



Training HPPAE Students in Health Care Settings: Looking Back and Moving Forward

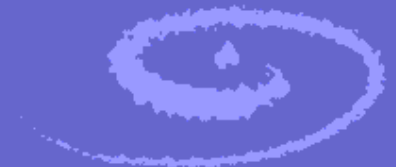
2014 CSWE Annual Program Meeting

October 24, 2014

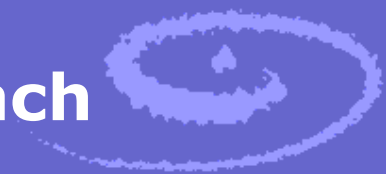


Welcome

- This session will explore past, present, and future opportunities for HPPAE students in health care settings
- HPPAE Background...

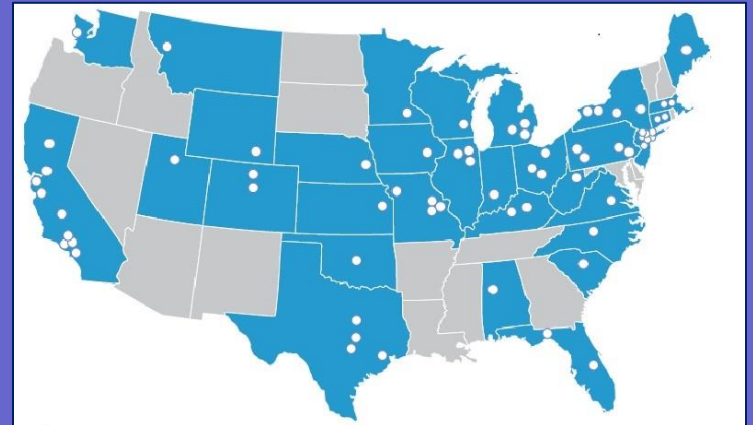


What is HPPAE?

- **A university and community partnership based on a collaborative educational model**
 - **Recruits MSW students to specialize in aging**
 - **Plays leadership role in national efforts to advance aging education in social work**
 - **Employs competency-based training**
 - **Offers a unique rotational approach to field education**
- 

HPPAE Outcomes

- Over the course of 12 years (2000–2012), 69 schools of social work in 33 states received funding to implement HPPAE
- By spring of 2012 approximately 2,600 HPPAE students graduated
- The HPPAE has been initiated in a total of 97 programs in 37 states



HPPAE Outcomes

- **Deans and Directors:**

- **89% report a positive impact on curriculum**
- **98% report a positive impact on field instruction**
- **100% report a positive impact on student learning**

- **Students**

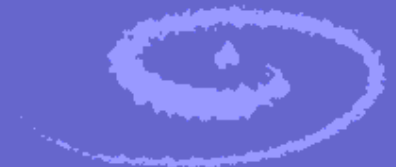
- **92% of students agree that the rotations enabled them to learn about the range of services for older adults**

"[The rotation] experiences have had a great influence on my understanding of social work."

(Impact of HPPAE on Social Work Education, 2013)

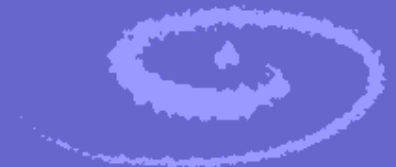
HPPAE: Goals and Strategies

- **Institutionalize HPPAE within the CSWE Gero-Ed Center to ensure the ongoing and continued development of the social work workforce with aging expertise**
- **Implement the HPPAE in 12 GRECC sites and 3 non-GRECC sites by 2015**



Presenters

- **Victoria Rizzo, PhD, LCSW-R; Binghamton University, State University of New York**
- **Marilyn Luptak, PhD, MSW; University of Utah**
- **Robyn Golden, LCSW, MA; Rush University Medical Center**
- **Paul Gould, PhD, LCSW; Binghamton University, State University of New York**





Setting the Stage: *Studies of the Cost-Effectiveness of Social Work Services in Aging: An Updated Review of the Literature*



