

# **A Guide to Develop and Implement Living Longer/Living Better Initiatives in Indiana Communities: Developing Local Community Care Coalitions**

## **Indiana Commission on Aging**

**JoAnn M. Burke, Ph.D., Chair**

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**Robert Bischoff**

**Katie Ehlman, Ph.D.**

**Sue Grossbauer**

**Debra Lambert**

**Margaret Smith**

**Michael Sullivan**

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This guide includes evidenced-based strategies to help Indiana communities become more age-friendly and dementia-friendly by bringing attention to social determinants of health in communities. In addition, it provides information about structures and processes that **integrate health care and aging services at a local level** so older adults and their families can better navigate the continuum of acute health care and long-term aging services and supports in their communities.

## **Acknowledgements**

Indiana Commission on Aging and their desire to take this initiative statewide

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Other cooperative partners include Saint Mary's College (Notre Dame, IN) Graduate Nursing Program, and the project Advisory Committee to the Indiana Commission on Aging consisting of AARP Indiana, Dementia Friends Indiana, Indiana Association of Area Agencies on Aging, Indiana Division of Aging, Indiana Hospital Association, Purdue University Extension, and Qsource.

JoAnn M. Burke, Ph.D., LCSW, LMFT, BSN      Project Director

Doctoral nursing students from Saint Mary's College who participated in the development of the guide include:

Megan Bontrager

Oluwatoyin Fadeyi

Luci Gouin

Yumi Otsuka

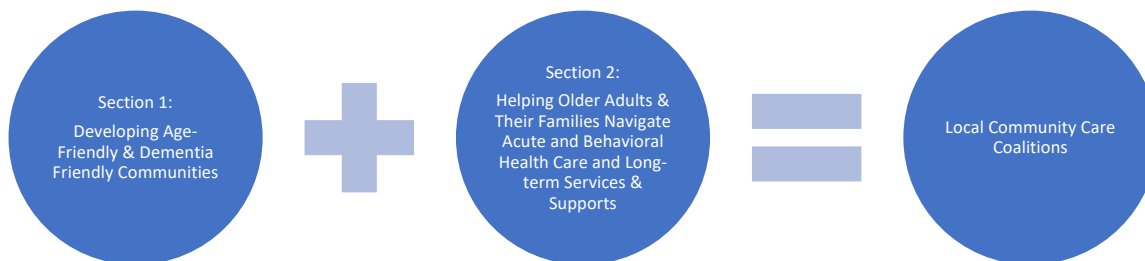
Kelly Woods

Special thanks to the Tipton, Indiana Community Care Coalition and their Education Committee for the privilege of conducting a pilot study in Tipton that served as the impetus for the development of this initiative. This informal care coalition was started in 2015 and is composed of interested members of the community, IU Health Tipton Hospital, Miller's Merry Manor and Autumnwood Assisted Living, Area 5 Agency on Aging, Encore Lifestyle and Enrichment Center (senior center), Tipton City Mayor, Purdue Extension, and other organizations serving the Tipton community. The mailing list for the Tipton Care Coalition has grown to 85 and meetings are held every other month. In Fall 2018, the Education Committee held a two-night education program. The first night focused on helping Tipton become more age-friendly and the second evening focused on helping older adults and their families better navigate the health care and aging services in the community. This toolkit is partially based on the experiences learned from developing this on-going initiative in the Tipton community.

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## Statement of Purpose



The purpose of this Guide for the development of local community care coalitions throughout Indiana is two-fold: (1) to help Indiana communities become more age and dementia friendly and (2) to help older adults and their families more easily navigate the health care and aging services in their communities. This guide supports the five goals of Indiana’s state aging plan (Indiana Division of Aging State Plan 2019-2022 available at <https://www.in.gov/fssa/da/3462.htm> ). For that reason, the Indiana Commission on Aging asked the Project Director to assemble an advisory committee to work with her to develop the guide and make it available to communities across the state.

### 2019-2022 Indiana State Plan on Aging

Goal 1: Improve the performance of Indiana’s aging network to efficiently and effectively meet the needs of its growing senior population.

