted thought the greatest success on the PMD was seen in patients on warfarin therapy or those who had mental and cognitive health issues (Buckwalter, KC, Wakefield, BJ, Hanna, B, Lehmann, J., 2004). Medicaid's 'Money Follows The Person (MFP)' Rebalancing Demonstration Grant that helps states rebalance their Medicaid long-term care systems is an ideal funding opportunity to introduce medication adherence technology.

WEIGHT LOSS: NUTRITION

Nutrition is an important ingredient in the prevention and management of most health conditions (American Diabetes Association, 2005). Rising health care costs and increasing numbers of older adults are driving the need and interest in prevention; and nutrition education plays a critical role. According to the Centers for Disease Control and Prevention the incidence of elders being overweight is 73% and obese is 38%, which in turn contribute to ill health and higher costs.

Dietary intake affects the health of older Americans, because poor diet quality is associated with cardiovascular disease, hypertension, Type 2 diabetes, osteoporosis, and some types of cancer (U.S. Department of Agriculture and U.S. Department of Health and Human Services, 2005). An index that assesses the multidimensional components of diet is useful in describing diet quality. The Healthy Eating Index-2005 was developed by the U.S. Department of Agriculture (USDA) Center for Nutrition Policy and Promotion (Guenther, P.M., Reedy, J., and Krebs-Smith, S.M., 2008). It measures compliance with the diet-related recommendations of the *2005 Dietary Guidelines for Americans.* It has 12 components: total fruit; whole fruit; total vegetables; dark green and orange vegetables and legumes; total grains; whole grains; milk; meat and beans; oils; saturated fat; sodium; calories from solid fats, alcoholic beverages, and added sugars. In the CDC's 2008 study, they only found three components (whole fruit, total grains, and meat and beans) to meet dietary standards. The nine others fell short. Major improvements in nutritional health can be made by increasing intakes of whole grains, dark green and orange vegetables and legumes, and fat-free or low-fat milk products

and by incorporating foods and beverages that are lower in sodium and have fewer calories from solid fats, alcoholic beverages, and added sugars. Nutritional programs that can aid in enhancing elder nutrition and decrease being overweight or obese follow. Several of the nutritional programs encourage lay volunteers to serve as leaders. Involvement by the residents and/or Retired Senior Volunteer Program (RSVP) volunteers as trained lay leaders helps sustainability of the program and can also improve their quality of life. (see Nutrition Attachment C)

WEIGHT LOSS: PHYSICAL EXERCISE

Physical activity is beneficial for the health of people of all ages, including the age 65 and over population. It can reduce the risk of certain chronic diseases, may relieve symptoms of depression, helps to maintain independent living, and enhances overall quality of life (U.S. Department of Health and Human Services, 1996), (American College of Sports Medicine, 1998). Research has shown that even among frail and very old adults, mobility and functioning can be improved through physical activity (Butler, R.N., Davis, R., Lewis, C.B., et. al., 1998). Strength training is recommended as part of a comprehensive physical activity program among older adults and may help to improve balance and decrease risk of falls (Christmas, C. and Andersen, R.A., 2000). In 2008, the Department of Health and Human Services released updated guidelines for aerobic activity and muscle-strengthening activities for Americans. The CDC 2008 Physical Activity Guidelines for Americans recommends two types of physical activity each week to improve health—aerobic and muscle-strengthening. Experts recommend older adults engage in moderate physical activity for at least 30 minutes five days a week and muscle-strengthening activities on two or more days a week that work all major muscle groups. But statistics show that less than one-third of Americans aged 65+ meet this level. (http://www.ncoa.org/improve-health/center-for-healthy-aging/physical-activity/#sthash.fJa0n0p5.dpuf)

The National Council on Aging (NCOA), Center for Healthy Aging has produced evidence-based programs in physical activities which are proven to produce measureable health benefits for older adults. The NCOA list and several other physical activity and exercise tools that can be utilized across properties are listed in Attachment D.

BRAIN HEALTH

As the human body ages it naturally loses some ability to move quickly and easily. Staying physically active, maintaining a healthy diet, being mentally active, and maintaining social ties are a few ways to keep the brain healthier for a longer amount of time. Exercise is helpful in keeping a steady flow of blood to the brain and also helps produce brain cells. By exercising, oxygen consumption is improved which helps the overall function of the brain. Staying active also involves thinking, plotting, and making choices which exercises the brain and increases the mental activity. Only a short amount of moderate exercise per day is necessary in order to benefit (Alzheimer's Association, 2014). A longitudinal study by Whitmer, et. al., (2005) studied the relation of obesity and body mass index (BMI) to dementia in later age. The research showed that the risk of dementia was 74% higher for obese people and 35% higher for overweight people when compared to people with normal body weight. Poor diet and limited exercise is not only harmful to the body, but also harmful to the brain and may affect the functioning of the brain in later life. Keeping the body healthy and a normal body weight protects both the body and the brain from losing optimum function sooner than it should.

Maintaining a healthy diet and body weight is vital when it comes to brain health. A study by Kang, et al., (2005) found that intake of fruits and vegetables had a significant association with less cognitive decline in women. High fat diets increase the risk for heart disease and stroke which in turn increase the risk for dementia and Alzheimer's disease (Alzheimer's Association, 2014). Additionally, the antioxidants in fruits and vegetables have been found to decrease cognitive decline. Staying physically active and maintaining a healthy diet has many benefits for both the body and the brain.

In addition, social activity has a significant impact on the brain activity which is helpful in maintaining a healthy brain. Social activity is simply categorized as a group of people getting together to engage in an activity whether it is talking, playing games, being physically active, or even providing emotional support for each other. Social interaction has shown to act as a protective factor against dementia and loss of brain function. Interaction provides some stimulation of the mind and body.

Another way to keep the mind stimulated is staying mentally active. Mental activity has a wide range of possibilities. Constantly learning and staying curious of surroundings is helpful in keeping the mind active. Simple brain activities such as word puzzles, memory games, reading, and card game are also stimulating to the brain and keep the brain active and processing new information.

Most of these brain healthy activities can be combined into one event. For example a group of people playing games has the potential to keep the brain active, the body active, and keep social interaction. Planting a community garden and assigning each community member to a certain level of contribution would also be helpful with all four of these factors. Overall, a combination of a healthy diet, physical activity, social interaction, and brain stimulation are helpful in order to maintain optimum brain health.