**Victoria Rizzo, PhD, LCSW-R
Department Chair and Associate Professor
Department of Social Work
Binghamton University, State University of New York**

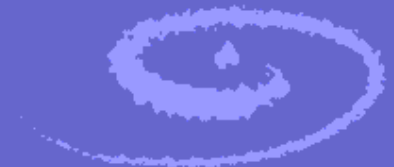


October 24, 2014



Acknowledgements

- The work presented here is based on two systematic reviews:
 - Rizzo, V., & Rowe, J. (2006). Studies of the efficacy of social work services in aging with a focus on cost outcomes: A review of the literature. *Research on Social Work Practice, 16*, 67–73.
 - Rizzo, V. & Rowe, J. (in press). Cost-effectiveness of social work services in aging: An updated systematic review. *Research on Social Work Practice*.



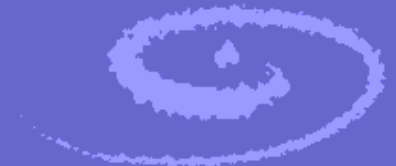
Background

- **2006 systematic review**
- **Included 40 articles reporting results of 34 studies published from 1987 to 2003**
- **Review revealed social work interventions can have positive impact on quality of life, health care costs, and**
- **use of health care services**
- **1/3 of articles included cost outcomes**



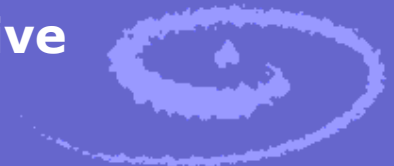
2013 Update of 2003 Study

- **Precipitating Events:**
 - **Passage of the Affordable Care Act (ACA)**
 - **Completion of the Hartford Social Work Geriatric Initiative (HGSWI)**
 - **IOM Report: Retooling for an Aging America**



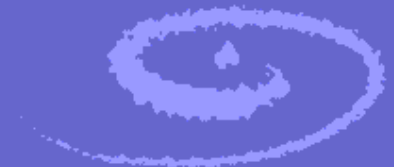
Systematic Review

- **46 articles report results of 44 studies in four categories:**
 - 1) Health (31 articles/28 studies)**
 - Care coordination (13 articles/10 studies)
 - End-of-life/palliative care/advanced illness (10 articles/studies)
 - Transitions in care (four articles/studies)
 - Disease management/other (four articles/studies)
 - 2) Depression/mental illness (seven articles/studies)**
 - 3) Caregiving (three articles/studies)**
 - 4) Geriatric evaluation and management (five articles/studies)**



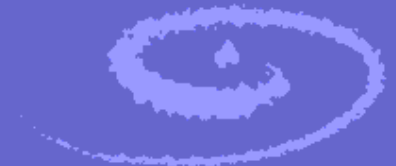
Quality of Life (QOL) Outcomes

- **63% of articles ($n = 29$) reported at least one positive QOL outcome (i.e., general health, mental health, mortality).**
- **25% ($n = 11$) reported positive outcomes for treatment planning and/or adherence.**
- **One study reported impact of social work processes in hospice setting on patient outcomes.**



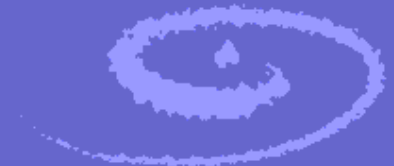
Cost Outcomes

- **14 articles in three intervention categories reported positive and significant cost outcomes**
- **Health: care coordination ($n = 7$), end-of-life/palliative care/advanced illness ($n = 5$)**
- **Caregiving ($n = 1$)**
- **Geriatric Evaluation and Management ($n = 1$)**



Cost Outcomes

- **Outcomes included:**
 - **Decrease in hospital admissions**
 - **Decrease in length of stay**
 - **Decrease in cost of care**
 - **Decrease in ED visits**
 - **Decrease in service utilization**
 - **Decrease in nursing home placement/length of stay/costs**



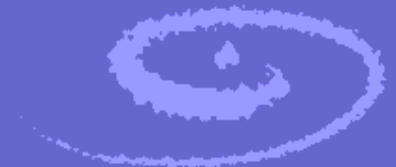
Questions?