Goal 2: Support caregivers’ ability to provide ongoing informal supports.

Goal 3: Enhance the current dementia care or specialty care competencies.

Goal 4: Strengthen statewide systems for advocacy and protection of older adults.

Goal 5: Institute policies and evidence-based programs to positively impact social determinants of health.

Each community is encouraged to work with the Area Agency on Aging serving that community as well as local hospitals serving the community to develop a **Community Care Coalition**. This guide provides recommendations, action steps, and resources to help local communities initiate action as needed and to sustain and support initiatives already underway.

## **Background**

### *Tipton Community Care Coalition*

After completing a sabbatical in South Korea where she studied population aging and urbanization, the Project Director returned to Indiana in 2006 with a renewed interest in learning more about how Indiana communities were being impacted by this global phenomenon. Planning to relocate to her home community of Tipton, she looked at the population demographic projections for that county and found that the county was declining in population, and it was growing older. Tipton County is projected to have the second highest percentage of older adults in the state by 2050 (STATS Indiana, 2018). She began to talk with the Tipton County (Community) Foundation, elected local officials, health care and aging services providers, as well as individuals expressing an interest in learning more about how population aging was impacting the community. One of the most urgent needs identified was senior transportation. On a subzero day, an older man had been taken to a medical appointment in his wheelchair in the back of a pick-up truck because the local senior center that provided senior transportation had no handicapped accessible van to accommodate his wheelchair. Through these conversations, an interest group developed that become the Tipton Community Care Coalition.

In spring 2015, the Project Director attended a presentation by Qsource in South Bend, Indiana. At that presentation, Qsource presented their plans from their 11<sup>th</sup> Statement of Work with the Centers for Medicare and Medicaid Services (CMS) and discussed their initiative to develop care coalitions in selected areas of the state to address specific health care issues related to Medicare beneficiaries. Knowing

there was a group of individuals and service providers in Tipton who were interested in population aging issues, she asked Qsource to informally support her as she brought together community members and health care and aging services providers as a care coalition to identify and address service gaps for older adults in that community even though this care coalition was not located in one of the planned service areas for Qsource. Qsource agreed to informally support this effort and thus began the formation of the Tipton Community Care Coalition. It started to meet in June 2015 and has been meeting every other month since. The e mail list has grown to 85 persons. While growing need for senior transportation continued to be a focus, other issues identified in the community included the lack of affordable senior housing and lack of sustainable funding for the senior center. This grassroots initiative in the Tipton community has had success in addressing some of the most urgent needs. One of the members of the Community Care Coalition worked with the local senior center to help them write a grant to INDOT for accessible transportation so a second mobility accessible bus could be added. Another has helped the Tipton Council on Aging that operates the senior center better understand their relationship with the Area Agency on Aging in order to improve communication and maximize services from the Area Agency on Aging in the community. As that Board strengthened and better understood how the aging services network functioned, it hired a qualified and ambitious administrator, and the services of the senior center and its senior transportation service improved immensely. Other successes include two affordable senior housing developments coming to the community that total \$9.2 million dollars. In addition, improved relationships with the Area Agency on Aging brought their implementation of a volunteer guardianship program to the community. Finally, in 2018 the Community Care Coalition decided to develop and implement a community education program that became the impetus for developing this guide for Indiana communities. That community education program included two curriculum modules: (1) Developing age-friendly/livable communities for all ages and (2) Helping older adults understand and navigate the health care and aging services in the community.

### *Taking the Tipton Experience Statewide*

The Project Director presented the work of the Tipton Care Coalition and its community education program to the Indiana Commission on Aging in January 2019. By statute, the role of the Indiana Commission on Aging is three-fold: (1) Encourage the study and discussion of the problems of the aging and the aged (2) Promote the organization of and officially recognize voluntary councils for the study and discussion problems of the aging and the aged and (3) Assist the division

(Indiana Division of Aging) in the development of a comprehensive plan to meet the needs of the aged (Indiana Code 12-10-2-7). At the January 2019 meeting, the Commission asked the Project Director to convene a meeting of an advisory group that would work with her to develop a guide to Develop and Implement Living Longer/Living Better Initiatives in Indiana Communities. The advisory committee met in spring 2019 and agreed to assist the Commission with this initiative. The Project Director also worked with the Graduate Nursing Program at Saint Mary's College, Notre Dame, Indiana where she taught a course on Social Determinants of Health and Population Aging in fall 2019. As part of the course, the doctoral nursing students assisted the Project Director with the development of the guide. The Project Director refined the guide and a draft was sent to members of the Advisory Committee in February 2020 for review and comment. The comments of the Advisory Board were incorporated into the Guide, and it was sent to the Commission in March 2020 for review and action.