In a study by Dannhauser, Cleverly, Whitefield, Fletcher, Stevens, & Walker (2014) a program called *ThinkingFit* was created to help older adults with mild cognitive impairment engage in more physical activities and cognitive stimulation through exercise. During the 12 week study period, the participants completed a combination of at least three physical activities, group cognitive stimulation activities, or individual cognitive stimulation activities per week. All of the activities were done from home or within the community of the participants' homes. For the physical activity, participants would complete 30-45 minutes of moderate activity. These activities included walking in their community or riding a stand-up bike. Group based stimulation consisted of a weekly 2.5 hour session with a leader and 8 or more participants. The activities in the groups included a variety of arts and crafts, playing music, cooking, and games. The leader of this group was trained to provide detailed instructions, present the information in a slower and more simplified format, providing individual and hands-on support. The groups were kept small in order to be manageable and effective. For the individual stimulation part of the study, participants were taken to a training facility in order to work on puzzles and games. These puzzles worked on and recorded the progress of memory, attention, and problem solving.

The results of this *ThinkingFit* study include three important factors. First, the retention rate of this study was significant. Between 62-80% of the participants retained 5.5 hours per week of the required activity hours. Researchers believe that this high retention rate

within this relatively inactive age group was due to high levels of support and supervision. Second, the physical activity of this group increased which is helpful in older adults maintaining the ability to be physically active. Finally, the cognitive level of participants was either stable or improving during and following the interventions (Dannhauser, et al., 2014).

These results are important because it shows that simple activities have the ability to make a difference in the cognitive ability of older adults. The activities in the study are simple activities that are done from home or within housing communities either alone or in groups. The individual stimulation aspect of the study was one in labs for research necessities, but could easily be done at home with word puzzles, memory games, and other cost efficient brain stimulating games. Service Coordinators within housing communities with an enhanced Service Coordinator program, trained community workers or volunteers could lead group stimulation activities at a low cost.

CHRONIC DISEASE SELF-MANAGEMENT

About 91% of older adults have a least one chronic condition, and 73% have at least two. Chronic conditions, such as diabetes, arthritis, hypertension, and lung disease, seriously compromise the quality of life of older adults, often forcing them to give up their independence too soon. Chronic conditions also place a significant financial burden on individuals as well as health care systems. In 2011, this cost totaled nearly $3 trillion. The traditional medical model – which focuses more on the illness than the patient – is costly and often ineffective. (http://www.ncoa.org/improve-health/center-for-healthy-aging/chronic-disease/#sthash.H2Ysx6ws.dpuf)

The Chronic Disease Self-Management Program (CDSMP) is a low-cost program that helps individuals with chronic conditions learn how to manage and improve their own health, while reducing health care costs. The program focuses on problems that are common to individuals suffering from any chronic condition, such as pain management, nutrition, exercise, medication use, emotions, and communicating with doctors.

Every day, millions of people with chronic conditions struggle to manage their symptoms. Four chronic conditions: heart disease, cancer, stroke, and diabetes cause

almost two thirds of all deaths each year. Diabetes affects 12.2 million Americans aged 60+, or 23% of the older population. An additional 57 million Americans aged 20+ have pre-diabetes, which increases their risk of developing Type 2 diabetes, heart disease, and stroke. 90% of Americans aged 55+ are at risk for hypertension, or high blood pressure and 77% of women aged 75+ have this condition, as do 64% of men aged 75+ (NCOA Chronic Disease Fact Sheet, 2011).

According to the National Governors Association, chronic diseases account for 75% of the money our nation spends on health care, yet only 1% of health dollars are spent on public efforts to improve overall health. The cost of chronic disease is estimated to be more than $2.8 trillion—an average of $9,216 per person (NCOA Chronic Disease Fact Sheet, 2011).

Addressing chronic conditions requires new strategies to delay health deterioration, improve function, and address the problems that people confront in their day-to-day lives. Probably the best known and mostly highly regarded self-management program for people with chronic conditions is the Stanford Chronic Disease Self-Management Program (CDSMP). Through a partnership with the U.S. Administration on Aging, with support from The Atlantic Philanthropies, the National Council on Aging promotes CDSMP through community workshops and the online version, called Better Choices, Better Health®. CDSMP is also supported in communities by grants from the Centers for Disease Control and state divisions on aging and disability.

CDSMP is led by a pair of trained lay-facilitators, many of whom have their own chronic health problems, who conduct workshops that cover 17 hours of material over a six-week period. During the program, approximately 15–20 participants focus on building the skills they need to manage their conditions by sharing experiences and providing mutual support. CDSMP helps people with diverse medical needs such as diabetes, arthritis, and hypertension develop the skills and coping strategies they need to manage their symptoms. CDSMP employs action planning, interactive learning, behavior modeling, problem-solving, decision making, and social support for change. It is offered in two venues, online and through in-person, community-based settings such as senior centers, churches, community health clinics, and libraries. The chronic disease

and diabetes self-management programs are available in Spanish, and the Stanford-developed CDSMP trainer manual is available in 23 different languages.

Based on a review of major published studies (Lorig, KR, et.al., 1999), CDSMP results in significant, measurable improvements in the health and quality of life of people with chronic conditions. CDSMP also appears to save enough through reductions in health care expenditures to pay for itself within the first year. Studies have indicated: Fewer emergency department visits, inpatient stays, and outpatient visits (minimum savings of $100 per participant), fewer hospitalizations (savings of $490 per participant), for a total health care cost savings of approximately $590 per participant. In addition, studies have shown improvement in exercise and ability to participate in one's own care over a two-year period and improved health status in 7 of 9 variables: fatigue, shortness of breath, pain, social activity limitation, illness intrusiveness, depression, and health distress. Finally, the CDSMP improved health behaviors and self-efficacy in variables related to exercise, cognitive symptom management, and communication with physicians (Lorig, KR, Sobel, DS, Stewart, AL, Brown Jr., BW, Ritter, PL, González, VM, Laurent, DD, Holman, HR., 1999). These results indicate a very strong program to utilize with the elder and disabled residents where possible.

ADVANCE PLANNING

The Agency for Health care Research and Quality (AHRQ) has reported that many patients have not participated in effective advance care planning. Although the Patient Self-Determination Act guarantees patients the right to accept or refuse treatment and to complete advance medical directives, AHRQ research reveals that less than 50% of the severely or terminally ill patients studied had an advance directive in their medical record and only about 30% of the general public have one. Of the severely ill only 12% of patients with an advance directive had received input from their physician in its development; between 65% and 76% of physicians whose patients had an advance directive were not aware that their patients had the directive; physicians were only about 65% accurate in predicting patient preferences and tended to make errors of under-treatment, even after reviewing the patient's advance directive (Kass-Bartelmes & Huges, 2009).