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Training HPPAE Students as Care Managers in a Medical Home Model for Low-Income Older Adults

Marilyn Luptak, PhD, MSW
Associate Professor and Chair, MSW Aging Concentration
Hartford Geriatric Social Work Faculty Scholar
College of Social Work, University of Utah

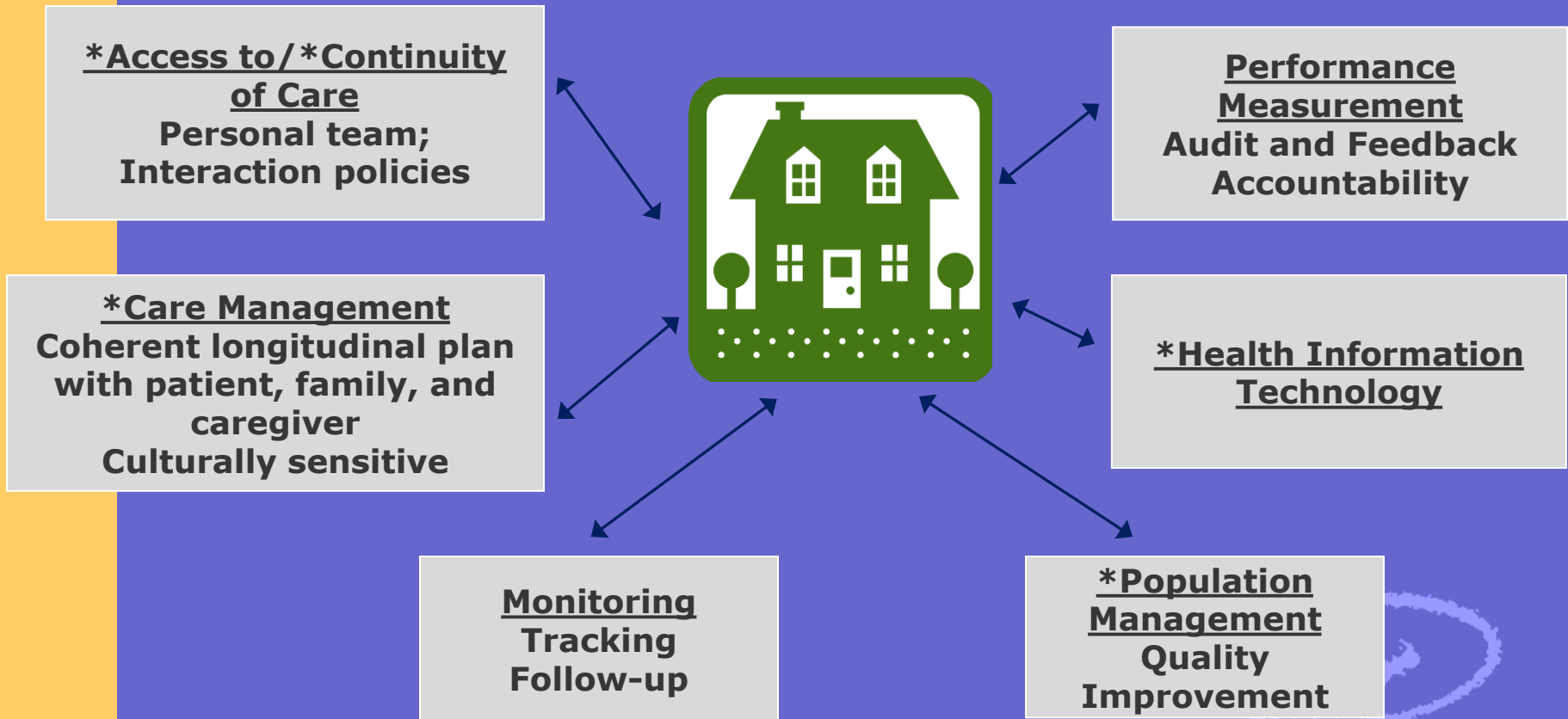
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Patient-Centered Medical Home Model