### Indiana Statewide Needs

Indiana ranked 51st in the Long-term Services and Supports State Scorecard released by AARP in 2017 (AARP, 2017). Because Medicaid is tax funded, the current situation is not sustainable without additional tax revenues. Thus, more services need to be channeled to Medicaid waivers for home and community-based services as increasing numbers of older adults seek these services. Helping older adults and their families understand that more older adults will need to remain in their homes or with their families instead of relying on Medicaid for nursing home care is critical. When state Medicaid funding is overwhelmed, wait lists and/or decreased payments to providers occur. The result is a lack of long-term services and supports for those who rely on Medicaid and other public funding sources. In order to avoid this situation, Indiana communities have an opportunity to take action now as population aging is happening rapidly!

For this reason, the Indiana Commission on Aging is encouraging communities throughout Indiana to become more age and dementia friendly. The Commission is also encouraging communities to initiate grassroots approaches to better integrate health care and aging services so older adults and their families know how to better access services and remain in their own homes or with their families as long as possible. While the Indiana Division of Aging has developed an ambitious state plan to improve this situation, government cannot do this alone. To better address the global phenomenon of population aging, individuals, families, communities, health care providers, and the aging services network need to work together at a local level to develop strategies to improve the quality of life for all

ages in their communities. This guide provides a way to use evidenced-based information based on local needs to structure the integration of health care and aging services at a local level utilizing a person-centered approach that can be customized to fit local culture.

### *Grant to Implement the Guide in Three Indiana Counties*

Through Saint Mary's College, the Project Director also applied for a grant from the Qsource Community Partnership Grant Fund. In 2020, a \$10,000 Qsource Community Partnership grant was awarded through Saint Mary's College that will permit the Project Director to work directly with key stakeholders to initiate and implement this guide in three counties in Indiana projected to have high percentages of older adults by 2050 (STATS Indiana, 2018). These counties are Brown, Randolph, and Marshall. The project report will provide feedback to the Indiana Commission on Aging and the associated Advisory Committee about the use of the Guide in these three counties. Upon approval by the Indiana Commission on Aging, the Guide will be available to communities throughout Indiana. It will be disseminated statewide by the organizations represented on the Advisory Committee.

### **Introduction to the Guide**

While some Indiana communities have initiatives well established that are focusing on age-friendly and dementia-friendly approaches, others have not addressed these issues at all. Likewise, there is variation in community and regional approaches to helping older adults and their families access health care and aging services with a more integrated approach. It may not be necessary to develop separate coalitions in some communities if there are initiatives already in place to address these issues. In those communities, the guide may be a means of supporting the initiatives already underway. In other communities, this guide provides a way to start and implement some initiatives. The guide is intended to be customized to fit the needs and culture of Indiana communities.

This guide is divided into **two sections: (1) Developing age-friendly and dementia-friendly communities and (2) Helping older adults and their families navigate acute and behavioral health care and long-term services and supports in their communities.** The Donabedian (1980) framework is used for both sections of the guide because it provides an evidenced-based method to study and implement changes in three components of both sections: **structure, processes, and outcomes.**



## **Structure**

- For Section I, structure refers to community resources such as number and types of senior transportation services and affordable senior housing units and senior centers, as well as zoning ordinances, local city and county plans that include plans for roads, streets, crosswalks, and signage as well as public library services, food stores, other businesses, and number and types of volunteer activities and opportunities for seniors to be employed part-time. It may also include utilization indicators.
- For Section 2, structure refers to acute health care resources, behavioral health care resources, and long-term services and supports available in the community such as the number and types of primary care providers, hospitals, behavioral health care providers, nursing homes, assisted living facilities, adult day care providers, home health care providers, and home personal care providers. It may also include utilization indicators.