If one loses the capacity to make decisions, someone will have to make decisions on their behalf. In this case, the person chosen as a stand-in (surrogate) decision maker should try to honor any wishes that the person expressed while they were still capable of making decisions. The person's expressed wishes are legally and ethically more important than what others want for the person, even if the others (i.e., family, spouse, friends, etc.) feel that they are acting in the person's best interest.

Two common types of advance directives (advance care plans) that express your wishes are: Living Wills and Durable Power of Attorney for Healthcare. Different states may have different names for durable power of attorney for healthcare, such as healthcare proxy or healthcare declaration. It is also important to remember that advance directives have some limitations. Whenever possible, healthcare professionals should respect the informed choices that have been expressed while they were still capable of making decisions. Following these advance directives demonstrates respect for individuality and self-determination. It is a legal and ethical obligation.

Most commonly, advance directives come out of the conversations that one has with relatives, friends, and healthcare workers while still capable. Advance directives should be written down carefully so that one's wishes are specific, clear, and available later if needed and cannot be easily challenged in court. In addition, they need to be re-visited regularly for any changes; and most importantly, communicated to your loved ones and health care professionals.

Living Wills - Laws or legal opinions that authorize living wills have been enacted throughout the United States. These are often called natural death, death with dignity, or right-to-die laws. Generally, these laws allow you to direct healthcare providers to withhold or withdraw treatment that is keeping you alive if you become terminally ill and are no longer capable of making decisions. In a few states, an individual may also appoint surrogate decision makers. Legal immunity is given to caregivers who comply with an appropriately drafted living will.

Durable Power of Attorney for Healthcare - The durable power of attorney for healthcare is more flexible and comprehensive than a living will. It allows you to designate a surrogate decision maker (such as a friend or relative) to make your medical decisions if you lose the ability to make them yourself. You give the surrogate your informed consent (or refusal) while you are still capable. You should discuss with your surrogate ahead of time the types of treatment(s) you would or would not want in specific situations so that your surrogate has some guidelines if the need arises.

Traditionally, family members act as surrogate decision makers (or stand-ins) for incapacitated individuals, because they probably know best the person's preferences and will act in their best interests. Family members are also normally consulted by the healthcare provider. However, the healthcare provider may sometimes decide that decisions by family members are questionable because of conflicting personalities, values, or interests. In addition, some family members may be estranged or unwilling to make decisions, or they may disagree among themselves. In other cases, older adults have no surviving relatives.

Physician Orders for Life-Sustaining Treatment (POLST) - Physician Orders for Life-Sustaining Treatment (POLST) is a recently developed program that is designed to improve the quality of care people receive at the end of life. It effectively communicates medical orders and patient wishes on a brightly colored form that can be transferred from one care setting to another and that healthcare professionals have promised to honor. Visit the National POLST Program website to find more information and to locate community or state-based POLST programs.

Importance of communication - Good communication can resolve many problems posed by advance directives. The person, their friends and family, and their healthcare providers should routinely share information on advance directives. A straightforward question Service Coordinators can ask to open the topic is: "Can we talk about how decisions will be made for your medical care in case you become too sick to talk directly to your doctor?" Service Coordinators can also help the resident ask the healthcare professional about situations that commonly develop with a particular illness

or condition, what the various treatments and treatment options are, and have them express personal wishes, including the designation of a surrogate decision maker. Advanced directives can also communicate the amount of discretion that one wants the surrogate to have and how they will let the surrogate know if there is a change of mind about something. It is also important to stress the importance of having periodic discussions about these issues with family members and friends.

Unfortunately, there is a quantitative and qualitative gap between what should happen with end of life planning and what actually exists. However, there is a one stop website that facilitates "Rest Of Your Life" planning which includes end of life planning, advance directives, legal, financial, insurance, social services, spiritual, and after life care issues – www.theROYL.com. This web application is a comprehensive and interactive tool that provides a personalized action checklist plan, a file of personalized information documents, a complete set of medical directives, a set of personalized legal documents, and a HIPPA-protected storage repository. Service Coordinators could utilize this tool, or many others that have been developed over the last couple of years, to standardize the approach to advance planning with their residents.

SUMMARY

The goal of this research white paper is to document what currently exists in wellness services and what enhanced wellness programming could be developed that: 1) improves participating resident's health; 2) improves participating residents and properties experience; 3) enhances the role of the Service Coordinators; and 4) reduces costs. This paper depicts the current demographics of the residents the AASC member Service Coordinators serve and the current role of the Service Coordinators. The research indicates that development and implementation of a focused and standardized approach to transitional care, falls prevention, medication self-management, chronic disease self-management (especially diabetes and heart disease), and advance planning (living wills and advance directives) would likely achieve the desired goals.

Our proposal puts forth the development and implementation of a demonstration project where the Service Coordinator role is enhanced and standardized in the areas of transitional care, falls prevention, medication self-management, chronic disease self-management, and advanced planning, as follows:

Transitional Care -We propose that the AASC member Service Coordinator serve as a Service Coordinator Transitional Coach (SCTC). They will be trained, via webinar, to serve as the primary transitional care team coach who will apply the 4-Pillars, advocate for, support, educate, and guide the resident and their caregivers to secure and receive appropriate community services and work to avoid a preventable readmission. The needed elements for this transitional care model demonstration include standardization of procedures such as notification of admission and discharge to hospital/emergency department, addressing Coleman's 4-Pillars to improve outcomes, and update the AASConline case management system to gather information relating to Transitional Care and measure outcomes.

Falls Prevention -We propose two options: 1) Service Coordinators work with MOB Master Trainers to teach volunteer residents in the MOB curriculum; or 2) Service Coordinator(s) become Master Trainer(s) who teach the MOB curriculum to resident

volunteers. In both cases, the resident volunteers will, ultimately, lead the classes. Involving the residents as volunteer trainers helps with sustainability of the program and improved quality of life for those residents.

We propose targeting the properties with the highest rate of falls and seek funding from Medicaid or other funding sources to support utilizing a PERS program and provide fall prevention education.