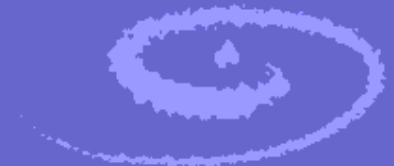
Health care teams partner with patients and caregivers to ensure that all of their health care is effectively managed and coordinated

*Features that correspond to lower costs



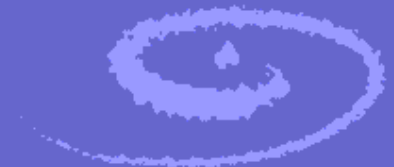
Development and Enhancement of a Medical Home Model for Low-Income Older Adults

- **University of Utah Center on Aging 2010 Pilot Grant Program:**
 - \$20,000
 - 07/01/10–06/30/11
- **Principal Investigators:**
 - Marilyn Luptak & Fran Wilby (College of Social Work)
- **Co-Investigators:**
 - Carole Stipelman (School of Medicine)
 - Gillian Tufts (College of Nursing)
 - Naomi Silverstone (College of Social Work)
- **Community-Based Research (CBR) Partner:**
 - Community Health Centers, Inc. (CHC) provides primary health care to uninsured, low-income families



Study Goals

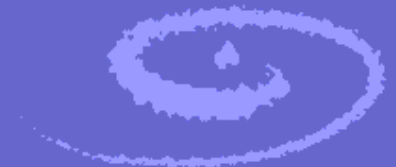
- **Examine the impact of HPPAE Student Care Managers on urgent care service utilization and rehospitalization among chronically ill older patients receiving care in a low-income community health center.**
- **Analyze demographic and health-related variables as predictors of urgent care service use and rehospitalization.**



Study Goals

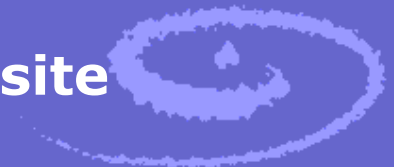
■ Relevance:

- **Two-thirds of adults aged 65+ have multiple chronic illnesses.**
- **The current health care system is ill-equipped to manage chronic disease in older adults.**
- **The PCMH model may improve the quality, efficiency, and health-related outcomes of care for these older adults.**



Community-Based Research (CBR) Study Design

- **Approved by the University of Utah IRB and the CHC Board of Directors**
- **Geographic Information System mapping to determine density of older adults living in the study site areas**
- **Two CHC sites in Salt Lake City**
 - **Intervention site: Stephen D. Ratcliffe (SDR) CHC**
 - **Non-intervention site: Central City CHC**
- **Convenience sample of adults, age 65 and older, at SDR and Central City**
- **Target enrollment: 100 participants per site**



Care Management Plus Model

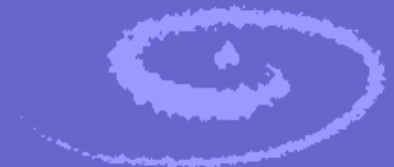
We adapted the Care Management Plus (CMP) model: A team-based approach, which fills in core gaps through a proactive, flexible system.



Teamwork and culture surrounds ALL!

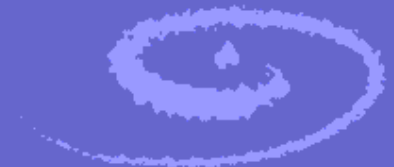
Preparing HPPAE Students to be Care Managers

- Six second-year MSW HPPAE Students completed 8 weeks of CMP curriculum
- Online modules with case discussions/assignments:
 - Role of Care Manager
 - Motivational Interviewing/Coaching
 - Chronic Disease Management and Geriatric Assessment/Tools
 - Family Assessment and Caregiver Support
 - Connection to Community Resources
- Topics included pain, palliative and hospice care, advance directives, hypertension, asthma, and COPD



Implementing the CMP Model at SDR CHC

- **HPPAE Student Care Managers were at SDR 4 days per week**
- **HPPAE Student Care Managers interacted with participants in the clinic, on the phone, and occasionally in patients' homes**
- **Referrals came through clinic data query, provider referral, and outreach**



Challenges...