## **Processes**

- For Section 1, processes describe how the needs of seniors are met through these structures.
- For Section 2, processes describe how the acute health care, behavioral health care, and long-term services and supports are delivered and integrated so older adults can easily navigate these services in the community.

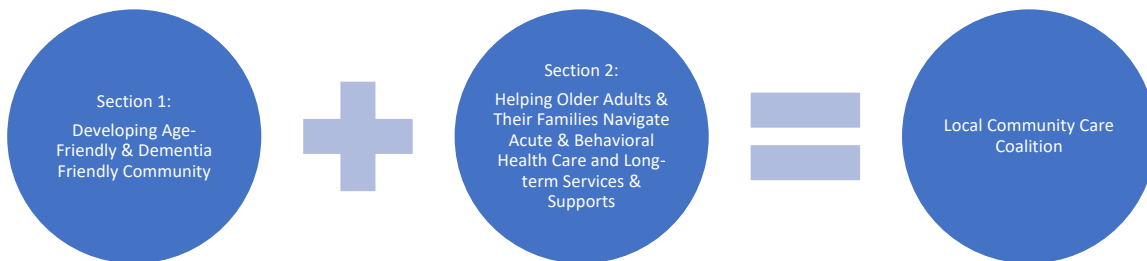
## **Outcomes**

- For Section 1, outcomes refer to the changes in the health status and well-being of community members that may result after evidenced based interventions are initiated in the community to address needed changes in structures and processes and may be measured by health indicators such as

rates of diabetes, rates of end-stage renal disease, and number of pedestrian injuries related to walkability problems in the community.

- For Section 2, outcomes refer to change in health status that may result after evidenced based interventions to address needed changes in structures and processes are initiated in the delivery and integration of the acute health care, behavioral health care (including substance use disorder prevention and treatment), and long-term services and supports available in the community. This may be measured by indicators such as reduced rates of emergency department usage, reduced rates of re-hospitalization, increased rates of screening by primary care offices for depression and dementias in older adults, reduced rates of opioid prescriptions, or increased numbers of older patients having advance care directives.

Organizational Chart for Local Community Care Coalition



Facilitation: The Leadership Team

To use this guide in local communities, facilitators already present in the local community are recommended to provide leadership in each of the sections. **Aging services specialists** (Program Directors, Options Counselors, Care Managers) from

Area Agencies on Aging and APRNs (Advanced Practice Registered Nurses) from local or regional hospitals/health systems are ideal candidates to provide leadership and expertise to utilize the Donabedian framework (**structure, process, outcome**) to identify, implement, and evaluate changes needed at the local level. **These facilitators comprise the Community Care Coalition Leadership Team that can give reports of the work they have been doing at the annual Community Care Coalition meeting. It is recommended that this Leadership Team composed of an Aging Services Specialist from the Area Agency on Aging serving the local community (Section 1) and APRNs from hospitals/health systems (Section 2) meet to plan the annual meeting of the Community Care Coalition. This recommendation is intended for communities starting Community Care Coalitions as well as those that have coalitions underway.** As this **Leadership Team is comprised of already existing resources within local communities in Indiana**, the purpose of the Community Care Coalition is to stimulate innovative community partnerships at the local level that can directly impact needs related to population aging in these communities. The annual meeting of the Community Care Coalition communicates this information to the public.