Medication self-management - Our proposal is to involve the Service Coordinator in a defined and structured role as a key health team partner along with hospital/home care staff (nurses, discharge planners, etc.). The SCTC will assist residents in understanding their medications by ensuring medication lists are maintained, updated, and medication reviews are performed by the resident's primary care physician and/or pharmacist, without providing direct medication management service. We also propose utilizing medication adherence technology when appropriate and affordable.

Chronic Disease Self-Management - We propose training Service Coordinator(s) as Master Trainers for The Chronic Disease Self-Management Program (CDSMP). The Master Trainers would then train resident volunteers to lead the program. The CDSMP program is designed to be facilitated by lay-volunteers, i.e. residents, typically, with a chronic disease.

Advanced Planning- We propose standardizing the approach to advance planning with residents by utilizing the Service Coordinators as navigators and/or coaches to encourage and assist the resident in self-documenting their own advance directives using a comprehensive and interactive planning tool. www.theROYL.com is one of several web-based applications that can easily be used to provide a personalized action checklist plan, a file of personalized information documents, a complete set of medical directives, a set of personalized legal documents, and a HIPPA protected storage repository.

We would also recommend the Service Coordinators across all properties adopt at least one or more of the referenced models relating to brain health, nutrition (see Attachment C), and physical fitness/exercise (see Physical Fitness/Exercise Attachment

D). Programs that are led by lay-volunteers are encouraged. Programming that involves resident volunteers have more likelihood of sustainability and health and wellness of the volunteer is likely to improve.

In order to measure success and produce outcome data, the AASConline system would require additional reporting criteria. Benchmark data would need to be captured and reported prior to beginning the demonstration. Outcome or impact data must be reported during the program to measure the effectiveness of enhanced service coordination.

CENTER FOR HEALTHY AGING

Center for Healthy Aging is a 501(c)3 organization dedicated to integrate public, private, and philanthropic resources to help educate and train caregivers, enhance wellness, and provide models of care that demonstrate efficiencies and cost savings while improving the quality of life for elders and providing easy access to quality of life programs. The Centers mission is to develop and provide innovative, effective, and efficient programs that are easily accessible and designed to improve the quality of life for elders by helping them maintain independence within their community - *"Adding Life To Years."*

Authors

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For more than 45 years, Dr. Lawrence J. Weiss has assessed and developed high quality, cost effective public and private health and human services for elders. He has served roles that encompassed health education and aging services administration, research and management, program planning and development, and process evaluation. Dr. Weiss was an Adjunct Associate Professor, University of Nevada School of Medicine and School of Nursing, and Associate Faculty in Public Health. He was the Director of the Sanford Center for Aging at the University of Nevada, Reno for 12 years, as well as the Director, TCONN (Transitional Care of Northern Nevada) for 3 years.

Dr. Weiss has served on several public health and education organizational boards, including NV Public Health Foundation, Circle of Life Hospice Foundation, National Council on Aging, Fellow of the Gerontological Society of America, Native American Suicide Prevention program, and delegate to the 2005 White House Conference on Aging.

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Marta Malone received her Bachelor's Degree in Accounting and Computer Information Systems from the University of Nevada, Reno. She spent 20+ years in the Manufacturing/Distribution industries developing quality processes and creating efficient processes through globally recognized methods and techniques. Marta has applied her background in training and quality improvement skills to the Program Officer and Educational Director for the Center.

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Kerry Walsh is currently enrolled in a Master's of Public Health program through San Jose State University. The program specializes in community health education with emphasis on program planning and community outreach. Kerry graduated from the University of Nevada in 2013 with a major in Psychology. During her time at the University of Nevada she worked in multiple psychology labs which involved experiments, data analysis, and evaluation. She is extremely passionate about public health and aspires to become involved with programs that can be influential within the community.

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1. How long have you been a Service Coordinator?

	Response Percent	Response Count
Under 1 year	15.8%	16
1-3 years	**27.7%**	**28**
3-5 years	20.8%	21
5-10 years	12.9%	13
10+ years	22.8%	23
answered question		**101**
skipped question		**0**

2. What area(s) do you serve?

	Response Percent	Response Count
City/Cities:	**100.0%**	**99**
State(s):	**100.0%**	**99**
answered question		**99**
skipped question		**2**

3. How many residents are in the property(ties) that you serve?

	Response Percent	Response Count
Under 50	14.9%	15
50 - 100	20.8%	21
101 - 200	**33.7%**	**34**
Over 200	30.7%	31
	Comment:	11
	answered question	**101**
	skipped question	**0**

4. How many residents do you work with routinely?

	Response Percent	Response Count
Under 10	6.0%	6
10 - 20	19.0%	19
21 - 50	31.0%	31
Over 50	**44.0%**	**44**
	Comment:	5
	answered question	**100**
	skipped question	**1**

5. On average, how often do you go into AASC Online?

	Response Percent	Response Count
Once per day	3.0%	3
Several times per day	**81.0%**	**81**
Less than 1 time per week	1.0%	1
1 - 5 times per week	7.0%	7
More than 5 times per week	8.0%	8
	Comment:	9
	answered question	**100**
	skipped question	**1**

6. On average, how long do you spend on AASC Online each time you go into the system?

	Response Percent	Response Count
Less than 5 minutes	1.0%	1
5 - 15 minutes	27.7%	28
16 - 30 minutes	**29.7%**	**30**
31 - 60 minutes	25.7%	26
More than 60 minutes	15.8%	16
	Comment:	6
	answered question	**101**
	skipped question	**0**

7. What types of assistance and/or programs do you bring to and/or arrange for the property(ites) you serve?

	Response Count
	96
answered question	**96**
skipped question	**5**

8. Do your residents have ICE (In Case of Emergency) cards or other emergency medical information?

		Response Percent	Response Count
Yes		**88.1%**	**89**
No		11.9%	12
		Comment:	23

answered question	**101**
skipped question	**0**

9. Typically, where are these kept?

	Response Percent	Response Count
Inside the resident's freezer/refrigerator	10.4%	7
On the front of the resident's refrigerator	**68.7%**	**46**
A special area in each resident's apartment	29.9%	20
Other (please specify)		20
answered question		**67**
skipped question		**34**

10. Are you notified when a resident you serve goes to the Emergency Room and/or is admitted to the Hospital?

	Response Percent	Response Count
Yes	**56.1%**	**55**
No	43.9%	43
Comment:		52
answered question		**98**
skipped question		**3**

11. How are you notified when a resident is admitted to the hospital?

	Response Percent	Response Count
Notified by Resident manager	41.3%	19
Notified by Other residents	**56.5%**	**26**
Notified by Family members	2.2%	1
Other (please specify)		25
answered question		**46**
skipped question		**55**