- **Numerous players:**
 - **Clinic personnel including doctors, PA's, nurses, medical assistants, and administrative personnel**
 - **University personnel and regulations**
- **Multiple cultural backgrounds and ethnicities**
- **Two sites: SDR CHC and Central City CHC with different study procedures at each site**



Participant Characteristics $N = 102$

Age:

- 60-69 $n = 43$ (42.2%)
- 70-79 $n = 44$ (43.1%)
- 80-89 $n = 15$ (14.7%)

Gender:

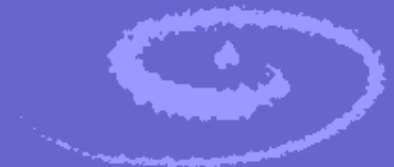
- Females $n = 70$ (68.6%)

Ethnicity:

- Hispanic $n = 64$ (62.7%)
- White $n = 28$ (27.5%)
- Asian $n = 9$ (8.8%)
- Black $n = 1$ (1%)

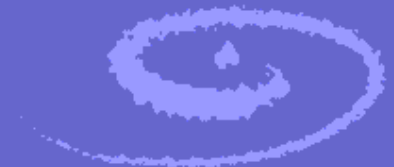
Marital Status:

- Married $n = 49$ (48%)



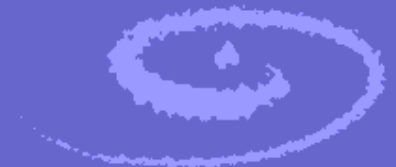
Salient Care Manager Interventions

- **Assisting participants to apply for and/or navigate Medicare and Medicaid**
- **Educating participants on how to access clinic services regardless of insurance status**
- **Securing prescription assistance for participants**
- **Connecting participants to community based resources (e.g., transportation, heat assistance, dental services)**
- **Advocating for participants with primary care physicians, pharmacies, home health agencies, etc.**



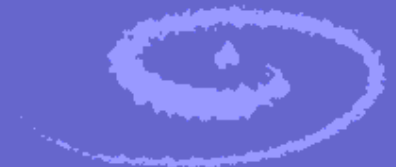
Intervention: Community-Based Services

Mrs. A came to SDR CHC in distress because her furnace had gone out that morning as temperatures plummeted in SLC. She is 75 years old, on a fixed income, and lives in a trailer. We met with her immediately to identify possible resources and printed off and completed a weatherization application from Salt Lake Community Action Program website. We then called and advocated for her with Community Action staff. She turned in her application with the required documentation and it was approved. The program responded to her needs the very same day. Her furnace is fixed and she is staying warm. She is very grateful for the help she found in her time of need.



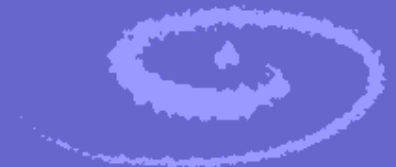
Intervention: Medication Assistance

Mr. B, a 66 year-old Hispanic male, came to SDR very confused about Medicare Part B premiums and the reasons for these outstanding bills. He was also off his diabetes and depression medications for 15 days prior to his clinic visit. On the first day, we found medications for him through a variety of drug companies who offered medications at a reduced rate, and he returned to the recommended medication regimen. He has followed up monthly since joining the study.



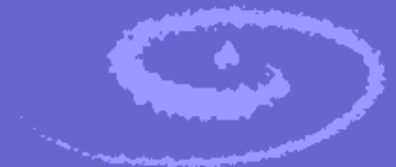
Intervention: Transportation

Mr. C came to the clinic needing medical transportation for him and for his wife. Both are over age 65 and are enrolled in the study. After the initial interview, we contacted Salt Lake County Aging Transportation service and Mr. and Mrs. C were signed up for medical transportation. A detailed instruction list was given to the couple so they could access medical transportation for future medical appointments.