### **Role of the Aging Services Specialist from Area Agency on Aging**

Within the state of Indiana, there are 16 planning and service areas for the Area Agencies on Aging, and they are served by 15 Area Agencies on Aging (one Area Agency serves two areas). Every other year, these Area Agencies on Aging in Indiana are required to conduct a study of their planning and service areas and to submit a plan for services to older adults in this area. Thus, the Area Agencies on Aging have data related to the social determinants for each community in Indiana. Social determinants that lead to health disparities are recognized situations related to where people live, work, and the systems of care (including acute and behavioral health care as well as long-term services and supports) that are available to them to deal with illness, disease, and disabilities (DHHS, 2018; World Health Organization 2011). Examples of social determinants that are related to health problems for older adults include poverty, low educational level, poor housing, lack of adequate healthy food, lack of transportation, lack of medications, lack of walkability, and social isolation. These problems can lead to poor quality of life, poor self-rated health, multiple chronic diseases, limited access to health care and long-term services and supports, unnecessary risks and vulnerabilities, and premature death. **The Department of Health and Human Services is giving more and more attention to the role that social determinants play in health disparities (DHHS, 2018). Simply put, health care costs are rising partially because**

communities in the United States are not giving enough attention to the social determinants of health.

Because Area Agencies on Aging are deeply involved daily in addressing the needs of the most vulnerable older adults in communities, an aging services specialist from the Area Agency on Aging serving the local community is recommended to give **leadership to Section 1** focused on helping communities become more age-friendly and dementia-friendly. The facilitator would convene a meeting with interested citizens and other invited key stakeholders and share the Area Agency on Aging's plan for the community based on the needs assessment they conducted. Information from Community Health Needs Assessments done by local or regional hospitals/health system ( <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3> ) could also be used in the discussion. Based on this information and additional discussion of those attending the meeting, issues related to helping the community become more age and dementia friendly would be discussed. Action steps to guide this discussion are listed in the next part of this guide. Helpful information from AARP is also included in the action steps. The group would be focused on prioritizing needs such as senior transportation, affordable senior housing, crosswalks or other identified issues. The facilitator from the Area Agency on Aging would act as a source of expertise and connection with additional resources at regional and state levels.

An example of using the expertise of this facilitator involves resources to deal with the need for dementia education. Indiana became the 10th state with a Dementia Friends program in 2017. The initiative was launched in Central Indiana in 2017 by CICOA and expanded in 2019 through partnership with the 15 area agencies on aging serving Indiana (CICOA, 2019). Thus, the aging services specialist from the Area Agency on Aging serving the particular local community can easily access the resources of Dementia Friends Indiana and bring those resources to the local community.

### **Role of the APRN (Advanced Practice Registered Nurse) from Each Local or Regional Hospital/Health System**

The Patient Protection and Affordable Care Act of 2010 includes a provision requiring all nonprofit hospitals to conduct a community health needs assessment (CHNA) and to develop an implementation strategies plan. Thus, nonprofit hospitals are required to conduct a CHNA at least every 3 years and implement strategies to address identified priority needs (Pennel, Burdine, Matarrita-Cascante,

2015). These community health needs assessments include information about health disparities in the community that are related to social determinants of health. In addition, they provide valuable information about the adequacy of structures and processes in place within the hospital/health system as well as its linkages to behavioral health resources and long-term aging services and supports.

The American Association of Colleges of Nursing's (AACN) definition of advanced practice nursing includes identifying and managing health outcomes at the population (community) level (AACN,2004). Thus, APRNs can advocate for needed resources and changes in structures and processes (and policies) by giving **leadership to Section 2** focused on helping older adults and their families navigate health care and long-term services and supports. **Communities with multiple hospitals/health systems may have multiple groups led by APRNs working on issues related to Section 2.** For example, one hospital/health system may be working with the Area Agency on Agency and nursing homes to improve care transitions. Another hospital/health system may be working to improve dementia and depression screening in primary care offices and the emergency department and improved transition processes to behavioral health providers and long-term services and supports. Yet another hospital/health system may identify diabetes management as a priority and may work to improve diabetes education in primary care, acute care, and with collaboration with Diabetes self-management programs offered by Area Agencies on Aging. They may include diabetes cooking classes offered by Purdue Extension. Some hospitals/health systems may decide to focus on multiple issues. Thus, the guide offers flexibility for communities to customize their work according to the needs in the community.

### **Local Community Care Coalition Annual Meeting**

It is recommended that the facilitators involved in Section 1 and Section 2 convene an annual Community Care Coalition meeting and invite local government, businesses, faith communities, and interested community members. This meeting would provide an opportunity for the entire community to learn about the initiatives being implemented to help the community better adapt to population aging and to improve population health through hearing about the work being done in Section 1 and Section 2.