12. When are you notified that a resident has gone into the hospital?

	Response Percent	Response Count
I am not notified	6.5%	3
When the resident is being transported	32.6%	15
While the resident is in the hospital	**54.3%**	**25**
When the resident is being released from the hospital	2.2%	1
When the resident has returned to the property	4.3%	2
Other (please specify)		24
answered question		**46**
skipped question		**55**

13. Do you visit the resident in the hospital?

	Response Percent	Response Count
Yes	36.2%	21
No	**63.8%**	**37**
	answered question	**58**
	skipped question	**43**

14. What do you do during your visit?

	Response Percent	Response Count
Companionship	52.6%	10
Advocate; understand their diagnosis and treatment	68.4%	13
Help the resident start or update their Personal Health Record	10.5%	2
Meet with the social worker/discharge planning staff	**73.7%**	**14**
	Other (please specify)	5
	answered question	**19**
	skipped question	**82**

15. What percentage of your residents have had a hospitalization with the last year?

	Response Percent	Response Count
Less than 10%	**52.6%**	**51**
11% - 25%	35.1%	34
26% - 50%	10.3%	10
More than 50%	2.1%	2
	Comment:	7
	answered question	**97**
	skipped question	**4**

16. What percentage of residents were discharged to a nursing home/rehab facility (step-down care) before returning to their residence?

	Response Percent	Response Count
Less than 10%	**78.1%**	**75**
11% - 25%	16.7%	16
26% - 50%	3.1%	3
More than 50%	2.1%	2
	answered question	**96**
	skipped question	**5**

17. What is the average length of stay for a resident who was admitted to the hospital?

	Response Percent	Response Count
Less than 3 days	**47.9%**	**45**
4 - 7 days	38.3%	36
8 - 10 days	5.3%	5
More than 10 days	8.5%	8
	Comment:	9
	answered question	**94**
	skipped question	**7**

18. What percentage of residents who were admitted to the hospital did NOT return to their residence?

	Response Percent	Response Count
Less than 25%	**100.0%**	**97**
26% - 50%	0.0%	0
51% - 75%	0.0%	0
More than 75%	0.0%	0
	Comment:	5
	answered question	**97**
	skipped question	**4**

19. Do you know the reason why a resident gets admitted to the hospital?

		Response Percent	Response Count
Yes		**57.3%**	**55**
No		42.7%	41
		answered question	**96**
		skipped question	**5**

20. Are you informed of the residents diagnosis and medical conditions?

		Response Percent	Response Count
Yes		**53.2%**	**50**
No		46.8%	44
		Comment:	46
		answered question	**94**
		skipped question	**7**

21. Do you know the residents primary care physician?

		Response Percent	Response Count
Yes		**84.0%**	**79**
No		16.0%	15
		Comment:	32
		answered question	**94**
		skipped question	**7**

22. Do you assist in arranging transportation for residents to visit their primary care physician after a hospitalization?

	Response Percent	Response Count
Yes	**78.3%**	**72**
No	21.7%	20
	Comment:	39
	answered question	**92**
	skipped question	**9**

23. Do you assist in developing and/or updating your residents list of medications?

	Response Percent	Response Count
Yes	46.3%	44
No	**53.7%**	**51**
	Comment:	29
	answered question	**95**
	skipped question	**6**

24. Are you notified when a resident is discharged from the hospital?

	Response Percent	Response Count
Yes	32.3%	31
No	**67.7%**	**65**
	answered question	**96**
	skipped question	**5**

25. Are you made aware of the residents discharge plan?

	Response Percent	Response Count
Yes	**54.5%**	**18**
No	45.5%	15
	answered question	**33**
	skipped question	**68**

26. Do you arrange transportation for your residents when they are discharged from the hospital?

	Response Percent	Response Count
Yes	32.4%	11
No	**67.6%**	**23**
	Comment:	13
	answered question	**34**
	skipped question	**67**

27. What percentage of your residents need your help arranging for and/or providing transportation when they are discharged from the hospital?

	Response Percent	Response Count
Less than 25%	**70.0%**	**7**
26% - 50%	30.0%	3
51% - 75%	0.0%	0
More than 75%	0.0%	0
	Comment:	1
	answered question	**10**
	skipped question	**91**

28. Do your residents have a Personal Health Record that contains information regarding: Personal information; Current health status; Primary Care Physician, Medications, Past hospitalizations/surgeries, Red Flags, etc.

	Response Percent	Response Count
Yes	**61.1%**	**58**
No	41.1%	39
	Comment:	40
	answered question	**95**
	skipped question	**6**

29. How is the Personal Health Record (PHR) completed?

	Response Percent	Response Count
Resident completes the PHR	44.6%	25
Resident completes the PHR with family member(s)	39.3%	22
Resident completes the PHR with a Service Coordinator	**62.5%**	**35**
Other (please specify)		15
answered question		**56**
skipped question		**45**

30. How is the Personal Health Record updated?

	Response Percent	Response Count
Resident updates the PHR	42.6%	23
Resident updates the PHR with family member(s)	31.5%	17
Resident updates the PHR with Service Coordinator	**61.1%**	**33**
Other (please specify)		16
answered question		**54**
skipped question		**47**

31. Do you know if a resident is readmitted to the hospital within 30 days of being discharged?

	Response Percent	Response Count
Yes	47.8%	43
No	**54.4%**	**49**
	Comment:	33
	answered question	**90**
	skipped question	**11**

32. Are you informed why the resident was readmitted to the hospital within 30 days of discharge?

	Response Percent	Response Count
Yes	**75.0%**	**33**
No	25.0%	11
	Comment:	17
	answered question	**44**
	skipped question	**57**

33. How frequently do you perform a re-assessment of ADL's (Activities of Daily Living) on each of your residents?

		Response Percent	Response Count
Less than 1 time per year		37.8%	28
Every 1 to 2 years		**60.8%**	**45**
More than 2 years in between		0.0%	0
No re-assessment of ADL's is done		1.4%	1
		Comment:	28
		answered question	**74**
		skipped question	**27**

34. Do you know when residents use 911?

		Response Percent	Response Count
Yes		48.1%	38
No		**51.9%**	**41**
		answered question	**79**
		skipped question	**22**

35. How are you notified when a resident uses 911?

	Response Percent	Response Count
Resident	56.3%	18
Resident manager	62.5%	20
Resident family member	40.6%	13
Resident neighbor	**65.6%**	**21**
Other (please specify)		11
answered question		**32**
skipped question		**69**