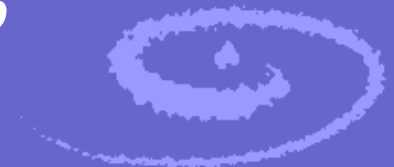
Interventions: Advocacy

Mr. D, a 69 year-old Vietnamese clinic patient, spoke very little English. He had worked at a local hotel for more than 10 years. With the assistance of a translator, Mr. D communicated to the care manager his immediate need for an official medical letter indicating he would be unable to return to work because of his pending heart surgery. He was afraid of losing his job. We intervened immediately with his PCP who wrote a letter regarding Mr. D's serious medical condition and he was excused from work until the first part of May following his heart surgery in March.



HPPAE Care Manager Reflections

- **Medical staff were resistant to making referrals to the study: *“Few referrals were given by the medical team, however, close to the end of the study, the medical staff started to give some referrals.”***
- ***“Being a care manager for the participants in the study brought mixed emotions. Finding resources that were available and useful was great and all participants were very appreciative for... resources offered. However, there were... participants who did not qualify for additional resources due to extenuating circumstance, and not being able to help was difficult.”***



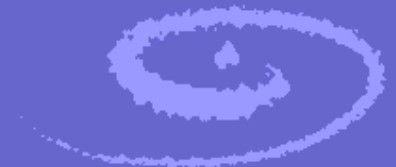
Questions?

- **Contact Information:**

Marilyn Luptak

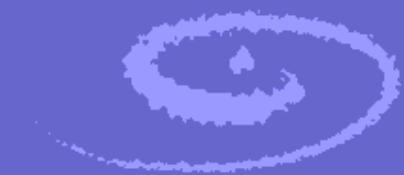
Tel: 801-581-3645

E-mail: marilyn.luptak@socwk.utah.edu



Selected References

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- PCMH Demonstration Guidelines. Retrieved from <http://www.pcpcc.net/content/pcmh-demonstration-guidelines>





Working With HPPAE Students at Rush University Medical Center



Robyn Golden, LCSW, MA
Director of Health and Aging
Rush University Medical Center



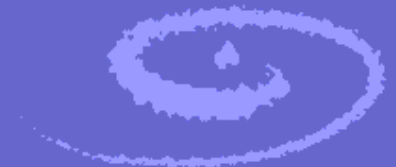
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Progress Made by HPPAE and Other Older Adult-Specific Programs

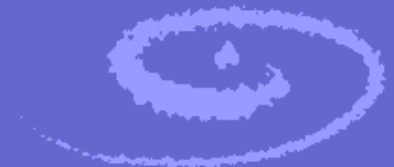
Institute of Medicine report *Retooling for an Aging America: Building the Health Care Workforce* (2008):

“The education and training of professionals in geriatrics has improved because of **the expansion of school-based opportunities, increased efforts in interdisciplinary training, and the development of alternative pathways to gaining geriatric knowledge and skills.**”



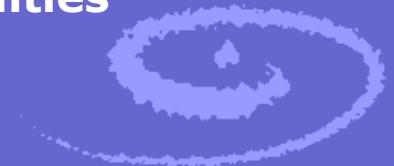
Need for HPPAE, Older Adult-Specific Programs

- **Projected shortage of geriatric providers, especially social workers**
- **Distinct concerns of older adults**
 - **Need for geriatric-specific training**
 - **Based on geriatric core competencies**
- **Range of field experiences to become familiar with entire continuum of care and range of services**



Social Work Core Competencies

- Identify as a social worker and conduct self accordingly
- Apply social work ethical principles to guide professional practice
- Apply critical thinking to inform and communicate professional judgments
- Engage diversity and difference in practice
- Advance human rights and social and economic justice
- Engage in research-informed practice and practice-informed research
- Apply knowledge of human behavior and the social environment
- Engage in policy practice to advance social and economic well-being and to deliver effective social work services
- Respond to contexts that shape practice
- **Engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities**