## **Section 1: Developing Age-friendly and Dementia-friendly Communities**

### **Why is it important for communities to become more age-friendly?**

The impetus for efforts to make communities more age friendly arose in 2000 when the United Nations and World Health Organization began to focus on “active aging.” This concept emphasizes ways in which many older adults continue to be physically active, employed, and more generally engaged in civic and economic life. The World Health Organization published a research report presenting a multidimensional framework for age friendliness in 2005. To support localities’ work toward becoming more age friendly, the World Health Organization launched its Global Network of Age-Friendly Cities and Communities in 2010, and it now includes over seven hundred communities across thirty-nine countries. In the United States, AARP launched its own U.S. network of Age-Friendly Cities and Communities. This network began with just six members in 2012 and now has approximately 300 affiliates (Greenberg, 2018). In addition, the National Association of Area Agencies on Aging developed a publication titled “A Blueprint for Action: Developing a Livable Community for All Ages” (National Association of Area Agencies on Aging, 2006). Recently, attention has been brought to the need for communities to give attention to factors that contribute to the social determinants of health such as adequate housing, transportation, nutrition, and income security (HHS, 2018). While these social determinants of health apply to all age groups, this particular guide is focusing on older adults. A suggested starting point for the discussion of this group is to focus on the current and projected population demographics for your community. Your Area Agency on Aging Facilitator has access to this information.

### **Why is it important for communities to become more dementia-friendly?**

Dementia Friends USA is a worldwide movement that is changing the way people think, act, and talk about dementia. It was developed by the Alzheimer’s Society in the United Kingdom and is now underway in the USA. By helping everyone in a community understand what dementia is and how it affects people, each of us can make a difference for people touched by dementia (Dementia Friends USA). In

Indiana, this initiative has become the Dementia Friends Indiana program and is available through CICOA, the Central Indiana Council on Aging, and its partnerships with all the other Area Agencies on Aging in Indiana. The Facilitator for this work group can easily access the resources of this Dementia Friends Indiana program for your local community. The incidence of dementias rises with advancing age so attention to this issue is essential for local communities so all sectors of the community are prepared to encounter it positively (Dementia Friends Indiana).

### Action Steps for Facilitator (Aging Services Specialist) for Section 1

#### **I. Identify and invite key stakeholders in local community to initial meeting**

Members could include county commissioners, mayors, city and county planners, police and fire and EMS administrators, county health departments, local senior centers, local senior transportation providers, Purdue Extension county educators, representatives of faith communities, members of civic groups, senior housing administrators, Chamber of Commerce (business leaders), public libraries, and other interested community members including Medicare beneficiaries. Local members of the Area Agency on Aging's advisory board or Board of Directors would also be valuable participants for this group. A staff member from Qsource is recommended to be included as a member of Section 1 also because they bring an added dimension of population health to the work of the group. Administrators and staff from hospitals/health systems such as social workers, administrators and staff from behavioral health providers, and administrators and staff from long-term service providers also bring vitally important contributions.

#### **II. Introductions**

#### **III. Assess Your Community's Progress Toward Becoming Age and Dementia Friendly:**

A. Review the Area Agency on Aging Plan for your local community

B. Review the local hospital's Community Health Needs Assessment (CHNA) for your local community

C. List the 8 Domains of a livable community using AARP material. (Prior to the meeting, download a PDF of an "Introduction to the 8 Domains of Livability" from AARP)

<https://www.aarp.org/livable-communities/network-age-friendly-communities/info-2016/8-domains-of-livability-introduction.html>

# The 8 Domains of Livability

The availability and quality of these community features impact the well-being of older adults — and help make communities more livable for people of all ages



1. Outdoor Spaces and Buildings

2. Transportation

3. Housing

4. Social Participation

5. Respect and Social Inclusion

6. Civic Participation and Employment

7. Communication and Information

8. Community and Health Services

**IV. Discuss each domain with the group using the Donabedian framework to assess structures, processes, and outcomes by utilizing the AARP Roadmap to Livability Collection.**

<https://www.aarp.org/livable-communities/tool-kits-resources/info-2017/roadmap-to-livability-collection.html>

In addition, the Aging Services Specialist can access resources from Dementia Friends Indiana and other resources related to dementias that are available in your community so you can use these resources in this discussion also.