36. Are the residents you serve regularly screened for common health issues?

	No	Yes	Rating Count
Cancer Screenings	**62.1% (41)**	37.9% (25)	66
Cardio/Pulmonary Health Programs	46.3% (31)	**53.7% (36)**	67
Cholesterol Screenings	44.8% (30)	**55.2% (37)**	67
Depression Programs	**62.1% (41)**	37.9% (25)	66
Diabetic Programs	29.6% (21)	**70.4% (50)**	71
Health / Wellness / Fitness Programs	22.9% (16)	**77.1% (54)**	70
Mental Health/Wellness Programs	47.8% (32)	**52.2% (35)**	67
Weight Loss/Nutrition & Exercise Programs	38.2% (26)	**61.8% (42)**	68
Orthopedic Programs	**59.4% (38)**	40.6% (26)	64
Substance Abuse Programs	**70.1% (47)**	29.9% (20)	67
Vision/Hearing Screenings	38.8% (26)	**61.2% (41)**	67
Medication Management	36.4% (24)	**63.6% (42)**	66
Falls Prevention	28.6% (20)	**71.4% (50)**	70
Brain Health	**56.9% (37)**	43.1% (28)	65
Chronic Disease Self Management (especially Diabetes & Heart Disease)	34.3% (23)	**65.7% (44)**	67
Emergency Planning - Advance Planning (e.g., Living Wills, advance directives)	22.5% (16)	**77.5% (55)**	71
Reduce social isolation	28.8% (19)	**71.2% (47)**	66
		answered question	**73**
		skipped question	**28**

37. On average, how many referrals have you made to your residents in the past 12 months for common health issues?

	None	Less than 3	4- 10	11-20	More than 20	Rating Count
Cancer Screenings	**57.7% (41)**	28.2% (20)	8.5% (6)	1.4% (1)	4.2% (3)	71
Cardio/Pulmonary Health Programs	**37.5% (27)**	33.3% (24)	15.3% (11)	2.8% (2)	11.1% (8)	72
Cholesterol Screenings	**52.2% (36)**	20.3% (14)	14.5% (10)	2.9% (2)	10.1% (7)	69
Depression Programs	24.0% (18)	**33.3% (25)**	25.3% (19)	10.7% (8)	6.7% (5)	75
Diabetic Programs	19.7% (14)	19.7% (14)	**29.6% (21)**	16.9% (12)	14.1% (10)	71
Health / Wellness / Fitness Programs	9.6% (7)	8.2% (6)	21.9% (16)	24.7% (18)	**35.6% (26)**	73
Mental Health/Wellness Programs	18.3% (13)	**28.2% (20)**	18.3% (13)	18.3% (13)	16.9% (12)	71
Weight Loss/Nutrition & Exercise Programs	**23.6% (17)**	15.3% (11)	22.2% (16)	18.1% (13)	20.8% (15)	72
Orthopedic Programs	**40.0% (28)**	31.4% (22)	17.1% (12)	5.7% (4)	5.7% (4)	70
Substance Abuse Programs	**48.5% (33)**	30.9% (21)	11.8% (8)	5.9% (4)	2.9% (2)	68
Vision/Hearing Screenings	9.6% (7)	28.8% (21)	**30.1% (22)**	12.3% (9)	19.2% (14)	73
Medication Management	16.9% (12)	**31.0% (22)**	25.4% (18)	5.6% (4)	21.1% (15)	71
Falls Prevention	18.1% (13)	**22.2% (16)**	**22.2% (16)**	15.3% (11)	**22.2% (16)**	72
Brain Health	**58.0% (40)**	13.0% (9)	14.5% (10)	4.3% (3)	10.1% (7)	69
Chronic Disease Self Management (especially Diabetes & Heart Disease)	24.6% (17)	17.4% (12)	**31.9% (22)**	5.8% (4)	20.3% (14)	69
Emergency Planning - Advance Planning (e.g., Living Wills, advance directives)	12.2% (9)	**27.0% (20)**	25.7% (19)	14.9% (11)	20.3% (15)	74
Reduce social isolation	18.3% (13)	21.1% (15)	23.9% (17)	8.5% (6)	**28.2% (20)**	71
					answered question	**77**
					skipped question	**24**

38. What types of health screenings do you arrange for the residents at your property (ties)?

	Response Percent	Response Count
High Blood Pressure	**97.3%**	**73**
Diabetes/High Blood Sugar	74.7%	56
Body Mass Index (BMI)/Weight Management	21.3%	16
Vision/Hearing	60.0%	45
Flexibility/Mobility	46.7%	35
Cholesterol	26.7%	20
Other (please specify)		11
answered question		**75**
skipped question		**26**

This survey was sent to the following properties: Franciscan Ministries, Wesley Housing of Memphis, KMG Prestige, Inc., and N&H Enterprises, Inc. This is a filtered summary of the survey that relates to Transitional Care activities. For a summary of the complete survey see Survey Results Attachment A. The intent of this recap is to determine what tasks associated to Transitional Care are already being performed by Service Coordinators, i.e.: Visiting the resident in the hospital, assisting the resident in completing and/or updating a Personal Health Record, and assisting the resident in completing and/or updating a list of their medications.

Out of 105 total responses, 12 Service Coordinators answered YES to all three of the following questions:

- Do you visit the resident in the hospital?
- Do your residents have a Personal Health Record that contains information regarding: Personal information; Current health status; Primary Care Physician, Medications, Past hospitalizations/surgeries, Red Flags, etc.?
- Do you assist in developing and/or updating your residents list of medications?