Social Work Practice Behaviors

Practice Behaviors under the core competency “engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities”:

Engagement

- Substantively and affectively prepare for action with individuals, families, groups, organizations, and communities
- Use empathy and other interpersonal skills
- Develop a mutually agreed-on focus of work and desired outcomes

Assessment

- Collect, organize, and interpret client data
- Assess client strengths and limitations
- Develop mutually agreed-on intervention goals and objectives
- Select appropriate intervention strategies

Intervention

- Initiate actions to achieve organizational goals
- Implement prevention interventions that enhance client capacities
- Help clients resolve problems
- Negotiate, mediate, and advocate for clients
- Facilitate transitions and endings

Evaluation

- Critically analyze, monitor, and evaluate interventions



Geriatric Social Work: Core Competencies

I. VALUES, ETHICS, AND THEORETICAL PERSPECTIVES

Knowledge and value base, which is applied through skills/competencies.

II. ASSESSMENT

III. INTERVENTION

IV. AGING SERVICES, PROGRAMS, AND POLICIES

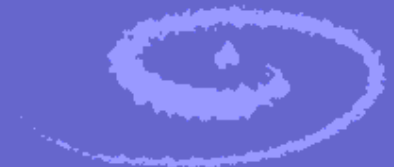
V. LEADERSHIP IN THE PRACTICE ENVIRONMENT OF AGING

Leadership skills are lifelong learning objectives for which a foundation is laid in social work education. Competence is built over years of practice and continuing education.

4. Plan strategically to reach measurable objectives in program, organizational, or community development for older adults.
5. Administer programs and organizations from a strength's perspective to maximize and sustain human resource (staff and volunteers) and fiscal resources for effectively serving older adults.
6. Build collaborations across disciplines and the service spectrum to assess access, continuity, and reduce gaps in services to older adults.
7. Manage individual (personal) and multi-stakeholder (interpersonal) processes at the community, interagency, and intra-agency levels in order to inspire, leverage power, and resources to optimize services for older adults.
9. Advocate with and for older adults and their families for building age friendly community capacity (including the use of technology) and enhance the contribution of older persons.

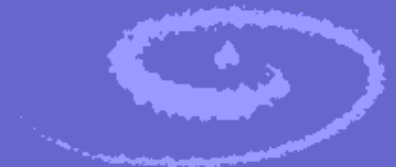
Rush University Medical Center

- Large urban hospital with 676 beds, 27 care units
- Hospital located in diverse neighborhood of Chicago
- Resource centers available to clients and family members
- Diverse socioeconomic, cultural, racial, and ethnic attitudes and educational background of clients



“The hospital of the future will be a health center, not just a medical center ... the hospital will offer valuable resources to the community on matters of health and well-being, and will be held increasingly accountable for the community’s health status.”

—Shi & Singh, 2004



Rush Health and Aging

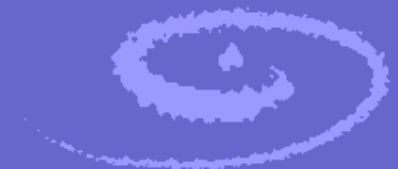
- **Rush Health & Aging programming using SW:**
 - **Inpatient:**
 - **The Bridge Model of transitional care**
 - **Outpatient:**
 - **Ambulatory Integration of the Medical and Social (AIMS) Program**
 - **BRIGTHEN Project**
 - **Resource Centers**
 - **Program Development & Grant Writing**
- **Effort toward developing, testing, and disseminating evidence-based programs**



HPPAE @ Rush: Grisel

Example: Grisel

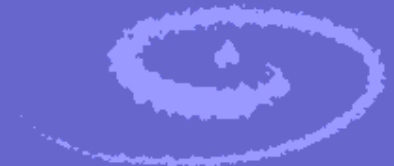
- HPPAE student from Loyola University Chicago School of Social Work
- Field placement at Rush
- Worked with BRIGHTEN
- Now, clinical social worker with AIMS Program