**IV. Identify one or two initiatives that the group prioritizes to address to make your community more age-friendly and dementia-friendly over the next year.** (Based on the initiatives chosen, be sure there is baseline data so there is a way to analyze change.)



For example, who provides senior transportation in your community (**structure**), and how is this service delivered (**processes**). Senior transportation (**outcome**) would need to be defined. Use the AARP transportation workbook that will provide a way to assess structures, processes, and outcomes related to senior transportation.

<https://www.aarp.org/content/dam/aarp/livable-communities/livable-documents/documents-2018/Book-4-Roadmap-to-Livability-Transportation-051118lr.pdf>

A. Organize a task group to work on each initiative. The group should have a designated leader and members.

B. These task groups should identify times and places to meet.

C. Ask each task group to utilize a SMART Approach (MacLeod, 2012) to define the operationalization of these initiatives (with associated outcomes)

- \*Specific
- \*Measurable
- \*Achievable
- \*Realistic
- \*Timely

D. Ask each task group to evaluate initiatives by reporting changes (include both quantitative and qualitative analysis-in other words both numbers and stories)

E. Ask each task group to prepare a report for the Annual Care Coalition Meeting

**V. Meet with the facilitators for Section 2 to arrange and organize the annual local care coordination meeting.**

**VI. After the annual meeting, reconvene Section 1 and reassess the need to continue on-going initiatives and/or identify new initiatives.** In this way, the efforts are sustained as long as needs are identified in the local community.

## **Section 2: Helping Older Adults and Their Families Navigate the Acute Health Care and Long-term Services and Supports in Their Communities**

This section of the guide is focused on the work of Section 2 led by APRNs from the hospital/health systems serving the local community. It provides steps that can be used to identify one or two initiatives that they will implement to help older adults and their families more easily navigate acute and behavioral health care and long-term services and supports in the local community. It is suggested that an aging services specialist from the Area Agency on Aging serving the local community be involved as a member for these work groups as well as key nursing staff including the hospital's emergency department and an MSW medical social worker from the hospital staff. A staff member from Qsource (contracted with the Centers for Medicare and Medicaid Services to work with hospitals/health systems, primary care providers, and nursing homes to improve the quality of care for Medicare beneficiaries across the state of Indiana) is recommended to be included as a member of this work group also. Other members could include members of the hospital's patient and family advisory council (Feinberg, 2017), and administrators and staff from aging services providers (nursing homes, assisted living, adult day care, home health care and hospice, personal home care providers, emergency medical response teams), administrators and staff from behavioral health providers, and others that serve the local community. It is recommended that the work done in Section 2 be presented to the Local Community Care Coalition annually so information regarding their work is shared with a wider audience.

### *Action Steps for Facilitators (APRNs) for Section 2*

#### **I. Identify and invite key stakeholders in local community to initial meeting**

Members could include staff from the hospital's emergency department, nurse care managers, hospital social workers, and other key staff members involved in care transitions. It could also include members of the hospital's patient and family advisory council (Feinberg, 2017), and administrators and staff from aging services providers (nursing homes, assisted living, adult day care, home health care and hospice, personal home care providers, emergency medical response teams),

administrators and staff from behavioral health providers, and others that serve the local community. A staff member from Qsource (contracted with the Centers for Medicare and Medicaid Services to work with hospitals/health systems, primary care providers, and nursing homes to improve the quality of care for Medicare beneficiaries across the state of Indiana) is recommended to be included as a member of this work group also. It is suggested that an aging services specialist from the Area Agency on Aging serving the local community also be involved as a member because the Area Agency on Aging is essential to linking older adults with home and community-based long-term services and supports.