Summary of demographics of the 12 SC's who perform tasks related to transitional care:

- 33% responders have been SC's for under 1 year, and 25% have been SC's for over 10 years. There were 17%, each who have been SC's for 5-10 years and 3-5 years, and 8% for 1-3 years.
- 7 of the responders were from Tennessee. One each was from: Florida, Michigan, Georgia, New Mexico, & South Carolina.
- 2 of the responders serve under 100 residents (1 serves 50-100, the other serves under 50); 1 serves 50-100, and the remaining 9 serve over 100 (4 serve 101-200 and 5 serve over 100).
- All of the responders work with 20 or more residents routinely.
- Comments about what types of assistance and/or programs the 12 SC's bring and/or arrange for the property(ies) they serve:
  - Wellness programs, Financial literacy, Nutrition
  - Transportation, housekeeping, information, food resources, medical, Medicare/Medicaid, nutrition, health, exercise/physical fitness, financial, Social security, smoking cessation, wellness..... a little of everything.....
  - Bring health & educational programs, applying for food stamps, Medicaid, health insurance, Working with doctors, nurses, discharge planners, assist in finding employment, completing application/forms, immigration assistance, etc.
  - Mental and physical health, various government benefits, transportation, resident council, food program
  - Health Care Fitness Benefits, Meals, Spiritual
  - Health and Wellness Safety, Healthy eating/cooking, Transportation, Food commodities, Medicare/Medicaid, Low income telephone

  - Flu Clinics, Blood Pressure, Checks Health, and Wellness Education Meetings/Classes, S.C. Benefit Bank, Transportation, Home Delivered Meals, Homemaker Service
  - Benefit/entitlement programs, home management/bills/mail, liaison with doctor's offices/hospitals, scheduling educational/wellness programs, counseling/problem solving, referrals for home medical equipment
  - Phone services, Homemaking services; Health services; WIC services; Commodities; Counseling; Advocacy; Smoking Cessation, Financial Counseling; Wellness; Activities; Alzheimer's Education; PRN needs
  - Exercise, Blood Pressure, Dermatologist, Podiatrist, Computers, Therapy, and much more
  - Transportation, Medical appointments and services, drug rehab assistance, blood pressure and blood sugar checks, medication management advisors, meals, flu shots, medical equipment provision, exercise, in house doctors and eye exams. senior companions, assistance with social security benefits, food stamps and free cell phones.
  - Health Educational Programs Health Screenings/Health Clinics Home Management Programs such as Homemaker services Fitness/Exercise Programs

- All except 1 SC reported that at least some of their residents have ICE (In Case of Emergency) cards or other emergency medical information. One SC stated that 50% of the residents have ICE cards, and that the SC has 95% of the residents ICE on file.
- 67% of the SC's reported that the resident's ICE is kept on the front of the resident's refrigerator. The remainder reported a special area in each resident's apartment. Comments from the SC's were that residents keep ICE in their Wallet/purse, on the inside of the their door, and Vial of Life kept on the refrigerator door, and ICE cars kept with insurance cards.
- All of the SC's reported they are notified when a resident goes to the Emergency Room. However, they are not notified consistently. One SC reported being notified only 50% of the time, others reported only being notified sometimes while one stated sometimes finding out after the fact.
- When SC's are notified about a resident being admitted to the hospital it is mostly by the resident manager (63%); then by other residents (25%) and family members (13%). Front desk staff, answering service, property manager, site assistants are other sources.
- 70% of the responders stated being notified when the resident is being transported to the hospital; 30% said while the resident is in the hospital. Comments were that it varies and one SC stated that most times he/she is the one that calls 911.
- The responders indicated that they visit the resident when they are in the hospital. 75% indicated they meet with the social worker/discharge planning staff; 67% Advocate; understand their diagnosis and treatment; and 58% visit the resident for companionship. Comments were that they assist with APS investigation; discuss the discharge plans with them; and all of the above at times depending if they have family there.

- 58% reported that less than 25% of their residents were hospitalized last year. 25% said 11-15% were hospitalized and 17% said 26-50% were hospitalized.
- 75% of the responders said that less than 10% were discharged to a nursing home/rehab (step-down care) before returning to their residence. 25% reported that 11-25% went to nursing home/rehab after hospitalization.
- 46% of the residents length of stay in the hospital was 4-7 days; 27% was 8-10 days; 27% was less than 3 days.
- All responders reported less than 25% of the residents who were admitted to the hospital did NOT return to their residence.
- A majority of the SC's indicated they know the reason why a resident gets admitted to the hospital (92%).
- Most SC's are informed of the resident's diagnosis and medical conditions (91%). Comments indicated that this only happens occasionally. One SC estimates it happens about 30% of the time. SC's are made aware by the resident or management when they are asking the SC to help.
- 92% of the SC's reported they know the residents primary care physician.
- 91% of the SC's indicated they assist in arranging transportation for the residents to visit their primary care physician after hospitalization. Comments were: If requested, sometimes, and whenever needed.
- All responders indicated they do or will assist in developing and/or updating the residents list of medications. Comments were they do it sometimes; per resident request; and whenever needed
- Only 8 of the 12 responders indicated they are notified when a resident is discharged from the hospital. Of those 8, 7 reported they are made aware of the residents discharge plan.
- Of the 8 who are notified when a resident is discharged from the hospital, only 3 reported that they arrange for transportation. Comments were: Per resident request; resident's family provides, I do if needed; usually not needed.
- Of the 12 SC's who responded Yes, that their residents have a Personal Health Record that contains information regarding: Personal information; Current health status; Primary Care Physician, Medications, Past hospitalizations/surgeries, Red Flags, etc., their comments were: 50% of them; Some do; All residents are encouraged to keep info, not all of them have, SC offers asst. to gather and keep this info; Vial of Life, intake, ADL assessments
- 83% responded the Resident completes the PHR with a Service Coordinator; 42% indicated the Resident completes the PHR with family member(s); 25% indicated the resident completes the PHR
- 92% reported they know when a resident is readmitted to the hospital within 30 days of being discharged. Comments: Occasionally; if they tell us or management informs us, family will call us as well.
- All of the SC's responded that they know why a resident was readmitted to the hospital within 30 days. Comments: Occasionally; SC inquires to find out the diagnosis; sometimes; By the resident if they speak, if not the family usually calls.