HPPAE @ Rush: Anne



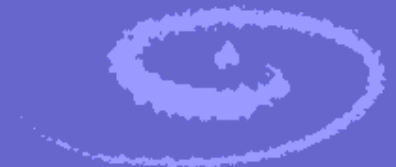
- **HPPAE student at Loyola**
 - Became aware of Rush's reputation as the place to be for innovation in social work with older adults
- **Has been staff since 2010**
 - Started with BRIGHTEN program
 - Later, managed the Resource Centers
- **Now is in a leadership position as the Manager of Social Work Services**



Employer Perspective

“When students graduate they have a solid understanding of services available to seniors and the barriers they face, experience challenging myths of aging, and a ready made network of colleagues in the field of aging.”

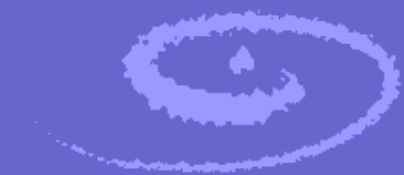
– Anne, Manager of Social Work Services



HPPAE Made Progress, but We Need to Continue to Grow Programming

2008 Institute of Medicine report *"Retooling for an Aging America: Building the Health Care Workforce"*:

- "The education and training of professionals in geriatrics has improved because of **the expansion of school-based opportunities, increased efforts in interdisciplinary training, and the development of alternative pathways to gaining geriatric knowledge and skills.**"
- "Even so, the committee concludes that in the education and training of the health care workforce, geriatric principles are still **too often insufficiently represented in the curricula, and clinical experiences are not robust.**"



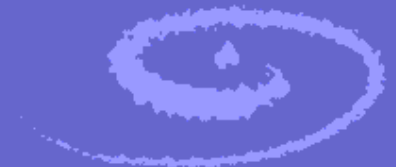
Questions?

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HPPAE-ly Aging

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Binghamton University, State University of
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October 24, 2014



Interprofessional Practice and Healthy Aging

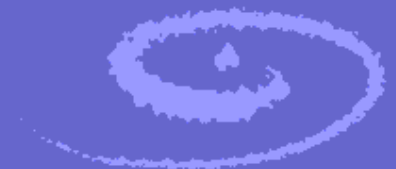
Opportunities for HPPAE students:

Primary Care Medical Home (PCMH)

Program for All-Inclusive Care of the Elderly (PACE)

Integrated Health Care Teams

HPPAE students in agencies that don't employ MSWs



Linking HPPAE Students With Aging Research



New placements associated with research studies

Faculty Field Supervisors



Incorporate stipends in study's budget

HPPAE students conduct intervention



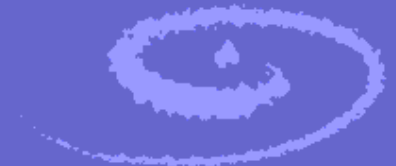
Pathways Project: Building Connections in Families Living With Dementia

- Recruit families for the study
- Conduct assessment, collect baseline data
- Eight-week arts-based intervention provide in group format:
 - Stimulate cognitive functioning
 - Facilitate socialization
 - Facilitate mutual aid
 - Enhance intra-familial communication
- Conduct final interviews, collect comparison data



Hospital 30-Day Readmission Reduction Study

- HPPAE students recruit study participants
- Follow a 30-day intervention protocol
 - Initial contact in hospital prior to discharge
 - Phone call to patient within 7 days of discharge
 - Home visit within 14 days of discharge
 - Follow-up phone call within 21 days of discharge
 - Additional contacts as needed within 30 days of discharge



Hospital 30-Day Readmission Reduction Study

- **Students assist patient /caregiver in resolving needs related to discharge plan and chronic disease management**
- **Identify and implement effective communication strategies with health care providers**
- **Identify additional resources**
- **Assess home safety and functioning**
- **Address mental health needs**



Questions?

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