## **II. Introductions**

### **III. Review your hospital's Community Health Needs Assessment (CHNA) for your local community**

### **IV. Review the Area Agency on Aging Plan for your local community (Ask the Aging Services Specialist from the Area Agency on Aging to present this information)**

### **V. Ask Qsource to discuss the quality improvement work they are promoting in the local community**

### **VI. Identify one or two initiatives that your group will address over a one year period. (Based on the initiatives chosen, be sure there is baseline data so there is a way to analyze change.)**

Examples of initiatives could include:

- \*attention to health and behavior assessments in primary care visits and the emergency department that involves screening for depression, dementias, and substance use disorders and integration with behavioral health services (“warm hand-offs”)
- \*attention to evidenced-based chronic disease self-management education coordinated between the health system and offered by the Area Agency on Aging
- \*attention to advance directives involving education and assistance around the importance of completing advance directives, the different types of directives, and how to identify which directive is most appropriate for the individual
- \*attention to issues related to Indiana's CARE Act and support

of family caregivers (AARP, 2016)

\*attention to health promotion related to obesity, diabetes, and smoking (Lewin Group, 2019 study supported by Indiana Hospital Association)- perhaps community nutrition education coordinated between hospital/health system and Purdue Extension

**VII. Discuss each initiative with the group using the Donabedian framework assess structures, processes, and outcomes.**

For example, who provides screening for depression, dementias, and substance abuse disorders within the hospital/health system (**structure**), and how are referrals made to behavioral health services and long-term services and supports (**processes**). **Outcomes** would need to be clearly defined and measured. Evidenced-based interventions are recommended and are available to APRNs in the professional nursing and care transitions literature. The Aging Services Specialist from the Area Agency on Aging can bring attention to the Aging and Disability Resource Centers located throughout the state that help families utilize home and community-based services as long as possible before institutional care is used.

A. Organize a task group to work on each initiative. The group should have a designated leader and members.

B. These task groups should identify times and places to meet.

C. Ask each task group to utilize a SMART Approach (MacLeod, 2012) to define the operationalization of these initiatives (with associated outcomes)

\*Specific

\*Measurable

\*Achievable

\*Realistic

\*Timely

D. Ask each task group to evaluate initiatives by reporting changes (include both quantitative and qualitative analysis-in other words both numbers and stories)

E. Ask each task group to prepare a report for the Annual Care Coalition Meeting

**VIII. Meet with the facilitator of Section 1 (and other Section 2 facilitators if there is more than 1 hospital/health system in the community) for a Leadership Team Meeting to finalize plans for the annual Local Community Care Coalition meeting.**

**IX. After the annual meeting, reconvene your group and reassess the need to continue on-going initiatives and/or identify new initiatives. In this way, the efforts are sustained as long as needs are identified.**

## Resources for Those Using this Guide

### AARP Livable Communities Contact Information

<https://www.aarp.org/livable-communities/>

Phone number: 866-448-3618

### Dementia Friends Indiana Contact Information

<https://www.dementiafriendsindiana.org/>

Phone number: 317-254-5465

e mail: [dfi@cicoa.org](mailto:dfi@cicoa.org)

### Indiana Area Agency on Aging Directory

<https://www.in.gov/fssa/inconnectalliance/886.htm>

### Indiana Association of Area Agencies on Aging Contact Information

<http://www.iaaaa.org/>

Phone number: 317-205-9201

e mail: [info@iaaaa.org](mailto:info@iaaaa.org)

### Indiana Division of Aging Contact Information

<https://www.in.gov/fssa/2329.htm>

Toll free number: 888-992-6978

### Indiana Hospital Directory

<https://www.in.gov/isdh/reports/QAMIS/hosdir/>

(Some communities are served by hospitals outside their counties so will not be listed. In that case, look at hospitals in adjacent counties.)

### Indiana Rural Health Association Contact Information

<https://www.indianaruralhealth.org/>

Phone number: 812-478-3919

[info@indianarha.org](mailto:info@indianarha.org)

### Purdue Extension County Office Directory

<https://extension.purdue.edu/about>

### Qsource Contact Information

Mitzi Daffron, Task Order Director

Phone number: 812-239-5757

e mail: [mdaffron@qsource.org](mailto:mdaffron@qsource.org)

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