References:

Healthy Eating for Successful Living – This program was developed by a collaboration of experts in the Boston area using the Stanford education model. In addition to including strategies for improving nutritional health, the program includes the elements that are important for participants to make effective behavior changes such as self-assessment and behavior -management, goal-setting, problem-solving and group support and interaction. The program is taught by trained lay leaders with back-up support from credentialed nutrition professionals. The program is adaptable for culturally diverse populations. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1829349/)

Eat Better & Move More - Developed through Older Americans Act funds and Administration on Aging 'YouCan!' campaign. This program recommends a nutritionist, dietitian, physical therapist, or other health or certified fitness professional to lead the class – although they suggest involving lay-persons/peers to make the classes more fun. Eat Better Move More is a 12-week program developed for congregate meal program participants. Weekly 30 minute sessions provide basic activity and nutrition education and encourage participants to be physically active and eat a more healthy diet. A second 12-week series is available for sites that have completed the first series. (http://nutritionandaging.fiu.edu/You_Can/index.asp; Guidebook: http://nutritionandaging.fiu.edu/You_Can/07.2YouCanGuidebook.pdf)

National Diabetes Prevention Program – This evidence-based lifestyle change program significantly reduces the risk of developing Type 2 diabetes among people at high risk, including those with pre-diabetes or a history of gestational diabetes. Participants work with a lifestyle coach in a group setting to make modest and attainable behavior changes, such as improving food choices and increasing physical activity. The intervention lasts for one year, including 16 weekly core sessions and six monthly post-core sessions. (www.cdc.gov/diabetes/prevention/about.htm)

Healthy Changes for Living With Diabetes - Developed by Providence Center on Aging in Portland, this ongoing program uses trained volunteer group leaders and a defined curriculum assist older adults in the day-to-day self-management of Type 2 diabetes by focusing on diet and physical activity during weekly group meetings. (www.ncbi.nlm.nih.gov/pubmed/19075087)

Eat Smart, Live Strong -This program was designed to improve fruit and vegetable consumption and physical activity among low-income able-bodied 60-74 year olds who are eligible for SNAP or other publically-funded nutrition programs. (http://snap.nal.usda.gov/resource-library/nutrition-education-materials-fns/eat-smart-live-stong)

MyPlate for Older Adults – Although MyPlate is not a 'program' – the My Plate for Older Adults poster can be posted and/or provided to residents as a reminder of healthy eating choices. In 2011 nutrition scientists at the Jean Mayer USDA Human Nutrition Research Center on Aging (USDA HNRCA) at Tufts University introduced the MyPlate for Older Adults which corresponds with MyPlate, the federal government's food group symbol. MyPlate for Older Adults calls attention to the unique nutritional and physical activity needs associated with advancing years. Although calorie needs decline with age due to a slow-down in metabolism and physical activity, nutritional requirements remain the same or in some cases increase. MyPlate for Older Adults provides examples of foods that contain high levels of vitamins and minerals per serving and are consistent with the federal government's 2010 Dietary Guidelines for Americans, which recommend limiting foods high in trans and saturated fats, salt and added sugars, and emphasize whole grains. MyPlate for Older Adults is intended to be a guide for healthy, older adults who are living independently and looking for examples of good food choices and physical activities. (http://www.nutrition.tufts.edu/research/myplate-older-adults

The National Council on Aging (NCOA), Center for Healthy Aging has produced the following evidence-based programs in physical activities which are proven to produce measureable health benefits for older adults:

Active Living Every Day (ALED) - uses facilitated group-based problem solving methods to integrate physical activity into everyday living. This program utilizes the ALED book and offers optional online support resources for participants and facilitators. The ALED program is flexible. It can be offered independently or with existing community-based physical activity programs.

EnhanceFitness - (formerly Lifetime Fitness Program) is a low-cost, highly adaptable exercise program offering levels that are challenging enough for active older adults and levels that are safe enough for the unfit or near frail. One-hour group classes include stretching, flexibility, balance, low-impact aerobics, and strength-training.

EnhanceWellness - (formerly the Health Enhancement Program) is an individualized, motivational self-care intervention that encourages older adults to take on health challenges and maintain control of their lives. A team of two professionals, typically a nurse and social worker, work with the individual to develop a plan and help that individual achieve his/her goals.

Fit and Strong! – This program combines flexibility, strength training and aerobic walking with health education for sustained behavior change among older adults with lower extremity osteoarthritis (OA). Fit & Strong! works with providers across the country to deliver an eight-week program that improves lower extremity stiffness , lower extremity pain, lower extremity strength, aerobic capacity, participation in exercise and caloric expenditure, and self-efficacy for exercise.

Healthy Moves for Aging Well - is a simple and safe in-home physical activity intervention developed and tested by Partners in Care to enhance the activity level of frail, high-risk sedentary seniors living at home. The model was developed for community-based care management programs arranging and delivering services to seniors in the home.

Walk with Ease - This Arthritis Foundation's program helps participants develop a walking plan that meets their particular needs, stay motivated, manage pain, and exercise safely. The Walk with Ease materials are based on programs that have been successfully implemented in research settings and have resulted in such benefits as increased physical activity, increased walking distance and speed, decreased pain and decreased depression.

Other physical activities and exercise tools include:

Go4Life - An exercise and physical activity campaign from the National Institute on Aging at NIH (National Institute of Health), it is designed to help older adults fit exercise and physical activity into daily life.

Physical Activity Programs Checklist - This checklist provides a brief method for assessing the quality of structured physical activity programs for older adults.

Making Physical Activity a Part of an Older Adult's Life - When it comes to getting the physical activity you need each week, it's important to pick activities you enjoy and that match your abilities. This will help ensure that you stick with them.

Moving Ahead: Strategies and Tools to Plan, Conduct and Maintain Effective Community-Based Physical Activity Programs for Older Adults -This publication is the product of presentations and discussions from the February 2007 PRC-HAN Research to Practice Symposium held in Seattle, WA.

Designing Safe and Effective Physical Activity Programs - This brief is the second in a series promoting best practices in physical activity programming for older adults.

Maintaining Participation of Older Adults in Community-Based Physical Activity Programs - This issue brief is the third in a three-part series about motivating, recruiting, and reengaging older adults in community-based physical activity programs.

Motivating Participants to Be More Physically Active - This brief is the fifth in a series promoting best practice physical activity programming for older adults.

Motivating Frail Older Adults to be Physically Active - This guide offers aging services providers simple assessment and behavior activation tools needed to motivate older adults to begin and adhere to physical activity.

Reference Guide of Physical Activity Programs for Older Adults - This reference guide describes multiple programs for promoting physical activity among older adults in the United States.

Physical Activity and Public Health in Older Adults: Recommendation From ACSM and AHA - This article issues recommendations the American College of Sports Medicine (ACSM) and the American Heart Association (AHA) for Adults, on the types and amounts of physical activity needed to improve and maintain health in older adults.

Arthritis Foundation's Life Improvement Series - The Arthritis Foundation's Life Improvement Series empowers people with arthritis through aquatic, exercise and self-help programs that are proven to increase mobility, reduce pain and stiffness, and reduce physician visits.

The National Council on Aging website has more detail on these articles and toolkits at: http://www.ncoa.org/improve-health/center-for-healthy-aging/physical-activity/tools-and-resources-1.html#sthash.cAtKLgyp.dpuf